The impact of sociocultural weight and body shape values on body dissatisfaction and eating behaviour, moderated by self-compassion in UK women with South Asian heritage

Beth Alice Pearson

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

The University of Leeds

School of Medicine

Supervised by: Dr Fiona Trew, Dr Gary Latchford and Dr Fameeda Ansari

June 2024

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.

Acknowledgments

I would first like to thank my friends and family who have been checking in on my progress and mental wellbeing throughout this whole journey! Your confidence in me and constant encouragement has given me the strength to keep pushing through every rough patch. A huge thank you to my husband, Steve, who has been my rock throughout all the ups and downs. You know what I need when I don't myself and I couldn't be more grateful for all the support you've given me emotionally and practically. Not to mention my cats, Arnie and Arlo, who are always next to me with a listening ear and a calming purr while I write!

I am so grateful to my supervisors Fiona and Gary, who have always lifted my confidence and have been my biggest cheerleaders. I have always walked away from thesis meetings with a huge smile on my face and that's all thanks to the amazing support you've given me. I would also like to say thank you to Fameeda, who kindly offered her time to support this project and share her expert guidance, giving me increased confidence in my language use and knowledge of the area.

I would also like to thank my friends Aieshah and Ramsha for inspiring me with your enthusiasm and passion around this topic and for sharing it far and wide to help recruitment. Lastly, a massive thank you to all the wonderful women who gave up their time to participate in this study and shared their experiences to support my project and the expansion of the research field.

Abstract

The impact of sociocultural factors on body image and eating behaviour has been extensively researched within White Western populations for decades. Only recently has the gap in understanding the experiences of women from South Asian (SA) heritage been explored. Research has revealed the conflicting experiences of women with SA heritage, who often experience feeling caught between two pervasive societal narratives. The pressures to conform to cultural values and beauty standards within SA tradition and Western society have been found to result in body dissatisfaction and eating behaviour difficulties. This thesis investigated the impact of sociocultural weight and shape attitudes from peers, the media and family, marriage pressures and cultural identity conflict, on aspects of body image and eating behaviour in women with SA heritage in the UK. It also explored the role of self-compassion as a moderator between these sociocultural influences, aspects of body image and eating behaviour.

Cross-sectional quantitative data was collected across the UK via a range of online forums and nationwide Universities. The online survey included the Sociocultural Attitudes Towards Appearance Questionnaire – 4R (SATAQ-4R), the marriage subscale in the Cultural Values Conflict Scale (CVCS-M), the Ethnocultural Identity Conflict Scale (EICS), the Eating Attitudes Test (EAT-26), the Multidimensional Body Self Relations Questionnaire–Appearance Scales (MBSRQ–AS) and the Self Compassion Scale (SCS).

A total of 89 participants completed the survey. The findings suggested that those who experience cultural identity conflict were more likely to have difficulties with eating behaviour and those with increased marriage and media appearance pressures resulted in the likelihood of experiencing overweight preoccupation. Findings also indicated that self-compassion may help to moderate the impact of societal narratives around weight and shape

from peers, leading to women with SA heritage feeling more satisfied with areas of their body.

This thesis builds on the foundational evidence within the research field exploring the impact of sociocultural factors on body image and eating behaviour in SA women in the UK. Addressing this research gap is a crucial step in widening access to services and reducing inequalities in the healthcare system in the UK.

Contents

List of Figures

List of Tables

List of Abbreviations

Abbreviation	Meaning
AN	Anorexia Nervosa
BASS	Body Areas Satisfaction Scale
BED	Binge Eating Disorder
BMI	Body Mass Index
BN	Bulimia Nervosa
CBT	Cognitive Behavioural Therapy
CFT	Compassion Focused Therapy
CVCS	Cultural Values Conflict Scale
CVCS-M	Cultural Values Conflict Scale -Marriage
DSM-5	The Diagnostic and Statistical Manual of Mental Disorders 5th Edition
EAT-26	Eating Attitudes Test
ED	Eating Disorder
EICS	Ethno-cultural Identity Conflict Scale
MBSRQ-AS	Multidimensional Body-Self Relations Questionnaire – Appearance Evaluation and Orientation Subscale
NHS	National Health Service
NICE	National Institute for Health Care Excellence
OP	Overweight Preoccupation
OS	Online Surveys
PIS	Participant Information Sheet
SA	South Asian

SATAQ-4R	Sociocultural Attitudes Towards Appearance Questionnaire – 4 Revised
SATAQ-F	Sociocultural Attitudes Towards Appearance Questionnaire - Family
SATAQ-M	Sociocultural Attitudes Towards Appearance Questionnaire - Media
SATAQ-P	Sociocultural Attitudes Towards Appearance Questionnaire - Peers
SCS	Self-Compassion Scale
UK	United Kingdom
US	United States

Chapter One: Literature Review

1.1 Background

Eating disorders (EDs) have been a topic of research interest within White Western academia for decades. Only in the last 30 years has it been highlighted that those with differing ethnic heritage also experience EDs and body dissatisfaction (Mumford, 1993; Striegel-Moore & Bulik, 2007). Findings regarding the prevalence of EDs across ethnic groups is mixed. Some studies report no significant ethnic differences (Cheng et al., 2019; Solmi et al., 2016), while others indicate increased rates for People of the Global Majority (Simone et al., 2022) or White adults (Udo & Grilo, 2018). Global differences in the prevalence and presentation of those with an ED, associated risk factors and treatment experiences are being explored further in People of the Global Majority, to improve healthcare and minimise inequalities (Tuomainen et al., 2024).

Studies have identified the prevalence of eating behaviour difficulties and body dissatisfaction in those with South Asian (SA) heritage in the UK (Abbas et al., 2010; Mumford et al., 1991). However, there is an underrepresentation of those with SA heritage being referred to eating disorder services in the UK (Abbas et al., 2010; Wales et al., 2017; Waller et al., 2009). The experiences of SA women in the UK sits within the context of the history of colonialism, migration to the UK and intergenerational beliefs and values that are key in maintaining cultural ties (Clarke et al., 1990). Understanding the assimilation to Western culture and its impact within the historical and present context is crucial for gaining insight into the mechanisms influencing the eating behaviour and body image of SA women in the UK.

This chapter will explore areas of sociocultural influence, shown to be experienced by women with SA heritage in the UK. Specifically, it will focus on the system surrounding a person, Western societal pressures and narratives, and SA cultural values. In addition, the concept of self-compassion will be explored to understand whether it acts as an internal protective barrier against the impact of the external world on eating behaviour and body image (Braun et al., 2016; Ferreira et al., 2013).

A brief scoping review was conducted to ensure all relevant literature was considered. Multiple search terms within eight categories were gathered to develop nine specific search strategies (Appendix 1), aimed at acquiring all the relevant literature aligned with the thesis aims. A comprehensive search of electronic databases was conducted in December 2022 and updated in June 2024. The database OVID was chosen due to its extensive library covering varied reference types and relevant disciplines. The data output was filtered to remove duplicates and sample populations who were not of SA heritage. The total number of papers acquired from each search is documented in Appendix 1. In addition to this search, multiple searches were conducted using Google Scholar to gather additional papers not captured within these search strategies.

1.2 Language

The language used within this body of literature varies in the interpretation of terminology and the evolution of meaning overtime. For the purpose of this thesis, the terms used throughout this research will be outlined and explored. The definitions of cross-cultural language used in eating disorder research vary. Researchers have attempted to define the differences between race, ethnicity and culture to prevent the interchangeability of the terms (Kawamura, 2015; Wildes et al., 2001).

The term ‘race’ has been highlighted as an inappropriate culturally constructed term because it is predominantly defined by physical characteristics (Beutler et al., 1996). It is a socially constructed ideology designed to empower certain groups, thereby exacerbating inequalities in other groups and failing to reflect how groups of people identify.

The term ‘ethnicity’ has been suggested in its place to account for the multitude of differences that embody a group of people, such as their ancestry, language, culture, religion, and nationality (Wildes et al., 2001). The term ’Culture’ has been defined as a more complex term referring to the “socially transmitted values, beliefs, traditions and behavioural norms shared by a group of people” (Kawamura, 2015). It is key to note the differences that exist within racial, ethnic and cultural groups and to consider the framework of intersectionality.

The term ‘Intersectionality’ refers to the notion that race, class, sexuality, ethnicity, ability and age are not mutually exclusive characteristics, but instead, they all interact, contributing to individual experience (Crenshaw, 1991). It’s important to consider intersectionality when reviewing the literature, because the conclusions drawn will be based on commonalities found. Therefore, they may not fully represent the whole population of women with SA heritage or capture their diverse individual experiences.

This thesis will refer to individuals with SA – Indian subcontinent - heritage (e.g., Pakistan, Bangladesh, Nepal, Sri Lanka and India). While this group is diverse, they share cultural norms originating from their shared past within the same territory and governance (Khasru, 2022). Within the research field, there are other terms used to encompass this population. For example, ‘Asian’ is often used to refer to those with heritage from the Far East (e.g., China, Korea, and Japan) and Southeast Asia (e.g., the Philippines, Vietnam, Cambodia, and Laos) as well as SA. However, the use of the term ‘Asian’ has been criticised

for its reductionist categorisation of a large and diverse group of people, which masks the differences between the populations within the group (Goel et al., 2021).

The terms ‘racialised minority’ and ‘ethnic minority’ to categorise a group of people in the UK, when juxtaposed with ‘White’, can demonstrate a language power imbalance. This thesis will use the term ‘People of the Global Majority’ when making these comparisons.

The term ‘migration generation’ has been defined in this thesis as follows: the first migration generation includes individuals who were born on the Indian subcontinent and later moved to the UK. The second generation comprises individuals who have one or more parents born on the Indian subcontinent and who also moved to the UK. The third generation consists of individuals who have one or more grandparents born on the Indian subcontinent and one or more parents born in the UK. The fourth generation includes individuals whose both grandparents and parents were born in the UK.

There are a vast range of terms and definitions used within eating disorder literature. Therefore, it is important that all researchers define their language use. This research acknowledges the moralisation of eating behaviour and food choices when the literature describes eating behaviour as; unhealthy, dysfunctional, abnormal, maladaptive, impaired and poor. These terms suggest that certain food choices and eating patterns are bad and others are good, based on the beliefs of diet culture. In addition, the use of the term ‘disordered eating’ suggests the categorisation of two types of eating behaviour, ‘normal’ and ‘disordered’. When in fact we understand eating patterns and food choices to be on a spectrum.

Behaviours related to the diagnosis of an eating disorder are often described as eating pathology, psychopathology or symptoms. This thesis will refrain from using pathologising terminology when describing those who experience distress relating to food and body shape/weight. Thus, to limit the perpetuation of locating the problem within the individual,

and open up perspectives considering the impact of imposed societal constructs of beauty. However, the term 'disordered eating' is occasionally referenced due to this being the terminology used by cited papers. It is important that the author's intended meaning is not altered, to ensure consistency within the research field. This thesis will use the term 'eating behaviour difficulties' where appropriate, to describe eating patterns that result in distress and difficulties in functioning.

1.3 Eating Disorders

1.3.1 Definitions

Eating disorders (EDs) are characterised by the persistent disturbance of eating patterns or behaviour intended to control weight, leading to significant impairment to health and psychosocial functioning (NICE, 2019; World Health Organization, 2018). Anorexia Nervosa (AN) is commonly characterised by the controlling of energy balance, which can be done by restricting food intake and increasing energy expenditure through exercise, medication (e.g. laxatives, diuretics), being in the cold and/or purging (NICE, 2017). Cognitive characteristics often include a preoccupation with food and weight with a desire for thinness and a drive for certainty and perfection (NICE, 2017). Adults with AN are classed as being at 'low weight' which is defined as a body mass index (BMI) of >18.5 (NICE, 2017). Bulimia Nervosa (BN) is the most common ED although services often focus on the treatment of AN, perhaps due to the increased risk of mortality for AN (Demmler et al., 2020). BN is characterised by recurrent binge eating, over concern about body shape and weight and the presence of weight control behaviours such as excessive exercise and purging (NICE, 2017). Demmler et al. (2020) found the median age of ED diagnosis was 20 years old, peaking between the ages of 15-19 for both genders, with AN being diagnosed younger (22) compared to BN (25) in women. Binge Eating Disorder (BED) is characterised

differently to AN and BN as it is defined by binge eating over a specific time period, associated with psychological distress with the absence of compensatory behaviour (NICE, 2017). The Diagnostic and Statistical Manual of Mental Disorders 5th Edition (DSM-5), is most commonly used to diagnose an ED, based on observed signs and symptoms (American Psychiatric Association, 2013).

1.3.2 Comorbidities

Comorbidities associated with EDs have been found to vary depending on the diagnosis and age of onset. They typically consist of; depression, anxiety and obsessive-compulsive disorders, substance and alcohol dependency and fertility and cardio-vascular problems (Bahji et al., 2019; Fairburn & Brownell, 2005; Ulfvebrand et al., 2015; Van Alsten & Duncan, 2020). Suicide and irreversible health complications have been reported as the main causes of death in people with EDs (Preti et al., 2011; Rome & Ammerman, 2003). This is higher than in the general population, despite a substantial decrease in suicide risk for those with AN in recent decades (Preti et al., 2011). It has been estimated that 700,000 people in the UK have an ED, with 90% being female (NICE, 2019). However, this figure is most likely an underestimation due to potential barriers in accessing health services such as; stigma, reluctance to report, practical constraints, service entry criteria and long waiting lists (Hamilton et al., 2022; Johns et al., 2019).

1.3.3 Risk Factors

EDs can appear complex and there are a range of biopsychosocial risk factors associated with the development of an ED. A critical review by Striegel-Moore and Bulik (2007) listed risk factors for AN, BN and BED including; gender, age, socioeconomic status and ethnicity. This review questioned the stereotypical view of adolescent White women

living in affluent countries being most at risk of an ED. It is now known that EDs can impact all populations of all genders and ages, and that a complex interaction of sociocultural factors could predict the development of an ED. 'Sociocultural risk factors' typically reference peers, the media and family. This term also recognises the societal norms relating to appearance, beauty and eating behaviour. A review by Culbert et al. (2015) found there to be an increased focus on female pressures to be thin, promoted in the media which can result in the internalisation of a thin-ideal body, shown to predict EDs in Western cultures. This was evidenced by the increase of AN and BN, as the exposure to the idealised thin body increased in society (Culbert et al., 2015). Alongside this, research found the absence of BN in societies with no exposure to Western influence (Klump et al., 2003).

So, why don't all women exposed to these risk factors develop an ED? Research has found that not everyone exposed to body ideals internalise them, lowering their risk of developing an ED (Hausenblas et al., 2013). This leads to the consideration of pre-existing factors which may interact with environmental influences, to exacerbate the risk of developing an ED. A range of risk factors have been suggested which include; personality traits such as neuroticism, perfectionism and impulsivity and neurocognitive processes such as cognitive flexibility and inhibitory control and gene associations (Culbert et al., 2015). Further research is needed to establish the intersection of biological and environmental risk factors.

1.3.4 Protective Factors

Factors that may be protective in preventing the development of an ED are increasingly explored in the research field. A review of predominantly White women in the US reported protective factors included; body appreciation, awareness and responsiveness to hunger cues, a lower BMI, sport participation, self-esteem and self-compassion (Tylka &

Kroon Van Diest, 2015). Alongside, external factors such as positive family relationships, regular family meals, media literacy and exposure to body accepting narratives (Tylka & Kroon Van Diest, 2015). Factors associated with lower BMI were found to be protective by reducing the presence of weight stigma (discriminatory acts and attitudes towards individuals, due to weight and size) and the development of body dissatisfaction and 'disordered eating' (Emmer et al., 2020). It may be that a combination of these factors results in increased protection against the wider sociocultural pressures for women.

1.3.5 Prevention and Treatment in the UK

In the UK it was estimated in 2012 that only 23% of those with an ED were receiving treatment (Layard, 2012). This may reflect the barriers in accessing services, alongside the eligibility criteria of ED NHS services within the UK. Criteria consists of specific frequencies of ED behaviours and BMI range, with the most commonly treated populations being AN and BN. Treatment guidelines for EDs include psychological therapy, physical monitoring and medication (NICE, 2017). However, there is a large variation in waiting times, eligibility criteria and how EDs are treated in the NHS inpatient and community settings, due to funding (NICE, 2017). Support is also offered by third sector charities such as BEAT and SEED, who are involved in supporting families, healthcare professionals and individuals with an ED through peer support, social media, helplines, chatrooms and resources.

Early intervention as a form of prevention is both key and a challenge to implement in ED populations. Primary services play an important role in early detection, and a lack of awareness, knowledge and skills could result in a lack of early support (Royal College of Psychiatrists, 2019). The same report offered recommendations to community ED services, to support links with local primary care, Universities and schools to offer early detection and signposting for all age groups to avoid the 'watchful waiting' approach.

It is important to highlight that the research described in this section has been predominantly explored with White Western populations. ED presentations, sociocultural risk/protective factors and interventions will vary based on an individual's context and their experiences of the world. Additionally, past research has focused on binary gender groups meaning those who identify as non-binary have been excluded from the research.

1.3.6 Eating Disorders in an International Context

Historically, EDs and eating behaviour difficulties have been identified in predominantly White, middle/upper class, Western populations and the prevalence in People of the Global Majority appeared to be low (Chowbey et al., 2012; Soh & Walter, 2013). This contradicts research stating that EDs are prevalent worldwide amongst groups of people with varying realities and experiences (Striegel-Moore & Bulik, 2007). However, there is a hypothesis that ED most commonly occur in cultures that are exposed to the idealised thin female body and value thinness among women (Striegel-Moore & Bulik, 2007). The accelerated globalisation of the Western idealised body shape meant that researchers predicted increased ED presentations worldwide, due to the increased internalisation of this ideal body (Catina & Joja, 2001; Gordon, 2001).

Risk factors have been found to vary amongst those of differing cultural heritage and religion. Abraham and Birmingham (2008) found that young women with Islamic affiliation were more susceptible to developing an ED when living in countries such as Britain, Israel, Cairo, Turkey and Oman, compared to young women of other religions. It was hypothesised that this was due to ascetic idealism, fasting rituals and potential conflict between religious family expectations and Western secularism. Solid conclusions should not be made as confounding variables were not controlled for and the study had a cross-sectional design with

a small sample size. In contrast, a book chapter by Richards et al. (2020) explored the protective elements of religion in mitigating the risks of the development of an ED.

A review by Becker and Fay (2006) documented the differences in the accessibility of care for an ED in 'minority ethnic groups' in the US, demonstrating that Afro-American, Latina and Hispanic individuals were less likely to have their ED behaviour difficulties recognised, referred and treated. Therefore, prevalence rates and information regarding the expression of EDs in People of the Global Majority may not be accurate or valid.

1.3.7 Eating Disorders in SA Populations

Epidemiologic data in South Asia is limited when compared to East Asia. However, research has revealed an increase in EDs in South Asia over the last three decades (Pike & Dunne, 2015; Thomas et al., 2016). Studies in India, Pakistan, Bangladesh and Nepal documented a presence of 21.6 - 37.6% of women scoring above clinical cut-off for eating behaviour difficulties, measured by the Eating Attitudes Test (Thomas et al., 2016).

This increase in EDs coincides with a period of unprecedented growth and social and economic transformation across Asia (Pike & Dunne, 2015). Resulting in shifts in traditional family culture, food supply, gender roles and population demographics (Pike & Dunne, 2015). All of this may influence the expression of ED presentations over time. Early research by Mumford (1993) noticed the failures in the Western diagnostic system and highlighted that diagnostic criteria accounts for the differences seen in the prevalence of EDs, as it does not take into account religious, cultural and beauty practices in non-Western groups.

1.3.8 Eating Disorders in UK populations with SA Heritage

A number of studies have highlighted the existence of EDs in People of the Global Majority in the UK (Brown et al., 2009; Kumari, 2004; Waller et al., 2009). However, much

of the research documenting prevalence is questionable due to small sample sizes and lack of culturally appropriate measures and diagnostic criteria. Although, there have been attempts to develop culturally sensitive screening and diagnostic assessment tools to encourage a better understanding of the variation in ED presentations amongst varied ethnic groups (Cummins et al., 2005; Franko, 2007; Rodgers et al., 2018).

A handful of studies have highlighted the prevalence of EDs and eating behaviour difficulties specifically in SA populations in the UK (Abbas et al., 2010; Mumford et al., 1991; Solmi et al., 2014). Differences were found in the prevalence of EDs in women from SA heritage when compared to women categorised into other ethnic groups. One study stated that SA women were less likely to present with an ED and have a diagnosis of AN (Abbas et al., 2010). Research has also suggested that women with SA heritage may have a higher prevalence of BN and 'negative eating attitudes' throughout their life (Ahmad et al., 1994).

This raises the question of what causes the differences in presentations, and is this resulting in the underdiagnosis of EDs in women with SA heritage? Tareen et al. (2005) reported an absence of the AN symptom 'fat phobia' or 'extreme weight preoccupation', as described above, which has been consistent with more recent research (Vaidyanathan et al., 2019). This presentation has been hypothesised to be due to the notion of 'fat phobia' being manifested differently or considered more socially acceptable (Kawamura, 2015).

Despite literature documenting a similar prevalence of EDs in a SA population to White populations in the UK, there is still an underrepresentation of women with SA heritage being referred to UK specialist ED services (Wales et al., 2017; Waller et al., 2009). Research has suggested several factors which may influence the recognition of an ED in People of the Global Majority in the UK, these include; norms and ideals around food and body image, low public awareness, religious practices and poor past experiences of services (Chowbey et al.,

2012). Alongside this, non-specialist service providers can be slow in the consideration of an ED and lack confidence in understanding the needs of those from racially minoritised groups (Chowbey et al., 2012).

This review has evidenced the well-researched range of biopsychosocial ED risk and protective factors in White populations, compared to the global majority. Key ED risk factors associated with women of SA heritage relating to their cultural context in the UK are typically not well defined in research. Given the life-threatening consequences an ED can cause, it is imperative that culturally relevant sociocultural influences are explored further to gain a better understanding of how to support women with SA heritage, within their context. This is important in challenging societal assumptions and adapting diagnostic and service eligibility criteria, to reflect the experiences of women with SA heritage who experience distress around their body and eating.

1.4 Body image in SA Women

Body image can be characterised by a person's thoughts, feelings and narratives about their body weight, shape, facial features, hair and skin colour. Body image links to physical, sexual and health outcomes across the lifespan (Runfola et al., 2013). The majority of women in Western society have been found to experience body dissatisfaction (Runfola et al., 2013). Eating behaviour difficulties and EDs have been associated with increased body dissatisfaction amongst American/Canadian women with SA heritage between the ages of 18-30 (Bhatti, 2018; Reddy & Crowther, 2007; Wildes et al., 2001). However, most research into body image focuses on the Western ideal female thin body shape and the internalisation of this ideal has been shown to be an ED risk factor (Striegel-Moore & Bulik, 2007). The link between this internalised ideal body and the development of an ED is not fully clear and is most likely part of a complex pattern of risks. The development of the internalised ideal has

been found to depend on the frequency of exposure and types of images viewed in the media, explored in a review by Rounsefell et al. (2020) in mostly White women. This leads to the question of whether the internalisation of the thin ideal is a risk factor for women with SA heritage.

The impact of the Western ideal body on body dissatisfaction may vary in women with SA heritage (Perera et al., 2002), perhaps due to the importance of thinness, which is similar to Western culture. Although, there appears to be a broader range of body sizes that are acceptable in SA culture (Perera et al., 2002). In addition, recent research states that whilst the Western internalised thin ideal is a factor influencing body dissatisfaction, it may operate differently for SA women (Goel et al., 2021). This research also suggests a possible opposing belief around being 'too thin' and the need to align with a 'healthy' ideal of a slightly bigger body. This may explain why there appears to be less drive towards thinness when diagnosing AN in women with SA heritage (Vaidyanathan et al., 2019). An important consideration in relation to the internalised thin ideal is that this does not apply to all those with an ED. Criticisms have suggested that the focus on this explanation could minimise the consideration of other factors such as genetic and biological influences (Striegel-Moore & Bulik, 2007).

Another valued aspect of body image for women with SA heritage is skin colour satisfaction. Colourism is a form of prejudice and discrimination against those with dark skin, closely related to race and racism (Dixon & Telles, 2017) Colourism occurs both within and between ethnic groups and is rooted in the history of colonialism, whereby having lighter skin was associated with power, status and attractiveness (Shaikh, 2017). Beliefs about skin-tone are often introduced directly or indirectly amongst family, friends and the media, and are reinforced by living in countries that perpetuate a racial hierarchy (Shaikh, 2017). Women

with SA heritage experiencing this racialised beauty ideal, have lower skin shade satisfaction and higher skin shade surveillance, increased body dissatisfaction and psychological distress (Craddock et al., 2023) and attempt to lighten their skin (Goel et al., 2021; Khasru, 2022).

Women with SA heritage living in the UK may experience a mix of two worlds, their traditional heritage culture and the dominant White Western culture. Hence, the experience of differing beliefs around beauty standards can uniquely influence body dissatisfaction in women with SA heritage (Goel et al., 2021). Research in the US has shown that women with SA heritage are more likely to internalise the Western beauty standards than African American or Hispanic/Latina women (Chin Evans & McConnell, 2003). Research has suggested that this may be due to the increased likelihood that SA women attempt to fit in with the cultural 'norm', due to the importance of collectivism in the Asian culture (Chin Evans & McConnell, 2003; Kawamura, 2011).

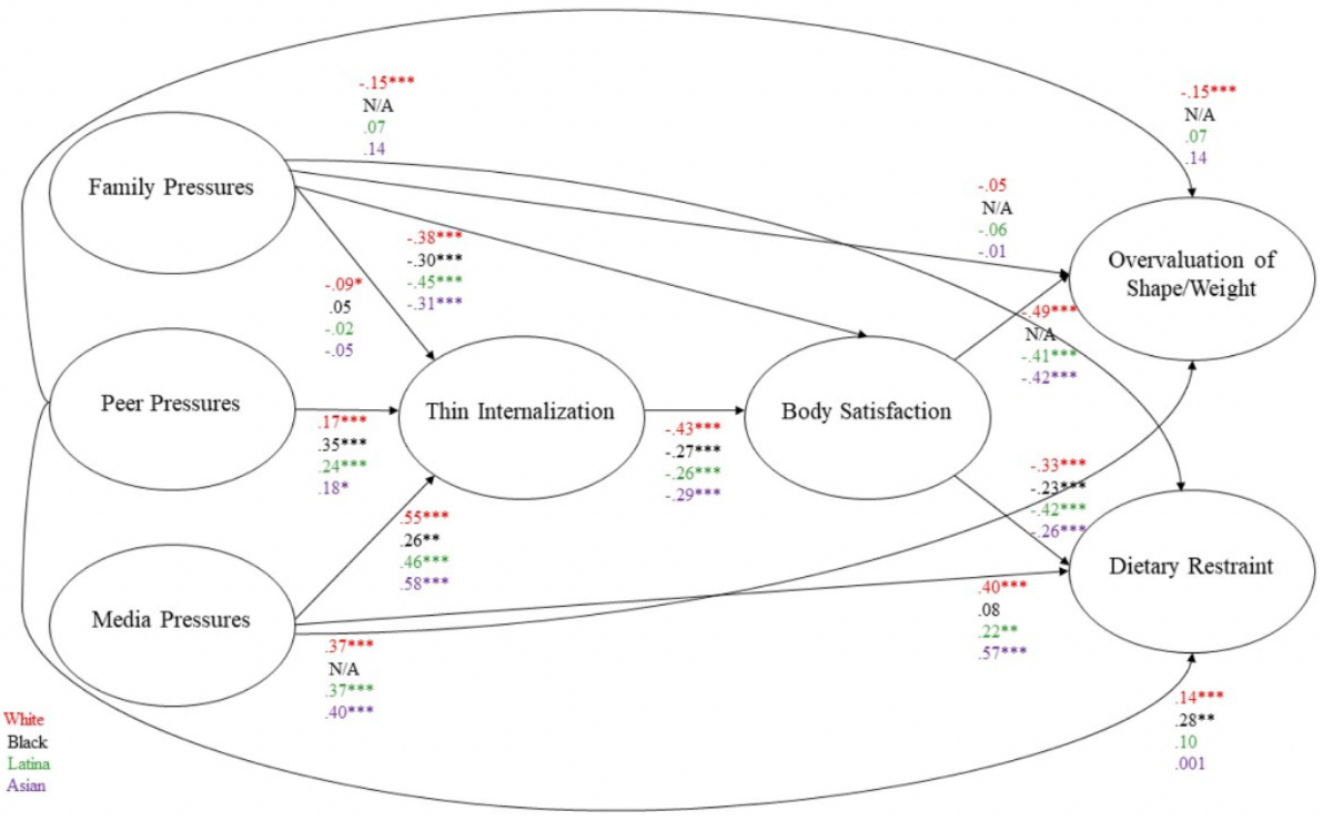
Factors influencing body image are complex and multi-faceted for women with SA heritage living in the UK. Further research is needed to gain a more in-depth understanding of the experiences increasing appearance dissatisfaction for this population.

1.5 Sociocultural Attitudes

Javier and Belgrave (2019) demonstrated the presence of external influences on the development of 'disordered eating', with the use of the bioecological systems model by Bronfenbrenner (1992). This model visualises the levels of societal influence, such as; interpersonal relationships (immediate family and peers) and environmental influences (media, SA cultural values, Western cultural values). These influences have also been presented in a tripartite influence model (Figure 1) by Burke et al. (2021). This model demonstrates the mechanisms through which external weight and shape pressures from

family, peers and the media are associated with the internalisation of the thin-ideal, body satisfaction, overvaluation of weight/shape and dietary restraint, in different ethnic groups (Burke et al., 2021).

Figure 1.
The Tripartite Influence Model of Body Image and Eating Pathology Multigroup Results by Burke et al. (2021).



Note. Standardised path coefficients are adjusted for sexual orientation and are listed from top to bottom: White, Black, Latina, Asian. *p < .05. **p < .01. ***p < .001.

1.5.1 Appearance-based Commentary

There are a range of terms used to define the positive and negative commentary based on body weight and shape and overall appearance. This thesis will define this term as 'appearance-based commentary', to encompass all aspects of appearance. Differing types of

appearance-based commentary have been explored in the literature such as; co-rumination, body/weight-related commentary and diet-culture conversations (McLaren et al., 2004; Rudiger & Winstead, 2013).

Self-objectification and low body esteem have been found to increase in women during puberty, due to their changing bodies being more of a focus and evaluated by others (Slater & Tiggemann, 2015). Thus, appearance-based commentary and social comparison (positive or negative) may increase vulnerability to body dissatisfaction and low self-esteem (Khasru, 2022). The term 'teasing' has also been used within the research to define negative comments around general appearance, weight and shape, shown to impact on body dissatisfaction and eating attitudes in women with SA heritage (Reddy & Crowther, 2007).

In addition, 'racial teasing', focuses on someone's physical features associated with their ethnicity and has been found to impact body image and eating behaviours in young women of SA heritage in the UK (Sahi Iyer & Haslam, 2003). Experiences of racial teasing have been found to be prominent within the UK and USA, whereby White peers negatively highlight difference, resulting in shame, assimilation pressures and low self-esteem of those with SA heritage (Goel et al., 2021; Mumford et al., 1991). Teasing from female peers of the same SA ethnicity has also been documented, commentary includes cultural pressures to adhere to SA beauty standards and values (Goel et al., 2021). According to the same study, male peers with SA heritage also appear to voice SA values and ideals and highlight social comparison (Goel et al., 2021).

1.5.2 Family

Familial narratives around weight and shape appear to be highly valued due to the importance of following parental rules and representing the family well within the SA

community (Goel et al., 2021). It is thought that this is compounded by the guilt felt by not adhering to these expectations (Goel et al., 2021). Parental control, relating to the choices in friendships, activities and romantic relationships, has been found to negatively influence eating behaviour (Mujtaba & Furnham, 2001). This may be due to the need for autonomy over appearance and life choices (Mustafa et al., 2017). In addition, Burke et al. (2021) found that SA women had the highest levels of family and peer appearance pressures when compared to Black, Latina and White women. However, it is important to note that it is not just negative comments that have been shown to increase body dissatisfaction, but also positive comments. Research has found that this is due to the social value put onto the female body, increasing body surveillance and self-objectification, linked to appearance anxiety and body dissatisfaction (Calogero et al., 2009; Herbozo et al., 2017).

1.5.3 Media

Appearance-based media is another form of social commentary widely consumed by young women. It acts to reinforce the narratives around the importance and value of beauty ideals in society. Women who have learnt to base their self-worth on appearance for the approval of society, may be more vulnerable to internalising the appearance-based narratives in the media (Khasru, 2022). Khasru (2022), explored factors influencing SA women's susceptibility to internalising these narratives. Factors included those who experience social comparison, cultural conflict with Western beauty ideals and the prevalence of objectification. Internalised appearance ideals can lead to self-objectification and an above average risk of low self-esteem (Khasru, 2022). In addition, it has been suggested that Asian Americans (including those with SA heritage) experience appearance pressures from the media, due to an underrepresentation of SA women in the media (Javier & Belgrave, 2015), resulting in body dissatisfaction and increased racial teasing. This external influence on

weight, shape and skin colour contribute to the internalisation of Western beauty standards, resulting in body dissatisfaction in those who do not fit this ideal (Reddy & Crowther, 2007).

1.5.4 Racial Discrimination

It is important to consider the role of power within UK society and the impact of racial discrimination on people with SA heritage. The term 'racial discrimination' refers to the socially constructed process influenced by power, whereby people are actively minoritised by all aspects of society due to their race (Milner & Jumbe, 2020). Racial discrimination, specifically around skin colour in women, has been documented in SA Americans across the US (Shaikh, 2017) and has shown to negatively impact on body image (Brady et al., 2017) and self-esteem (Goel et al., 2021). The stigma maintenance model of 'dysregulated' eating suggests that stigma and discrimination result in the need to cope with psychological distress, through the use of eating behaviour (Mason et al., 2019). However, this model was based on marginalised individuals and not specifically those with SA heritage. In addition, research has found that in a mostly White sample, social support and positive attitudes to group identity could buffer the impact of discrimination and impact on 'disordered eating' (Mason et al., 2021). There is a notably sparse area of research considering the impact of racial discrimination on eating behaviour and body image.

This research area demonstrates that external cultural, societal and environmental attitudes around weight and shape have been shown to negatively or positively influence body image and eating behaviour. There is a need to build on the limited research to explore the complexity of these relationships in women with SA heritage in the UK.

1.6 Cultural Identity Conflict

Acculturation is used as a term in the literature to define the process of adopting the attitudes, values and beliefs of the dominant culture (Negi et al., 2022). The term 'cultural conflict' is defined as the process of attempting to adapt to the dominant culture of society, while simultaneously contending with the competing values and beliefs of one's heritage culture (Inman, 2006). These experiences can impact aspects of identity such as values, beliefs and behaviours and is often discussed in the literature as 'cultural identity conflict', which has shown to cause distress (Szabó & Ward, 2022). The use of the term cultural identity conflict in the current research context, describes the pressures experienced by women with SA heritage to conform to both culturally traditional and Western standards of beauty in the UK (Mustafa et al., 2017; Reddy & Crowther, 2007).

As previously mentioned, racialised teasing may exacerbate feelings of cultural identity conflict due to ethnic discrimination (Reddy & Crowther, 2007). Other terms such as 'bicultural stress' and 'acculturative stress' have been used in the literature, referring to the stress associated with navigating two or more cultures.

1.6.1 Parental Expectations

A cultural narrative that may reinforce feelings of cultural identity conflict are the high expectations placed on SA women to uphold family reputation, differing from the Western culture around individualisation and increased autonomy (McCourt & Waller, 1996). An early study found that maternal control mediated the relationship between 'cultural issues' and eating behaviour in young women with SA heritage (Ahmad et al., 1994). This perceived control has been found to result in feelings of being restricted and a struggle for control, leading to 'low self-image' and increased risk of 'disordered eating' (Mustafa et al., 2017).

Importantly, these narratives and experiences are on a spectrum and may not be applicable to all families with SA heritage.

1.6.2 Competing Appearance Ideals

The presence of differing appearance ideals and cultural values within the dominant society and family heritage, have been found to impact on body image and eating behaviour in women with SA heritage (Doris et al., 2015; Goel et al., 2021; Kirschner, 2011; Nazir, 2016). As previously described, there are specific beauty standards for women with SA heritage, which partly align with the Western thin ideal female body, but perhaps operate differently (Goel et al., 2021).

The evolution of beauty standards is often a topic of exploration due to it changing over time and varying based on race and ethnicity. A recent review considers the differing standards across the globe and throughout time, demonstrating that beauty ideals are dynamic (Dimitrov & Kroumpouzos, 2023). An example of a changing standard is skin tone; studies have found that modern White women prefer a more tanned appearance (Dimitrov & Kroumpouzos, 2023). This may contribute to increased conflict with the SA beauty norm of light skin (Goel et al., 2021). Another appearance-related conflict is the use of revealing clothing, more accepted in Western society, which may result in social judgement due to the SA cultural value around women covering their body to remain 'modest and respectful' (Goel et al., 2021).

In addition, the visibly toned ideal has become increasingly observed within Western culture, emphasising health and fitness– known as 'fitspiration' (Robinson et al., 2017). Exposure to this athletic ideal has been shown to lead to body dissatisfaction, but not motivate engagement in exercise behaviour (Robinson et al., 2017). It could be hypothesised

that this adds to the complexity of the conflicting appearance-ideals and may lead to increased body dissatisfaction. Although, there is a lack of research around the impact of this ideal body on women with SA heritage.

1.6.3 Generational Differences

It has been suggested that there is increased risk of cultural identity conflict for second migrant generation women (Smart et al., 2011), specifically around 'sex' role expectations (Inman et al., 2001). Researchers have shared the hypothesis that first generation parents who maintain strong ties to their culture of origin may enforce these values and beliefs due to fears their children will lose this part of their cultural identity (Segal, 1991). Therefore, second generation women may struggle with a need for their own goals and sense of belonging, resulting in conflict with family members due to differences in acculturation (Inman et al., 2001). However, other research studies have suggested that generational beliefs and values are passed down the generations and the conflict can still be present in all generations (Tsong & Smart, 2015).

1.6.4 Coping with Psychological Distress

The presence of psychological distress or low mood are well-known factors contributing to the presence of an ED. The use of over or under-eating can help to cope with difficult emotions and create a sense of certainty and safety, which maintains the function of the ED (Cooper & Fairburn, 2011; Gowers & Green, 2009). Hence, cultural conflict can be influenced by a complex myriad of factors causing distress, which may manifest in specific eating patterns to cope with those feelings (Bhatti, 2018). In addition, research has shown that those who experienced trauma had increased difficulties with body dissatisfaction and 'disordered eating' (Smart, 1999).

As this review has highlighted, there are a range of factors that may impact on feelings of cultural identity conflict in women with SA heritage within the UK, resulting in body dissatisfaction and eating behaviour difficulties. Multiple hypotheses result in a complex picture of possible influences, which are important in informing prevention and treatment interventions for EDs in the UK.

1.7 Cultural Significance of Beauty and Marriage

An often-valued aspect of SA culture is marriage and the focus on marriage may be a more central focus at a specific age. Early research with East Indian Americans shared the assumption that the value of marriage is about the alliance of two families and that the choice is often left to the elders (Prathikanti, 1997). It has also been suggested that the value of marriage is emphasised to maintain the links to SA cultural heritage, especially if there is a sense of cultural identity conflict (Inman et al., 2001). The value of marriage is communicated through 'cultural scripts' directly and indirectly by family and peers, contributing to the pressures of being 'marriageable' and attractive to a partner (Mehrotra, 2016). It has been noted in the research that often SA women, mothers or 'aunties' (SA women of the older generation) prioritise weight above other beauty standards, as this is seen as equating to health and marriage prospects (Goel et al., 2021; Mishra et al., 2023). The idea of being marriageable focuses mainly on physical ideas of beauty, such as; having light skin, thin, no body hair and having long hair (Goel et al., 2021; Mehrotra, 2016).

Research has documented the prevalence of social commentary, food surveillance and unsolicited beauty advice from family members, contributing to women dieting to enhance marriage prospects (Goel et al., 2021; Mishra et al., 2023). These cultural scripts could enhance the feeling of women's bodies being objectified and subject to consistent evaluation within the community, linking to difficulties with body image (Frederick et al., 2016; Goel et

al., 2021). Factors which may contribute to these perceived pressures on marriage include, the need to adhere to social expectations from family and excel at household chores to be a good daughter-in-law (Mehrotra, 2016). In addition, a study found that unmarried second-generation women of SA heritage experienced high maternal control and high cultural value conflict, leading to increased symptoms of depression, compared to married women (Varghese & Rae Jenkins, 2009).

Values around marriage within a SA population will vary and it should be noted that this is on a spectrum for all families. However, it is thought that there are factors that may increase marital pressures and differences in how these pressures are experienced. Based on the limited research available, marital pressures appear to be linked to increased depression, dieting and body image difficulties. Therefore, it is important to include values around marriage as a sociocultural influence to explore, in the context of eating behaviour and body image.

1.8 Self-Compassion

Protective factors are key when considering what prevention and treatment interventions can focus on, to reduce the development and maintenance of an ED. As discussed earlier, there are a range of hypothesised protective factors associated with EDs, one of which is self-compassion. Neff (2003b) conceptualised self-compassion as being kind and understanding of oneself, recognising common humanity, and holding painful thoughts in awareness without overidentifying with them. Self-compassion has been associated with more noncontingent and stable feelings of self- worth over time, stronger protection against social comparison, public self-consciousness, self-rumination, anger and closed-mindedness (Neff & Vonk, 2009). The evolutionary theory of self-compassion suggests that the absence

of the development of self-compassion may result in increased shame and guilt, leading to increased body dissatisfaction and eating behaviour difficulties (Gilbert, 2014).

Recent studies have found that self-compassion is a protective factor in the development of body dissatisfaction and eating behaviour difficulties within Western cultures (Linardon, 2021; Seekis et al., 2019). In addition, self-compassion interventions have been found to be an effective and useful tool when working with people who struggle with body dissatisfaction and 'disordered eating' (Fidan, 2022).

Self-compassion has been researched within People of the Global Majority, including Asian American populations. Studies have found that the increased presence of self-compassion reduced the impact of interpersonal shame (Wei et al., 2020) and public stigma around receiving psychological help (Mateer et al., 2023). It has also shown to reduced depressive symptoms, increased life satisfaction and subjective wellbeing (Chong, 2020; Yu & Chang, 2020). This research is cross-sectional and so stability of self-compassion and the impact of external variables on this construct is unknown.

There is extremely limited research exploring the direct mediating or moderating effects of self-compassion in women with SA heritage, on body image and eating behaviours. Relojo (2016) explored the use of expressive writing in this population, to see if self-compassion moderated the effects of exposure to thin-ideal images and found no beneficial effects. A recent study also found that self-compassion and social connectedness moderated the impact of racial discrimination on depression in Asian American students (Liu et al., 2020). It could be hypothesised that if self-compassion can moderate the impact of racial discrimination, it may also reduce the risk of developing an ED (Mason et al., 2021). Due to cultural identity conflict being another factor contributing to the development of an ED

(Mustafa et al., 2017), it is wondered whether self-compassion could help to reduced cultural identity conflict and, thus, reduce eating behaviour difficulties.

Within the research field, self-compassion in the context of body image has been described as 'body appreciation' or 'positive body image' and has become an area of focus over recent years. The ideas around positive body image often focusses on body functionality, rejection of media imagery and acceptance of 'imperfections' (Grogan, 2021). In a study comparing ethnic differences in body appreciation, SA women in the UK scored lowest on a body appreciation scale when compared to African Caribbean, 'Caucasian' and Hispanic women (Swami et al., 2009). The link between self-compassion and body appreciation has been researched on predominantly White women in America. One of these studies suggested that self-compassion may help to preserve women's body appreciation when subject to body-related pressures (Homan & Tylka, 2015). However, this link has not been identified in women with SA heritage in the UK.

This research highlights the importance of exploring the role of self-compassion within ED literature in women with SA heritage. The development and stability of this protective factor in relation to body image and eating behaviour, may have important implications for prevention and treatment interventions for this population.

1.9 Research Limitations

There are several limitations of the literature discussed in this chapter around body image and eating behaviour, in women with SA heritage. Firstly, many papers acquired through this scoping review describe their sample as 'Asian American' women, predominately describing Chinese, Indian, Filipino, Korean and Japanese American citizens. This categorisation of 'Asian American' is not broken down into the varying ethnic groups it encompasses. This means it is difficult to know the exact heritage of the participants and

could minimise experiences unique to specific groups. In addition, much of the research focuses on body image in terms of weight and shape and fails to more broadly consider all aspects of a woman's body, including skin colour, hair and eye colour (Winter et al., 2019).

The qualitative study by Goel et al. (2021) has been heavily focussed on in this literature review due to the depth of information that the nature of qualitative methodology provides and the lack of this level of detail in other studies. This method is necessary when exploring a gap in the literature, however, limitations of this paper need to be addressed due to the level of influence this has on the current thesis. The study sample consisted of 54 SA American women within seven focus groups, meaning it is not possible to generalise the findings to all populations of SA women or to those identifying as another gender. Furthermore, some of the themes created and referenced were based on a small number of participants thoughts and feelings. Alongside this, much of the quantitative research within the area is based on cross-sectional correlational relationships, meaning causation is not possible to determine and the impact longitudinally is often not known.

1.10 Literature Summary

This literature review has summarised emerging research, research gaps and a general lack of understanding of cultural-specific factors influencing eating behaviour difficulties and body dissatisfaction in women with SA heritage. Key questions remain around how cultural identity conflict, marriage pressures and weight and shape attitudes from peers, family and the media, influence eating behaviour difficulties and body image. There is a significant gap in the research considering protective factors, such as self-compassion as a potential moderator in preventing the internalisation of beauty and body size and shape ideals. The level of influence of these sociocultural factors on eating behaviour and body image in largely unknown in populations of women with SA heritage. Therefore, there is a need for

research to consider a range of external influences, on a larger community sample size with a statistical underpinning, to better define potential relationships.

1.11 Enhancing the Research Field

This thesis aims to explore the relationships defined in past literature between key sociocultural influences, on body image and eating behaviour, and the role of self-compassion in moderating these relationships, in women with SA heritage. As the first cross-sectional quantitative study to investigate these relationships in a UK population, it expands on this under researched area, which is predominantly represented by qualitative research in American and Canadian populations.

1.11.1 An Under Researched Population

Women with specifically SA heritage are the focus of this thesis in order to reduce the minimisation of people's experiences by including too many groups of people with Asian descent, which may encompass varying cultural differences. This thesis chose not to compare cross-culturally with a White population, to reduce the complexity of the thesis and prevent a shift in focus away from the varied experiences of women with SA heritage. Furthermore, only those identifying as a woman are included in this thesis. This is due to the novel exploration of a specific racially minoritised population group with a foundation of past research to build on.

1.11.2 Limited Appropriate Measures

There is a fundamental lack of appropriate measures for women from minoritised groups, exploring cultural values and ideals to reliably understand the presentation, attitudes and development of body dissatisfaction and eating behaviour difficulties (Sotiriou, 2021). Many of the measures used have been developed with North American populations and may

not be sensitive to UK cultural differences. In addition, not all measures used in the literature have been validated on a SA population with a few being validated on an 'Asian' population, whereby SA participants are a small percentage or not specified. It is often the case that measures are developed and validated on White Western populations and adapted or validated with People of the Global Majority at a later date. Thereby, limiting the number of relevant measures exploring important constructs, detailed in much of the quantitative research around body image and eating behaviour in SA populations.

Despite the limited library of appropriate measures, this thesis chose measures based on whether they were validated on a SA population, and the relevance of the construct they are measuring to the research question.

1.11.3 Informing Prevention and Treatment Interventions

The outcomes of this thesis are important in helping to inform and improve prevention and treatment interventions for this population. Healthcare often attempts to fit individuals into the Western model of treatment. However, it is important to adapt these models of care to the needs of those with an ED from SA heritage, and in the context of their cultural values and beliefs. Research has documented multiple barriers associated with the Western model of care for those with SA heritage (Sinha & Warfa, 2013; Wales et al., 2017). These barriers highlight the need for a community-based approach to care, which would favour co-creation with the SA community, to understand and support their needs. These approaches should be focused on both prevention and treatment.

Chapter Two: Thesis Aims

2.1 Main Aim

The main aim of this thesis is to explore the impact of a range of sociocultural influences on aspects of body image and eating behaviour, amongst a sample population of women with SA heritage in the UK.

2.2 Research Questions

1. Do sociocultural attitudes around weight and shape, marriage pressures and cultural identity conflict, impact on overweight preoccupation, body areas satisfaction and eating behaviour in women with SA heritage in the UK.
2. Does self-compassion moderate the relationships between the predictor and outcome variables, described in research question 1.

2.3 Hypotheses

H1: In women with SA heritage in the UK, sociocultural attitudes around weight and shape, marital pressures and cultural identity conflict, measured by the Sociocultural Attitudes Towards Appearance Questionnaire – 4R (SATAQ-4R) the marriage subscale in the Cultural Values Conflict Scale (CVCS-M) and Ethnocultural Identity Conflict Scale (EICS), will increase the likelihood of eating behaviour difficulties, as measured by the Eating Attitudes Test (EAT-26).

H2: In women with SA heritage in the UK, sociocultural attitudes around weight and shape, marital pressures and cultural identity conflict, measured by the SATAQ-4R, CVCS-M and EICS, will increase the likelihood of overweight preoccupation (OP) as measured by Multidimensional Body Self Relations Questionnaire–Appearance Scales (MBSRQ–AS).

H3: In women with SA heritage in the UK, sociocultural attitudes around weight and shape, marital pressures and cultural identity conflict, measured by the SATAQ-4R, CVCS-M and EICS, will decrease the likelihood of body areas satisfaction (BASS) as measured by the MBSRQ–AS.

H4: In women with SA heritage in the UK, self-compassion, measured by the Self Compassion Scale (SCS), will moderate the relationships between the predictor and outcome variables described in H1, H2 and H3.

Chapter Three: Reflective Position

3.1 My Reflective Position

Throughout the development of this thesis, I have been aware of the importance of reflexivity and my position as a young, white, middle class, woman in academia. I have considered the impact that this has on my internal bias when viewing the research, developing the thesis, interpreting the data and during the write up. I have a level of power and privilege due to my characteristics, that has allowed me to be in the position I am in academia and research. I have not had first-hand experience of living within a SA culture. The way I have experienced and explore the world will be very different to the women with SA culture in the UK. Therefore, I believe it is important that I follow guidance on writing reflectively (Jamieson et al., 2022) and keep a journal to be able to better understand the impact of my position on the research and readers, specifically, those with SA heritage.

3.2 Development of the Research Question

Understanding the development of EDs and self-compassion have been key interests of mine, from working in an adult EDs service and predominately practicing Compassion Focussed Therapy (Gilbert, 2010) throughout my training. Through speaking to colleagues and friends from the SA community, I became aware of the lack of representation of women with SA heritage living in the UK in this research area. This was concerning when learning about the proportion of women with SA heritage who suffer with their body image and difficulties with eating behaviour, and the under-representation of these women in ED services. This motivated me to focus on this population group, rather than expanding on an already extensively researched field of White women's experiences, thus, perpetuating inequalities and the dominance of White culture.

3.3 Why Me?

Some may, understandably, question a White female researcher exploring the challenges of a racially minoritised group of which she is not a part. I have no experience of living within a SA community, nor am I hugely familiar with the cultural and religious beliefs that are such a valuable part of the community. The notion of the 'White saviour' is undoubtably oppressive to racially minoritised groups and removes agency from individuals by White people thinking they know best and want to rescue, rather than empower. There are important ethical issues associated with White researchers researching ethnicity, of which are important to highlight and I aim to minimise (Agyeman, 2008; Chadderton, 2012).

My values encompass those of fairness and equality, meaning my awareness of the lack of research in my field of interest for women with SA heritage in the UK, directly conflicts with my values of equality. I have noticed in practice the lack of knowledge around eating behaviour and body dissatisfaction in racially minoritised groups and how this could potentially lead to less effective and sensitive interventions compared to White counterparts.

In addition to this, as a White researcher I feel passionate in questioning and challenging the White dominant discourses in ED research, intervention and service structure. I also feel it is important that White researchers challenge White discourses and consider clinical implications outside of the Western-centric view, to prevent further marginalisation and invisibility of the experiences of people from racially marginalised groups in the UK (Agyeman, 2008). Furthermore, it is important to consider who 'gatekeeps' the research that is chosen to be funded and published. We don't always know who this is, but we understand the presence of institutional racism and the underrepresentation of those from racially minoritised backgrounds in positions of power in academia. Hence, this is reflected in the published research as there are many overlooked gaps in mental health research with

minoritised groups. More specifically, there is an underrepresentation of SA women accessing the Doctorate in Clinical Psychology course and conducting research. As this inequality is being addressed by course leads, this leads me to question whose responsibility is it to research racially minoritised groups, and is it ethical to conclude that research with racially minoritised group is a responsibility of only those from racially minoritised groups? I believe it is the responsibility of us all to challenge areas of injustice and make this transparent within the research field.

Just being reflective around these issues does not make any form of oppression acceptable, which is why I have considered the ways in which I can take responsibility within this thesis to minimise this ethical issue.

3.4 My Unconscious Bias

My naivety is apparent, and I wanted to ensure I wasn't falling into the 'White saviour' role. I chose to seek guidance from a supervisor with lived experience and experience of working in an ED service. I also organised a language consultation with our University Equality, Diversity and Inclusion Lead. Alongside this, I had multiple conversations with friends and a fellow peer, who are both women with SA heritage, and a group of young SA women who visit a local mental health organisation for SA women, Roshni Ghar. From these conversations, I actively learnt more about my potentially oppressive position, the cultural experiences of women with SA heritage and both the positive and negative external influences impacting on their attitudes towards their bodies. I am aware I have blind spots in my knowledge and understanding and I hope through the research process, reading the literature and gaining feedback through supervision I can explore these further.

3.5 Aims and Intentions

Throughout this thesis, I aim to ensure my White privilege is transparently named and that I continuingly reflect on my positioning through the use of a journal, so to not fall into the 'White saviour' trap. I will also continuingly consider the current research and measures used with a critical eye and reflect this in my writing. I aim to be consciously aware of my language use, by seeking continued consultation and integrating the knowledge gained from experts by experience into the research. In addition, when interpreting the data and offering future considerations I intend to keep the following 5 areas in mind, suggested by Stam (2021) to activate an 'ethic of solidarity'; "probing positionality, interrogating epistemic assumptions, disrupting hierarchies of power, shifting asymmetrical dialogue, and practicing decolonial research".

3.6 Expert by Experience Involvement

It was important to hear from the voices of experts by experience to shape all aspects and stages of this research, and this was considered at multiple levels. During the research design stage, an informal focus group was conducted at a mental health charity called Roshni Ghar with three young women with SA heritage. Alongside this, informal discussions with three experts by experience were conducted to hear their knowledge of the area and personal experiences. These discussions were vital in shaping the research questions, expanding the researcher's knowledge and reinforcing the themes found in the evidence base. For example, the women's experiences of the pressures on marriage were a theme throughout these discussions and led to further exploration and inclusion in the thesis design.

In addition, the research team includes a field supervisor who is an expert by experience and professional in the area of EDs. Two other members of the research team have expertise in EDs and quantitative design.

Chapter Four: Methodology

4.1 Ethical Approval

Ethical Approval was granted by the University of Leeds, Faculty of Medicine and Health Ethics Committee on the 22/05/2023 (reference number: MRC 22-062). Confirmation of ethical approval can be found in Appendix 2.

4.2 Epistemological Stance

It is acknowledged that the chosen methodology reflects a positivist 'scientific' stance, commonly not seen to be in-line with social constructionist ideas. However, I find my own views of the world align with the views of critical realism, whereby the 'real' world is not wholly observable. This stance reflects the beliefs that we construct our ideas about the world based on our perspectives and experiences, through what we observe. This lens will be reflected in the interpretation of the data based on the experiences of the women in this study and in the clinical implications.

4.3 Design

This thesis employed an online self-report, cross-sectional design utilizing quantitative methods to investigate the effects of sociocultural influences on overweight preoccupation, body areas satisfaction and eating behaviour in a population of women with SA heritage in the UK.

4.4 Participants

Those who identify as a female, with SA heritage, living in the UK and over the age of 16 were invited to participate in this thesis.

4.5 Recruitment

An opportunity sample of women who met the inclusion criteria were invited to take part in an anonymous 20-minute online survey. A power calculation was considered but not completed due to the research being preliminary and there being no published studies that have reported effect size on direct predictors or correlates between the chosen measures. The feasibility of gaining a large sample size would not be realistic due to time and external constraints, all efforts would be made to recruit as many women as possible in the allocated time with the available resources. A reasonable prediction of the recruitment rate was based on a minimum of 10 participants per predictor variable (VanVoorhis & Morgan, 2007), meaning 60 participants would be needed for the analysis.

4.5.1 Recruitment via Social Media

The survey was shared on multiple social media platforms (e.g. LinkedIn, Twitter, Facebook and Instagram). The online survey was shared using a poster advertisement including a QR code to access the survey (Appendix 6). Online posts also included a paragraph of text describing the thesis with the weblink (Appendix 8).

4.5.2 Recruitment via University Departments

Two University of Leeds departments (Faculty of Medicine & Health and Biological Sciences) and the University of Sheffield Doctorate of Clinical Psychology programme, shared the recruitment poster via email with the students enrolled in their courses.

4.6 Measures

Six questionnaires were chosen to form the survey, hosted on 'Online Surveys (OS)'. The OS platform was chosen to facilitate a web-based survey with the hope of reaching a

larger audience. The survey length was carefully considered to minimise participant burden and encourage a larger sample. All measures have been included in Appendix 3. The following overview categorises the measures into: Demographics, Predictor variables, Dependent variables and Moderator variables.

4.6.1 Demographics

Demographic measures were gathered at the beginning of the survey including; age, SA heritage, marital status and migration generation to the UK (first, second, third). Migration generation was defined in the survey as; first migration generation referring to those who were born on the Indian subcontinent and moved to the UK. Second generation were defined as those with at least one parent born on the Indian subcontinent who moved to the UK and the third generation was defined as those with at least one grandparent born on the Indian subcontinent and parent/s born in the UK. Fourth generation was defined as at least one grandparent and parent who was born in the UK.

Table 1

Outcome Measures, Including Predictor, Dependent and Moderator Variables.

Measure	Construct	Reference
Cultural Values Conflict Scale (CVCS-M)	Attitudes towards marriage	(Inman et al., 2001)
Ethno-cultural Identity Conflict Scale (EICS)	Cultural Identity Conflict	(Ward et al., 2011)
Sociocultural Attitudes Towards Appearance Questionnaire (SATAQ-4R)	Sociocultural attitudes of peers, family and the media	(Schaefer et al., 2017)
Multidimensional Body-Self Relations Questionnaire – Appearance Evaluation and Orientation Subscale (MBSRQ-AS)	Attitudes towards different aspects of body image	(Cash, 2000)
Eating Attitudes Test (EAT-26)	Characteristics associated with an eating disorder.	(Garner & Garfinkel, 1979)
Self-Compassion Scale (SCS)	Self-compassion	(Neff, 2003a)

4.6.2 Predictor Variables

The predictor variables chosen were based on past research and reinforced by the experiences of the experts by experience, who were consulted in the development of the thesis.

Cultural Values Conflict Scale (CVCS). The 'marriage' subscale (CVCS-M) containing three items within the CVCS, a 24-item measure, was used to assess attitudes towards marriage (Inman et al., 2001). Responses were answered on a 5-point Likert scale from 1 (strongly agree) to 5 (strongly disagree). It is acknowledged that this subscale could be perceived as generalising and assuming of the traditional SA values around marriage. The

CVCS-M was used due to limited relevant and validated measures around marital pressures, experienced by a sample of SA women. The CVCS was developed and validated with 319 SA American women, adequate internal consistency (Cronbach's alpha of 0.84 for the total scale score) and test-retest reliability was achieved (Inman et al., 2001). It is acknowledged that by using the CVCS-M and not the whole scale, there will be an impact on these psychometric properties.

Considerations were made for women completing the survey who were married and where these pressures may no longer apply. To account for this the women were asked 'If you are already married or in a civil partnership, please answer this question based on how you felt prior to this time' to ensure meaningful responses and prevent confusion.

Ethno-cultural Identity Conflict Scale (EICS). The EICS is a 20-item measure used to explore the degree in which a woman with SA heritage identifies with the values and beliefs of their heritage culture, when living in a Western culture which may have conflicting values and pressures (Ward et al., 2011). Items are scored on a 5-point Likert scale from 5 (strongly disagree) to 1 (strongly agree) with 4 items reverse scored. The lower the total mean score, the greater the 'ethno-cultural identity conflict'. Experiences of cultural identity conflict have been shown to cause stress and is a risk factor for developing mental health difficulties (Szabó & Ward, 2022). This measure has been used in studies with a large sample of 262 young people with SA heritage, aged 16-26 (Stuart & Ward, 2011). Ward et al. (2011) demonstrated an acceptable level of internal consistency across three studies in New Zealand with varying ethnic groups including Chinese, South Asian and European (Cronbach alphas ranging from 0.89 to 0.92.).

Sociocultural Attitudes Towards Appearance Questionnaire-4 Revised (SATAQ-4R). The SATAQ-4R is a 31-item measure used to explore the impact of sociocultural attitudes

from peers (SATAQ-P), family (SATAQ-F) and the media (SATAQ-M) on internalised weight stigma (Schaefer et al., 2015). Items are scored on a 5-point Likert scale from 1 (definitely disagree) to 5 (definitely agree), the higher the mean score for each subscale the greater the felt pressure on weight/shape.

The subscale measuring the impact of sociocultural attitudes towards appearance from significant others (SATAQ-SO) will not be included in the analysis. This thesis focussed on researching the evidence base for sociocultural influences, such as those included in the 'tripartite influence model' (Burke et al., 2021) . The subscales measuring the internalisation of muscular, general attractiveness and thinness will not be included, due to the scope of this thesis and the focus on the sociocultural impact on body image and eating behaviour.

Research has validated this questionnaire with 'Asian Americans' or 'Asians', however, there are a huge range of ethnicities within this grouping and it is unknown what proportion of the sample were of SA heritage (Lim, 2016; Schaefer et al., 2015; Schaefer et al., 2017) . A limitation to this questionnaire is that it does not define the ethnicity of the peers; research suggests there may be differing attitudes and narratives from SA peers and White peers, impacting internalised weight stigma differently (Goel et al., 2021). The scale demonstrated excellent reliability and good convergent validity and internal consistency (Cronbach's alpha for all subscales was 0.84 or higher) (Schaefer et al., 2015).

4.6.3 Dependent Variables

The dependent variables of body dissatisfaction and eating behaviour difficulties were chosen to explore the impact of the predictor variables on characteristics associated with an eating disorder.

Multidimensional Body-Self Relations Questionnaire – Appearance Evaluation and Orientation Subscale (MBSRQ-AS). The MBSRQ-AS is a shorter version of the original scale with 34 items measuring attitudes towards different aspects of body image (Brown et al., 1990; Cash, 2000). This scale was chosen as it encompasses multiple aspects of body image rather than just shape and weight, for example skin, hair and facial features, resulting in a more cohesive view of someone's attitudes towards their appearance. Subscales include, appearance orientation (AO), appearance evaluation (AE), overweight preoccupation (OP), body areas satisfaction scale (BASS) and self-classified weight (SCW) and were scored on varied 5-point Likert scales with reverse scored items. Adequate internal consistency coefficients have been reported across all subscales, Cronbach's alphas ranged from 0.73 to 0.90 (Cash, 2000). This scale has been used within multiple ethic groups including those with SA heritage and with translated versions available (Fahiz, 2019; Naqvi & Kamal, 2017).

Eating Attitudes Test (EAT-26). The EAT-26 is a 26-item measure (based on the original EAT-40) which has been used extensively within ED research and within populations with SA heritage, in order to measure characteristics of EDs (AN, BN and BED) (Furnham & Patel, 1994; Garner & Garfinkel, 1979; Garner et al., 1982; Mumford et al., 1991; Wildes et al., 2001). Items are scored on a 6-point Likert scale, ranging from 3=always, 2=usually, 1=often and 0=sometimes, rarely and never. The subscales of the EAT-26 relate to the presentation of BN and food preoccupation, dieting and oral control. The scale also includes five behavioural questions considering laxative use and binge, purge, and exercise frequency. However, this measure is not used to diagnose an ED but can help to aid understanding. Garner et al. (1982) found the scale to have adequate validity and reliability, with a high internal consistency (Cronbach's alpha = 0.90).

4.6.4 Moderator Variable

Self-compassion has been suggested as being a predictor, mediator and moderator in the literature (Fidan, 2022). A moderator variable has been defined as "the effect of an independent variable X on a dependent variable Y is moderated by the variable M if it's size, sign or strength depends on or can be predicted by M" (Hayes & Rockwood, 2017). Past research had suggested that self-compassion is a moderator, whereby it changes the strength and/or direction of the relationship between the predictor variables on eating behaviour and body image (Braun et al., 2016; Tylka et al., 2015). In contrast, some studies have considered self-compassion as a mediator that facilitates the association between predictor variables and eating behaviour and body image (Ferreira et al., 2013).

The role self-compassion plays in the relationship between external predictors and eating behaviour and body image is somewhat unclear. However, self-compassion has been chosen as a moderator variable in this thesis, to demonstrate the strength and direction of the relationship between the predictor and dependent variables. It is thought that those with increased compassion may be less likely to experience body dissatisfaction when exposed to external pressures.

Self-Compassion Scale (SCS). The SCS measures the construct of self-compassion, described as 'being kind and understanding to oneself in instances of pain or failure' and has been correlated with positive mental health outcomes (Neff, 2003b). Participants rate a 5-point Likert scale from 1=almost never to 5=almost always. The SCS has been shown to have good test-retest reliability with an overall score of 0.93, and good internal consistency, Cronbach's alpha was .92 (Neff, 2003a).

Twenty two percent (n=51) of the population the scale was validated on were described as having 'Asian' heritage (Neff, 2003a). However, this encompasses many ethnic groups and

may not include those with SA heritage. Recent studies have validated the scale with Sri Lankan and Asian American (a broad range of Asian ethnicities) populations but not explicitly with those with SA heritage (de Zoysa et al., 2022; Liu et al., 2020; Wei et al., 2020).

4.7 Procedure

4.7.1 Participant Screening

Inclusion Criteria. Inclusion criteria for the study was (a) those who identify as female with SA heritage and (b) 16 years of age or over. Those invited to participate in the research were women with SA heritage, (heritage of those with roots in the SA countries of India, Pakistan, Afghanistan, Bangladesh, Sri Lanka, Nepal, Bhutan, and the Maldives).

Exclusion Criteria. Males were excluded from the study due to the main focus being those who identify as female, to expand on past research and address a gap in the field. However, it is acknowledged that there are challenges with categorising people into gender binary groups and that this excludes those who do not identify as having a binary gender.

Those under the age of 16 were excluded from this study due to the measures not being valid on those under the age of 16, and the evidence base for this study all include samples over the age of 16. The research also excluded people unable to give consent and unable to speak fluent English, as funding was insufficient to translate and validate the measures chosen.

4.7.2 Online Survey

Participants took part in the study by accessing the online survey using a weblink (https://leeds.onlinesurveys.ac.uk/thesisbp) or via a QR code which directed them to the OS platform. Participants were welcomed by a brief introduction and the Participant Information Sheet (PIS), it was requested that they take their time to read all the information prior to

proceeding (Appendix 4). A link to a downloadable PIS was located at the bottom of this page to ensure participants could save a copy of the PIS to refer back to. Prior to the survey completion, all participants were asked to read a number of consent statements (Appendix 5) and click 'next' to agree to all statements and begin the survey. The survey was timed to take an average of 20-minutes to complete.

Priming effects were taken into account when considering the order of questionnaires in the survey. It was decided that questionnaires relating to both body image and eating behaviour would be placed towards the end of the questionnaire, so to not impact the participant's views of external sociocultural influences. In addition, these questionnaires may be viewed as more distressing to complete, and so they would be closest to the supportive resources on the last page. The survey order is visually displayed in Appendix 9. However, the questionnaires defined as most sensitive is subjective, meaning priming effects are not ruled out.

4.7.3 Study Withdrawal

Participants were notified prior to the completion of the survey that once they click 'Finish' at the end of the survey, their data can no longer be withdrawn and it will be stored on the University of Leeds OneDrive ready for analysis. Participation was entirely voluntary and as it was an online study, participants were made aware that they can close the browser window without any further prompting or pressure to continue. By doing this, all further questions will have ceased and no data will have been stored until the participant clicked 'Finish' at the end of the survey.

4.7.4 Prize Draw

Following completion of the survey, participants were given the option to provide an email address to participate in a prize draw to win one of several £30 Love2Shop vouchers. This was implemented to encourage uptake, although resource could not offer all participants a cash incentive.

4.8 Ethical Considerations

4.8.1 Psychological Distress

This research required respondents to divulge information about potential sociocultural pressures on weight and shape from family, peers, partners and the media, alongside cultural identity conflict and pressures on marriage. The recollection of these experiences may have triggered distress, especially if they were associated with discrimination, bullying or particularly distressing or traumatic memories. It is hoped that the number of people who found disclosing this type of information distressing was small. However, if through participating in the study the participant became unduly distressed, they were encouraged in the PIS to contact the lead researcher or their GP/current NHS clinician/s if they continue to feel distressed. In addition, links to helpful resources, helplines and organisations were provided at the end of the survey.

Participants were able to contact the research team if they wished to make a complaint or had any concerns or questions about the information provided. When a participant contacted the researcher, any potentially identifiable email correspondence was immediately deleted after replying.

4.8.2 Alternative Survey Versions

To address the ethical issue of the digital divide, there was an option to receive paper copies of the survey to be posted back to the researcher. However, this was not requested by any participants. The use of translated versions of the measures were considered and it was concluded that this did not feel necessary due to the sample population being English speaking. Alongside this, many of the questionnaires did not have translated versions available. However, this is an ethical issue as it is excluding those in the population who do not speak English.

4.9 Approach to Data Analysis

This section outlines the strategy with respect to case inclusion / exclusion and validity checks of the data. It also presents the analysis strategy including justification of the statistical tests employed.

4.9.1 Data Preparation and Screening

Data Extraction. Data from the OS platform was exported to Excel and confidential email addresses were removed to a separate file. The data was cleaned, coded, reverse scored and checked for missing data prior to being imported into the IBM Statistical Package for the Social Sciences Version 29 (SPSS 29). All electronic documents were stored on the University of Leeds OneDrive with access granted to the lead researcher only.

Data from the OS platform was exported to Excel and confidential email addresses were removed to a separate file. The data was cleaned, coded, reverse scored and checked for missing data prior to being imported into the IBM Statistical Package for the Social Sciences Version 29 (SPSS 29). All electronic documents were stored on the University of Leeds OneDrive with access granted to the lead researcher only.

Data Cleaning. The data was prepared for analysis by formatting, coding and reverse scoring where necessary. New variables were created to calculate the outcome measure subscales and total scores.

4.9.2 Error Protocol

Missing Item Data. The completion of survey items was optional, meaning participants were not prompted if they had missed responding to an item. This means there is a chance of random or intentional missing data throughout the dataset. If there is less than 40% missing data for each item, a multiple imputation process will be conducted to calculate five output datasets of replacement data. The pooled imputed data will then be used in data analysis. Multiple imputation was chosen as it has been shown to be a valid method for handling missing data, to avoid creating false precision and provide accurate estimates (Li et al., 2015). In addition, multiple imputation is robust to the violation of the normality assumptions, it produces appropriate results even with a small sample size and is more accurate than using a single imputation method (Kang, 2013).

Missing Variable Data. Where there is more than 40% complete missing variable data, the entire case will be removed from analysis (Jakobsen et al., 2017).

4.9.3 Questionnaire Analysis

SATAQ-4R. The scores on each sub-scale (SATAQ-Peers, SATAQ-Family and SATAQ-Media) are expressed as the mean sum of the ratings from the individual items that the sub-scale is composed of. No reverse scoring was necessary for the three chosen subscales.

CVCS-M. The CVCS three-item marriage subscale is calculated as the mean sum of the individual items. The higher the score the greater the felt pressures on marriage.

EICS. The EICS is calculated as a total mean score of all 20 items with four items reversed scored. The lower the total mean score, the greater the 'ethno-cultural identity conflict'.

MBSRQ-AS. The MBSRQ-AS subscales of body areas satisfaction (BASS) and overweight preoccupation (OP) were calculated as the mean sum of the ratings for each item in the subscale. No reverse scoring was necessary for these subscales. Low scorers on the BASS are suggested to feel less content with the size or appearance of several areas of their body and high scores on the OP indicate increased weight vigilance, 'fat' anxiety, dieting and eating restraint.

EAT-26. The EAT-26 was calculated as a total score raw score ranging from 0-78. A score at or above 20 indicates a high level of concern around dieting, body weight and problematic eating behaviours. Quartiles will be presented to understand the sample in relation to the cut-off score.

SCS. The mean scores for each subscale were calculated following the reverse scoring of the subscales self-judgement, isolation and over-identification. The means of each subscale are used to compute a total mean score. No clinical norms are indicated, it is suggested that a high score indicated greater self-compassion.

4.9.4 Statistical Analysis

Consultation with a statistician was sought on two occasions to check appropriateness of the planned analysis and interpretation of the data. Data was analysed using IBM SPSS Version 22.

4.9.5 Descriptive Statistics

The data was initially analysed using descriptive statistics (frequency count, percentages, means and standard deviations). The demographic data included age, South Asian heritage, migration generation and marital status.

4.9.6 Preliminary Analysis

All outcome data is explored using descriptive statistics (means, standard deviations, minimum and maximum values). Histograms, box-plots, scatterplots and estimates of skewness and kurtosis are used to identify outliers and normality assumptions. Comparative normative data of the key variables is to be explored to understand how it compares to other community samples.

4.9.7 Multiple Linear Regression

Linear regression is a widely used model for exploring the strength and direction of the relationship between variables within many research fields, including social sciences (Montgomery et al., 2021). It is commonly known that regression models do not imply a causal relationship and theoretical considerations should be considered when interpreting the data.

Multiple linear regression analysis was chosen as an extension of linear regression, due to there being more than one predictor (independent variable). Three multiple linear regressions were used to explore the relationships between six predictors and three outcome variables. These analyses indicated the strength of the relationship and the amount of variance in eating behaviour, overweight preoccupation and body areas satisfaction explained by marriage, media, family and peer pressures and cultural identity conflict.

Method of Multiple Linear Regression. All multiple regression models entered the continuous predictor variables into the analysis using a sequential regression method of entry. Block-wise selection was chosen to account for theoretical evidence and to distinguish the impact on the dependent variable as predictors were entered.

Three separate multiple linear regression analyses were completed for each dependent variable: eating behaviour (EAT-26), overweight preoccupation (OP) and body areas satisfaction scale (BASS) (two MBSRQ-AS subscales). Two body image subscales were chosen as target outcome measures out of the completed five. This was due to the relevance of these subscales to the research question, when compared to the MBSRQ-AS subscales measuring appearance evaluation, appearance orientation and self-classified weight. Overweight preoccupation was viewed as an important variable to focus on in the analysis due to past research highlighting narratives around weight being valued higher than other beauty standards by older SA women in the community (Goel et al., 2021), although it has been suggested that this may vary and drive for thinness is experienced less in women with SA heritage due to beliefs around being 'too thin' (Goel et al., 2021).

Body areas satisfaction was included as a target variable due to the importance of considering body image as not just weight but also a woman's satisfaction with their facial features (including skin), hair, lower torso, mid torso, upper torso, muscle tone, weight, height and overall appearance. Research has identified aspects of SA beauty standards that include having light skin, no body hair and having long hair (Goel et al., 2021). Both of these variables may be influenced by pressures on marriage, due to this leading to a focus on physical beauty and ideas around being 'marriageable', resulting in negative body image (Mehrotra, 2016).

Each block of predictors entered into the regression is considered a model. The first block of predictor variables included the SATAQ subscales of appearance-based pressures from family, peers and media, named model 1. These predictors were entered first due to the research base indicating significant relationships between these sociocultural attitudes towards appearance on body image and eating behaviour in Asian American women (Burke et al., 2021; Javier & Belgrave, 2019; Rounsefell et al., 2020). These predictors were grouped in one block due to their equal level of importance. The second block (model 2) entered into the analyses included the subscale of marriage in the CVCS (CVCS-M). Narratives around marriage have been shown to be communicated by family and peers, increasing the pressures to meet beauty standards to be 'marriageable' (Goel et al., 2021; Mehrotra, 2016). Hence, this was chosen as the next predictor due to the link to sociocultural attitudes (model 1), potentially increasing the impact on body image and eating behaviour. The third block included the total score for the EICS measuring cultural identity conflict (model 3). This was chosen as the last entered predictor due to the complex and relatively unknown relationship to body image and eating behaviour. Multiple hypotheses suggest these links may be compounded by parental expectations, competing appearance ideals, strength of cultural values and racial teasing (Chan & Hurst, 2022; Goel et al., 2021; Mustafa et al., 2017).

The amount of variance in the outcome variables, accounted for by the predictor variables, will be demonstrated by stating the adjusted R^2. Presentation of the adjusted R^2 was preferred due to this being a more conservative value which is more accurate in explaining the model's goodness of fit.

Assumptions. Each multiple linear regression was chosen to explore the amount of variance in eating behaviour and aspects of body image, explained by the sociocultural attitudes of the media, family, peers and the pressures on marriage and cultural identity

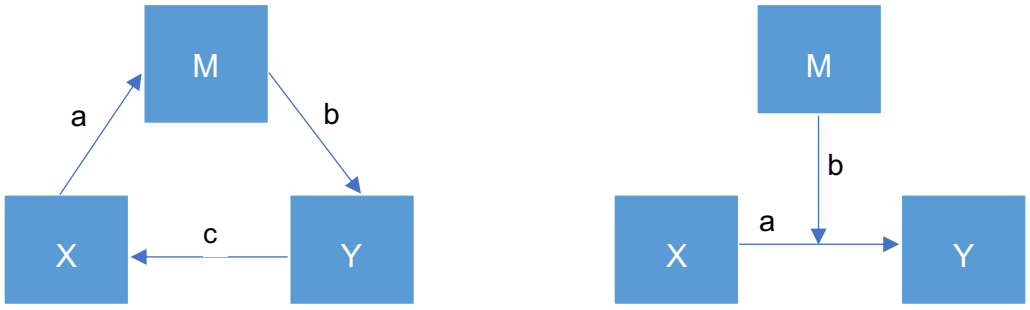
conflict. Several assumptions were considered prior to conducting the multiple regression analyses. These consisted of; homoscedasticity, an appropriate sample size for each variable entered, normally distributed residuals and a low level of multicollinearity between predictors. It was important that these assumptions are met to reduce error and ensure the analyses is as accurate and reliable as possible.

4.9.8 Moderated Multiple Linear Regression

A moderation analysis was chosen to explore whether interactions between the continuous predictor and outcome variables are influenced by self-compassion, the continuous moderator variable (Jose, 2013). This analysis was conducted within a multiple regression format to determine the interaction effect of the moderator variable on the independent and dependent variables (Jaccard & Turrisi, 2003). Moderation analysis differs from mediation analysis as it allows you to test for the influence of a third variable on a relationship between two variables, rather than exploring the causal link between all variables, see figure 2.

Figure 2.

Basic mediation and moderation models.



Mediation Model Moderation Model

Chapter Five: Results

This chapter presents the cross-sectional quantitative analysis results, exploring the impact of external sociocultural influences (as measured by the SATAQ-4R, CVCS and EICS) on eating behaviour (as measured by the EAT-26) and body image (as measured by the MBSRQ-AS), moderated by self-compassion (as measured by the SCS). The relationships between these variables will be explored for this sample of SA women, using the statistical analyses detailed in Chapter Four (Methodology).

5.1 Participant Characteristics

Data were collected from 89 participants. The demographics for the sample are described in Table 2. The age of participants ranged from 17 to 56, with a median age of 27. Regarding ethnicity, the largest proportion of participants (46.1%) identified as Pakistani heritage with the majority identifying as being from the second migration generation (56.2%). With regard to marital status, the majority (51.7%) reported to be single.

Table 2

Characteristics of the overall sample (N=89).

Sample Characteristics	
Age n(%)	
17-20	16(18)
21-30	40(44.9)
31-40	20(22.5)
41-50	8(9.0)
51+	4(4.5)
Missing	1(1.1)
Min-Max	17-56
Mean (SD)	29.5 (9.51)
Ethnicity n(%)	
Bangladeshi	10(11.2)
Indian	25(28.1)
Pakistani	41(46.1)
Maldivian	3(3.4)
Ski Lankan	4(4.5)
Nepalese	5(5.6)
Mixed heritage (Indian/British)	1(1.1)
Marital status n(%)	
Married	30(33.7)
Civil partnership	3(3.4)
Divorced	2(2.2)
Separated	5(5.6)
Single	46(51.7)
Widowed	3(3.4)
Migration Generation n(%)	
First	0
Second	50(56.2)
Third	18(20.2)
Fourth	4(4.5)
Unknown	4(4.5)

Table 3

Summary table of Mean (SD) and Range (Min-Max) of key variables.

Variable	Mean (SD)	Range (Min-Max)
Sociocultural Attitudes - Peers (SATAQ-P)	2.13 (0.98)	1 to 5
Sociocultural Attitudes - Family (SATAQ-F)	2.71 (1.20)	1 to 5
Sociocultural Attitudes - Media (SATAQ-M)	3.21 (1.20)	1 to 5
Cultural Identity Conflict (EICS)	3.25 (0.73)	1.70 to 4.65
Marriage Pressures (CVCS-M)	3.44 (1.19)	1 to 5
Eating Behaviour (EAT-26)	15.87 (13.01)	0 to 49
Overweight Preoccupation (MBSRQ-OP)	2.87 (0.96)	1 to 5
Body Areas Satisfaction (MBSRQ-BASS)	3.08 (0.74)	1.11 to 5
Self-Compassion Scale (SCS)	2.99 (0.60)	1.48 to 4.41

Note: Colours have been used to demonstrate variable category including predictors, outcomes and moderator.

The sample were asked whether they had previously been treated for an ED within the EAT-26 measure, 21.3% of the sample answered 'yes'.

5.2 Missing Data

Missing data was present for 25 individual items, with the majority of items missing just one participant's data (1.1% missing data) and just one item missing 3 participant's data (3.4% missing data). Guidance for the management of missing data was not indicated for all measures. Hence, where there was less than 40% missing data for each item, a multiple imputation process was conducted to calculate five output datasets of replacement data (Kang, 2013). The pooled imputed data was used in all data analysis, apart from frequency

data where specified. Data was removed prior to analysis for one participant's EICS survey data and two participants CVCS-M survey data, due to over 40% of the variable being incomplete.

5.3 Preliminary Analysis

All outcome data was explored using descriptive statistics (means, standard deviations, minimum and maximum values).

5.3.1 Outliers

To check for outliers, minimum and maximum scores were examined for all variables. This was corroborated by inspection of box plots. Outliers were then checked for feasibility and any data entry errors corrected. Outliers were considered to be values more than three standard deviations from the mean. While data entry errors could be identified as values outside of the minimum or maximum score on the measure scale. Any data point considered to be an outlier was removed from the analysis.

5.3.2 Normality Checks

Normality of all variables were assessed graphically using histograms (see Appendix 10), scatterplots and statistically using values of skewness and kurtosis. All variables follow a normal distribution and parametric tests were used in the analysis.

5.3.3 Assumptions for Multiple Regression

Preliminary assumption checks for all multiple linear regression analyses were conducted (see section 4.9.7). A total of 86 participants for each regression model exceeded the minimum required to identify an effect at a good level of power (VanVoorhis & Morgan, 2007). Visual tools were used to assess for normality due to statistical tests having low power

in small sample sizes (Mishra et al., 2019). Scatterplots demonstrated linear relationships between the dependent variables (eating behaviour, overweight preoccupation and body areas satisfaction) and all predictor variables (media, peers, family, marital pressures and cultural identity conflict), meeting the linearity assumption. The normal distribution of residuals for all three dependent variables was checked using P-P plots, they were all found to follow a line of normal distribution. Hence, it can be assumed that all regression models captured the key sources of variation and that any errors were random. Residuals for all three dependent variables were equal across the regression line, meaning the data meets the assumption of being homoscedastic. Multicollinearity checks found that correlations between the predictors did not exceed r=0.7, meeting the assumption that correlations between variables were not 'highly correlated'. A correlation of over r=0.7 is commonly described as the "cut-off to diagnose the presence of a strong bivariate correlation" (Yoo et al., 2014).

5.4 Comparative Normative Data

Comparative normative data of the key variables was explored to understand how this study's data compares to data from comparable community samples where available, see Table 4. Unfortunately, there was no comparable SATAQ-4R data for a sample of women with SA heritage, to compare with the current study's subscale means. However, comparative data is available for nationalities categorised as Asian American (Lim, 2016), Chinese (Huang et al., 2023), Italian (Stefanile et al., 2019) and American (Schaefer et al., 2017). When compared to a majority White American sample, the subscale means demonstrated only slight differences to the current mean scores (Schaefer et al., 2017).

A community sample of 319 SA women aged from 20 to 44, in the US completed the CVCS-M subscale (M=3.34) (Inman et al., 2001). When comparing the mean sample scores, the current study's sample was just 0.1 higher (M=3.44). In addition, the EICS development

study (Ward et al., 2011) gathered a sample of 304 women between the ages of 16 to 77 years old of varying ethnic heritage and found a smaller mean (M=2.01) when compared to the current study (M=3.25).

Existing community data of 204 school-aged women with SA heritage in the UK were found to have a mean EAT-26 score of M=10.60 (Mumford et al., 1991), consistent with the founders of the EAT-26 who presented a mean of M=9.90 in a community sample of women (Garner et al., 1982). In a comparative community sample of White women, research found a mean score of M=8.53 (Furnham & Adam-Saib, 2001). This normative data differs from the current sample mean which was much higher (M=15.87).

Normative data for the MBSRQ-AS with a comparative sample of Indian and Afghan women present an OP mean of M=2.50 and a BASS mean of M=3.30 (Fahiz, 2019). Alongside this, normative mean data for a sample of majority White women in the US is; OP (M=3.03) and BASS (M=3.23) (Cash, 2000). The current mean score for OP (M=2.87) was greater than the SA sample comparison but lower than the majority White sample. The current mean score for the BASS (M=3.08) was lower than both comparative samples.

The SCS moderator variable has no clinically relevant norms. However, the current study's mean SCS score of M=2.99, indicates a moderate level of self-compassion and scores varying across the spectrum from low to high (Neff, 2003a). When compared to a sample of majority White women, the total mean SCS score was M=3.15, which is greater than the current study's mean score.

Table 4

Comparative mean scores from community samples.

Variable	Current Study Mean (Mean(SD))	Historical SA Sample Data	Historical Majority White Sample Data
SATAQ-P	2.13 (0.98)	-	2.21 (1.10) (Schaefer et al., 2017)
SATAQ-F	2.71 (1.20)	-	2.45 (1.21) (Schaefer et al., 2017)
SATAQ-M	3.21 (1.20)	-	3.48 (1.34) (Schaefer et al., 2017)
EICS	3.25 (0.73)	2.01 (Ward et al., 2011)	-
CVCS-M	3.44 (1.19)	3.34 (Inman et al., 2001)	-
EAT-26	15.87 (13.01)	10.6 (Mumford et al., 1991) 9.9 (Garner et al., 1982)	8.53 (9.5) (Furnham & Adam-Saib, 2001)
MBSRQ-OP	2.87 (0.96)	2.50 (Fahiz, 2019)	3.03 (Cash, 2000)
MBSRQ-BASS	3.08 (0.74)	3.30 (Fahiz, 2019)	3.23 (Cash, 2000)
SCS	2.99 (0.60)	-	3.15 (Neff, 2003a)

Note: Colours have been used to demonstrate variable category including predictors, outcomes and moderator.

5.5 Sociocultural Influences on Body image and Eating Behaviour

The first research question explores the impact of sociocultural attitudes around weight/shape, marriage pressures and cultural identity conflict impact on body image and eating behaviour in women with SA heritage in the UK.

5.5.1 H1: Eating Behaviour

The results of the analysis found that the pooled total scores (average of all 5 imputed data sets) on the EAT-26 were M= 15.87, SD=13.01. Clinical cut offs (total score of 20 or above) suggest that n=29, 32.6% of participants had difficulties with eating behaviour, indicating a likely presence of an eating disorder. The highest proportion of the sample scored within the first quartile of total scores ranging from 0-10 (n=37, 41.6%) evidenced in Table 5.

Table 5

Scores on the EAT-26 outcome measure, represented in quartiles.

Score on the EAT-26	Frequency (N=89)	%
0-10	37	41.6
11-20	26	29.2
21-30	14	15.7
31-49	12	13.5

Note: Analysis is based on the 5th set of imputed data.

Correlations. Correlations between the EAT-26 outcome variable and predictors were considered prior to regression analysis, see Table 6. Results found that pressures from peers and self-compassion significantly correlated (r=0.181 p=.048, r=-0.220 p=.021). This suggests that the higher the score for appearance-based pressures experienced from peers, then the higher the score for eating behaviour difficulties. The lower the score for self-compassion then the higher the score for eating behaviour difficulties.

Marriage pressures and cultural identity conflict were highly significant to the .01 level (r=0.252 p=.01, r=-0.530 p=<.001). This suggests that the greater the pressures on marriage the higher the score for eating behaviour difficulties. It could also be suggested that increased cultural identity conflict results in a higher score in eating behaviour difficulties. All correlations can be found in Appendix 11.

Table 6

Correlations between eating behaviour (EAT-26) and predictors.

	SATAQ-M	SATAQ-F	SATAQ-P	CVCS-M	EICS	SCS
EAT-26	0.011	0.139	0.181*	0.252**	-0.530**	-0.220*

Note: Analysis is based on pooled imputed data.
*Correlation is significant at the .05 level (2-tailed)
**Correlation is significant at the .01 level (2-tailed)

Multiple Linear Regression. Hypothesis 1 predicted that sociocultural pressures experienced by the media, peers and family, pressures on marriage and cultural identity conflict would lead to a change in eating behaviour. This regression model was conducted to explore the level of influence the predictors may have on eating behaviour. The standardised coefficients (β), level of significance (Sig) and confidence intervals are presented in Table 7.

Table 7

Results of the multiple linear regression analysis for eating behaviour.

				95% Confidence Interval	
Model	Variable	β	Sig	Lower	Upper
1	SATAQ-M	-0.561	0.673	-3.161	2.039
	SATAQ-F	0.969	0.523	-2.002	3.940
	SATAQ-P	1.926	0.258	-1.410	5.262
2	SATAQ-M	-0.439	0.735	-2.981	2.104
	SATAQ-F	-0.148	0.924	-3.215	2.918
	SATAQ-P	2.394	0.153	-0.890	5.678
	CVCS-M	2.727	0.027*	0.310	5.143
3	SATAQ-M	-0.810	0.483	-3.072	1.453
	SATAQ-F	-0.540	0.698	-3.267	2.188
	SATAQ-P	0.843	0.580	-2.144	3.829
	CVCS-M	0.801	0.492	-1.485	3.086
	EICS	-9.057	<0.001**	-12.780	-5.330

Note: All analyses presented were calculated using the pooled imputed data for each model. *Correlation is significant at the .05 level (2-tailed). **Correlation is significant at the .01 level (2-tailed).

The results indicated that model three, including all predictor variables, significantly predicted eating behaviour ($F(5,80) = 6.727$, $p=<.001$). It was found that the predictor variable of cultural identity conflict significantly predicted eating behaviour ($\beta=-9.057$, $p=<.001$). It could be suggested that the greater SA women's experiences of cultural identity conflict, the increased risk they are of having eating behaviour difficulties. However, the confidence intervals are wide, suggesting a lack of certainty and imprecision.

The variance in EAT-26 accounted for by the predictors, which were entered into the analysis in blocks, is demonstrated in Table 8. In the first model, 0.4% of the adjusted variance in eating behaviour was explained by sociocultural attitudes of the media, family and peers. In the second model, 4.9% of the adjusted variance in eating behaviour was explained by sociocultural attitudes of the media, family and peers and pressures on marriage. In the third model, 25.2% of the adjusted variance in eating behaviour was explained by all predictor variables, including cultural identity conflict.

Table 8

Variance in EAT-26 accounted for by the predictors for each model.

Model	R^2	Adjusted R^2
1	0.039	0.004
2	0.093	0.049
3	0.296	0.252

5.5.2 H2: Body Image - Overweight Preoccupation.

The results of the analysis found that the pooled total scores (average of all 5 imputed data sets) on the OP subscale were M= 2.87, SD=.96. There are no suggested clinical cut offs for this scale, a higher score on the OP reflects greater overweight anxiety, weight vigilance and focus on dieting and eating restraint. The majority of the sample scored within the mid-quartile (total scores between 2-3), see Table 9. This suggests that the majority of the sample experience a measurable degree of overweight preoccupation and eating restraint.

Table 9

Scores on the OP outcome measure and represented in quintiles.

Score on the OP	Frequency (N=89)	%
1	10	11.2
2	38	42.7
3	25	28.1
4	14	15.8
5	2	2.2

Note: Analysis is based on the 5th set of imputed data.

Correlations. Correlations between the OP outcome variable and predictors were considered prior to the regression analysis, see Table 10. All predictors were found to be significantly correlated to the outcome of OP. Results found that pressures from peers (r=0.198 p=.034) and cultural identity conflict (r=-0.225, p=.019) significantly correlated to the .05 level. This suggests that the higher the score for appearance-based pressures experienced from peers, the higher the chance of overweight preoccupation. Alongside, those who experience increased cultural identity conflict (lower EICS scores), will have a higher chance of experiencing overweight preoccupation.

The pressures around weight and shape from the media (r=0.393, p=<.001) and family (r=0.450, p=<.001), marriage pressures (r=0.346, p=<.001) and self-compassion (r=-0.406, p=<.001) were highly significant to the .01 level. This suggests that the greater the pressures around weight and shape from the media and family, increased marriage pressures and lower self-compassion, the more likely they experience overweight preoccupation.

Table 10

Correlations between the outcome measure of OP and six predictors.

	SATAQ-M	SATAQ-F	SATAQ-P	CVCS-M	EICS	SCS
OP	0.393**	0.450**	0.198*	0.346**	-0.225*	-0.406**

Note: Analysis is based on pooled imputed data.
*Correlation is significant at the .05 level (2-tailed)
**Correlation is significant at the .01 level (2-tailed)

Multiple Linear Regression. Hypothesis 2 predicted that sociocultural pressures experienced by the media, peers and family, pressures on marriage and cultural identity conflict, will lead to a change in OP. This regression model was conducted to explore the level of influence the predictors may have on OP. The standardised coefficients (β), level of significance (Sig) and confidence intervals are displayed in Table 11.

Table 11

Results of the multiple linear regression analysis for OP.

				95% Confidence Interval	
Model	Variable	β	Sig	Lower	Upper
1	SATAQ-M	0.186	0.032*	0.016	0.356
	SATAQ-F	0.277	0.005**	0.082	0.472
	SATAQ-P	-0.015	0.894	-0.233	0.203
2	SATAQ-M	0.194	0.021*	0.029	0.360
	SATAQ-F	0.201	0.049*	0.001	0.400
	SATAQ-P	0.017	0.875	-0.196	0.231
	CVCS-M	0.186	0.020*	0.029	0.344
3	SATAQ-M	0.194	0.023*	0.027	0.361
	SATAQ-F	0.200	0.051	-0.001	0.402
	SATAQ-P	0.016	0.886	-0.204	0.237
	CVCS-M	0.185	0.031*	0.017	0.353
	EICS	-0.006	0.966	-0.281	0.269

Note: All analyses presented were calculated using the pooled imputed data for the third model. *Correlation is significant at the .05 level (2-tailed). **Correlation is significant at the .01 level (2-tailed).

The results indicated that all predictor variables, significantly predicted OP ($F(5,80) = 6.805$, $p=<.001$). It was found that the predictor variables of media and marriage pressures significantly predicted OP ($\beta=0.194$, $p=.023$, $\beta=0.185$, $p=.031$). Hence, it could be suggested that the greater SA women's experiences of marriage pressures and sociocultural pressures from the media, the increased risk of experiencing overweight preoccupation.

The variance in OP accounted for by the predictors, as they were entered into the analysis in blocks, is demonstrated in Table 12. In the first model, 22% of the adjusted variance in overweight preoccupation was explained by sociocultural attitudes of the media, family and peers. In the second model, 26.4% of the adjusted variance in OP was explained by sociocultural attitudes of the media, family and peers and pressures on marriage. The third model accounted for less variance in OP (25.5%) than the second model. Meaning that the addition of cultural identity conflict reduced the amount of variance in OP, explained by all predictor variables.

Table 12

Variance in OP accounted for by the predictors for each model.

Model	R^2	Adjusted R^2
1	0.248	0.220
2	0.298	0.264
3	0.298	0.255

5.5.3 H3: Body Image - Body Areas Satisfaction

The results of the analysis found that scores on the body areas satisfaction scale (BASS) were M= 3.08, SD=.74. There are no suggested clinical cut offs, higher scores on the BASS indicate being generally content with most areas of their body. The majority of the

sample scored within the mid quartile of scores 2-3, perhaps suggesting a greater proportion of the sample being unhappy with the size or appearance of areas of their body, see Table 13.

Table 13

Scores on the BASS outcome measure and represented in quintiles.

Score on the BASS	Frequency (N=89)	%
1	7	7.9
2	29	32.5
3	41	46.1
4	11	12.4
5	1	1.1

Note: Analysis is based on the 5th set of imputed data.

Correlations. Correlations between BASS outcome variable and predictors were considered prior to the regression analysis, see Table 14. Results found that pressures from family (r=-0.222 p=.036) and marriage pressures (r=-0.264 p=.013) significantly negatively correlated to the .05 level. This suggests that the higher the score for appearance-based pressures experienced from family and marital pressures, the greater the chance of SA women experiencing dissatisfaction with areas of their body. Cultural identity conflict (r=0.273 p=.01) and self-compassion (r=0.355 p=<.001) were highly significant to the .01 level. This suggests that the greater the experienced cultural identity conflict and the lower their self-compassion, the greater the chance that SA women experience dissatisfaction with areas of their body.

Table 14

Correlations between the outcome measure of BASS and six predictors.

	SATAQ-M	SATAQ-F	SATAQ-P	CVCS-M	EICS	SCS
BASS	-0.134	-0.222*	-0.167	-0.264*	0.273**	0.355**

*Correlation is significant at the .05 level
**Correlation is significant at the .01 level

Multiple Linear Regression. Hypothesis 3 stated that sociocultural pressures experienced by the media, peers and family, pressures on marriage and cultural identity conflict influence BASS, an aspect of body image. This regression model was conducted to explore the level of influence the predictors may have on BASS. The standardised coefficients (β), level of significance (Sig) and confidence intervals are displayed in Table 15.

Table 15

Results of the multiple linear regression analysis for BASS.

				95% Confidence Interval	
Model	Variable	β	Sig	Lower	Upper
1	SATAQ-M	-0.012	0.869	-0.158	0.134
	SATAQ-F	-0.101	0.235	-0.268	0.066
	SATAQ-P	-0.078	0.415	-0.265	0.109
2	SATAQ-M	-0.019	0.796	-0.162	0.124
	SATAQ-F	-0.041	0.642	-0.214	0.132
	SATAQ-P	-0.103	0.275	-0.287	0.082
	CVCS-M	-0.147	0.035*	-0.283	-0.011
3	SATAQ-M	-0.013	0.862	-0.156	0.130
	SATAQ-F	-0.034	0.696	-0.207	0.138
	SATAQ-P	-0.077	0.423	-0.265	0.111
	CVCS-M	-0.114	0.120	-0.259	0.030
	EICS	0.152	0.206	-0.083	0.386

Note: All analyses presented were calculated using the pooled multiple imputed data.
*Correlation is significant at the .05 level (2-tailed).

The results indicated that model three, including all predictor variables, did not significantly predict BASS (F (5,80) = 2.315, p=.051). It was found that none of the predictor variables significantly predicted BASS. Hence, the null hypothesis was accepted and conclusions state that pressures from the media, family and peers, marriage pressures and cultural identity conflict have no significant impact on the dissatisfaction of areas of the body in SA women.

The variance in BASS accounted for by the predictors, as they were entered into the analysis in blocks, is demonstrated in Table 16. In the first model, 2.4% of the adjusted variance in BASS was explained by sociocultural attitudes of the media, family and peers. In the second model, 6.5% of the adjusted variance in BASS was explained by sociocultural attitudes of the media, family and peers and pressures on marriage. The third model demonstrated that 7.2% of the variance in BASS was explained by all predictor variables.

Table 16

Variance in BASS accounted for by the predictors for each model.

Model	R^2	Adjusted R^2
1	0.058	0.024
2	0.109	0.065
3	0.126	0.072

5.6 The Impact of Self-Compassion

The second research question aimed to understand whether self-compassion moderates the relationships described above. Hypothesis 4 suggested that, in women with SA heritage in the UK, self-compassion will moderate the relationships between the predictor variables of sociocultural attitudes around weight and shape, marital pressures and cultural

identity conflict, and outcome variables of body areas satisfaction, overweight preoccupation and eating behaviour.

5.6.1 H4: Self Compassion Moderator Analysis

A moderated multiple linear regression analysis was used to establish whether the continuous variable of self-compassion significantly interacts and changes the relationship between the predictor variables and outcome variables of eating behaviour (Table 17), overweight preoccupation (Table 18) and body areas satisfaction (Table 19).

Eating Behaviour. The results indicated that the relationship between peer pressures and eating behaviour was significantly moderated by self-compassion (β=0.223, SE=0.109, p=.042), see Table 17.

Table 17

Results of the SCS moderator multiple linear regression analysis for the EAT-26.

			95% Confidence Interval	
Variable	β	Sig	Lower	Upper
SATAQ-M	0.023	0.816	-0.168	0.213
SATAQ-F	0.164	0.096	-0.029	0.358
SATAQ-P	0.223	0.042*	0.008	0.437
CVCS-M	0.016	0.838	-0.141	0.174
EICS	-0.125	0.211	-0.322	0.071

Note: All analyses presented were calculated using the pooled multiple imputed data.
*Correlation is significant at the .05 level (2-tailed).

The results from this analysis suggests that the strength and size of the relationship between peer pressures and eating behaviour was influenced by the women's' level of self-compassion. This may imply that self-compassion may act to reduce the impact of peer pressures, leading to fewer eating behaviour difficulties. Together, 11.5% (R^2=0.115) of the

variance in EAT-26 total scores was accounted for by peer pressures, self-compassion and the interaction between self-compassion and peer pressures. The relationship between the predictors of family and media appearance pressures, cultural identity conflict and marital pressures, and the outcome of eating behaviour, were not significantly moderated by self-compassion.

Overweight Preoccupation. None of the relationships between the predictors of peer, family and media appearance pressures, cultural identity conflict and marital pressures, and the outcome of overweight preoccupation were significantly moderated by self-compassion, see Table 18.

Table 18

Results of the SCS moderator multiple linear regression analysis for OP.

			95% Confidence Interval	
Variable	β	Sig	Lower	Upper
SATAQ-M	0.063	0.476	-0.110	0.236
SATAQ-F	0.131	0.130	-0.039	0.302
SATAQ-P	0.086	0.413	-0.120	0.291
CVCS-M	0.080	0.281	-0.066	0.226
EICS	0.026	0.811	-0.186	0.238

Note: All analyses presented were calculated using the pooled multiple imputed data.

Body Areas Satisfaction. The results indicated that the relationship between peer pressures and body areas satisfaction was significantly moderated by self-compassion (β=-0.233, SE=0.105, p=.026), see Table 19.

Table 19

Results of the SCS moderator multiple linear regression analysis for BASS.

			95% Confidence Interval	
Variable	β	Sig	Lower	Upper
SATAQ-M	0.030	0.751	-0.153	0.213
SATAQ-F	-0.148	0.118	-0.333	0.037
SATAQ-P	-0.233	0.026*	-0.440	-0.027
CVCS-M	0.062	0.420	-0.089	0.214
EICS	0.019	0.858	-0.192	0.231

Note: All analyses presented were calculated using the pooled multiple imputed data.
*Correlation is significant at the .05 level (2-tailed).

These results suggest that the strength and size of the relationship between peer pressures and body areas satisfaction was influenced by the women's level of self-compassion. This may imply that self-compassion may act to reduce the impact of peer pressures, leading to feeling more satisfied with areas of their body.

Together, 16.1% (adjusted R^2=0.161) of the variance in BASS total scores was accounted for by peer pressures, self-compassion and the interaction between self-compassion and peer pressures. The relationship between the predictors of family and media appearance pressures, cultural identity conflict and marital pressures, and the outcome of BASS, were not significantly moderated by self-compassion.

Chapter Six: Discussion

This chapter will provide a summary of the key findings, exploring the influence of sociocultural factors on eating behaviour and body image in a sample of women with SA heritage. Findings will be situated within existing research and strengths and limitations will be noted. The chapter will conclude with a discussion of clinical implications and future research, to raise awareness of the importance of understanding SA women's experiences of eating and body image in the UK.

It is often assumed that a researcher utilising quantitative methods embodies a positivist lens, and that stances closer to social constructionism are incongruent with this method. As previously discussed, the researcher will be viewing the results and reflecting on them from a critical realist stance to dispel these misconceptions.

6.1 Overview of Thesis Aim

The main aim of this thesis was to gain a richer understanding of the impact of known sociocultural factors on eating behaviour and aspects of body image in women with SA heritage in the UK. Within this research field, samples are typically drawn from a White Western demographic, limiting the usefulness for People of the Global Majority. Hence, understanding of SA cultural pressures around marriage and the impact of cultural identity conflict are not widely considered in research or in health services. This is a preliminary study and, therefore, a cross-sectional design was chosen, using quantitative methods. This ensured study feasibility and generated a 'snapshot' view of a complex picture, for further exploration.

6.2 Summary of Thesis Results

6.2.1 Effect on Eating Behaviour

One of the main findings suggests that the greater SA women's experiences of cultural identity conflict, the higher the risk of them experiencing eating behaviour difficulties. This finding, though novel, is perhaps unsurprising given research suggesting that the competing beauty standards between SA and Western cultures impact on body image and eating behaviour (Doris et al., 2015; Goel et al., 2021; Kirschner, 2011; Nazir, 2016). The relatively small sample size of this thesis and significant outcome, further emphasises the strength of this relationship and the importance of this sociocultural factor in understanding eating behaviour.

The mean age of the sample in this study was 29.5 years old, with just over half of the sample being from the second migration generation. It has been suggested by previous research by Smart et al. (2011), that there is an increased risk of cultural identity conflict among women in the second migration generation. This perhaps sheds light on how SA women, specifically those who are from second migration generation, may experience identity conflict due to the pressures from both the SA and Western cultures in relation to eating behaviour. However, this hypothesis may only relate to half of the sample, as just less than half were from the third, fourth and 'unknown' migration generation.

Hypotheses in the research field propose that cultural identity conflict may stem from increased pressures around gender role expectations and a diminished sense of belonging and individual goals, leading to family conflict (Inman et al., 2001). It has been suggested that this conflict may be reinforced by first generation parents who enforce SA cultural values and beliefs, to maintain strong ties to their culture of origin and fear their children will lose this

part of their cultural identity (Segal, 1991). However, it is unclear if these factors influence the current sample. In addition, conflicting research indicates that cultural identity conflict can be experienced by individuals across all generations (Tsong & Smart, 2015). Therefore, it remains uncertain whether the presence of cultural identity conflict is specific to migration generation, as there has been no comparison research across generations.

The findings in this thesis do not define the underlying mechanisms behind the relationship between cultural identity conflict and eating behaviour. However, inferences could be made when viewing the findings through a social identity theory lens, whereby individuals develop their understanding of themselves through their membership of social groups (Mcleod, 2023). If a woman with SA heritage is a member of multiple culturally diverse groups, their sense of self, belonging, purpose and self-worth may be questioned. Alongside, the pressures to meet SA cultural standards and role expectations (McCourt & Waller, 1996). The additional pressures within the dominant Western society in the UK often emphasises individualism and autonomy, leading to SA cultural values being viewed as restrictive and intrusive (Furnham & Shiekh, 1993). The conflicting pressures described above may then manifest in eating behaviour difficulties (Nazir, 2016).

Additional hypotheses to understand the relationship between cultural identity conflict and eating behaviour have been suggested in the research. These include; the impact of distress associated with cultural identity conflict (Szabó & Ward, 2022), racialised teasing (Reddy & Crowther, 2007) and pressures to achieve competing thin body ideals (Goel et al., 2021) which may also manifest in eating behaviour difficulties. Reinforcing this relationship further, positive ethnic identity has been found to be protective in reducing the risk of developing an eating disorder (Rodgers et al., 2018).

This result may be viewed with caution due to the presence of wide confidence intervals. This could indicate the need for a larger sample or that there is high variability within the sample. However, when the EICS measuring cultural identity conflict was added to the multiple regression model, the adjusted variance explained by the predictor variables increased from 4.9% to 25.2%. Suggesting that cultural identity conflict is a key factor leading to change in eating behaviour difficulties.

In summary, this finding adds to the literature highlighting the importance of exploring factors that increase cultural identity conflict and influence the relationship with eating behaviour. This includes mapping differences across age and migration generation.

6.2.2 Body Image: Overweight Preoccupation

This thesis found that the greater SA women's experience of marriage pressures and pressures around weight and shape from the media, the higher the risk of experiencing overweight preoccupation. Preoccupation with weight and shape has also been found to increase the likelihood of developing eating behaviour difficulties (Calugi et al., 2018; Sharpe et al., 2018).

Body image can be defined as the way someone relates to multiple aspects of their appearance, including weight, shape, facial features, hair and skin colour. The category of 'overweight preoccupation' "assesses a construct reflecting fat anxiety, weight vigilance, dieting, and eating restraint" (Cash, 2000, p.1). When reflecting on existing research, the preoccupation both Western and SA communities have around weight and shape appear to manifest differently (Goel et al., 2021). Hence, it is important to explore what aspects of sociocultural influence impact on the relationship between overweight preoccupation and eating behaviour in women of SA heritage.

Marriage Pressures. The alliance of two families has been thought of as a valued aspect of the SA culture, resulting in the increased focus around marriage prospects as women move into adulthood (Prathikanti, 1997).

The findings of this thesis complement those of existing research, which have found that SA communities often focus on being a 'healthy' weight, specifically in relation to being 'marriageable' (Goel et al., 2021; Mishra et al., 2023). Marriage has been described as the 'core motivator', whereby all weight and shape ideals associated with a SA woman are based (Goel, 2019). This may emphasise feelings of objectification and awareness of body surveillance by the community, linking to increased body image difficulties and dieting (Frederick et al., 2016; Goel et al., 2021). The majority of the current study sample of women were aged between 16 to 30 and single, this is suggestive of the 'marriageable' age where these pressures may be more prominent, compared to women who are older and married.

Marriage pressures have also been found to impact eating behaviour difficulties and weight control strategies (Hoque, 2011), although this was not found in the current study. This may suggest that marriage pressures influence the preoccupation with being overweight but this does not impact on eating behaviour, within this sample. It could be hypothesised that preoccupation with weight is not a strong enough influence to result in eating behaviour difficulties. It could also be due to the value of accepting and sharing food within the community, which may buffer the relationship between body image and eating behaviour (Goel et al., 2021).

Research has also suggested that the values and beliefs surrounding marriage in SA culture may increase when there is a sense of cultural identity conflict, as marriage may help to maintain the links to SA cultural heritage (Inman et al., 2001). This provides an example of

the complexity of the relationships between aspects of identity, sociocultural influences and the links to overweight preoccupation.

The question remains as to whether overweight preoccupation due to marriage pressures, is associated with a 'drive for thinness' or a drive for a 'healthy' weight. Research has highlighted the differences in SA weight and shape values, describing being 'too thin' as undesirable (Goel et al., 2021). What does the 'healthy' SA ideal body look like? Research has suggested that this expectation is narrow, poorly defined and on a scale from too thin to overweight, with the 'healthy' ideal being somewhere along this spectrum (Goel, 2019). Perhaps meaning that the goal is relatively unknown and may result in a constant focus on weight and shape to prevent falling into the undesirable categories of 'too thin' or 'overweight'.

How achievable is the 'healthy' ideal body? This is a key question to consider, if a woman manages to navigate what the 'healthy' ideal body looks like, is this a realistic and achievable weight to maintain without an impact on wellbeing? An external factor that may make this challenging is the cultural value of sharing and accepting food. Accepting food is often a form of respect in SA culture and women have described eating more than they feel comfortable eating, due to experiencing this pressure (Goel, 2019). In contrast to this message, commentary from the community around becoming 'too big' or 'too fat' have been described as prevalent (Goel, 2019; Goel et al., 2021), increasing vulnerability to body dissatisfaction and low self-esteem (Khasru, 2022). Alongside this is the conflicting and changing Western weight and shape ideals consisting of both the thin ideal (Culbert et al., 2015) and athletic ideal (Robinson et al., 2017).

It could be hypothesised that the above pressures may contribute to SA women's experience of cultural identity conflict, due to the weight and shape goals they are exposed to

within society and their ability to achieve them. As described in the first finding of this thesis, increased cultural identity conflict may then increase the likelihood of eating behaviour difficulties.

Media appearance pressures. This thesis found that increased media appearance pressures may lead to increased overweight preoccupation in women with SA heritage. This finding is consistent with research suggesting that social media is one of the main sociocultural influences on body image and eating behaviour over the past 20 years (Reddy & Crowther, 2007; Rounsefell et al., 2020). Research has suggested that this is due to the internalisation of weight and shape ideals, which may lead to self-objectification and low self-esteem (Khasru, 2022). There are multiple factors, in-line with objectification theory (Fredrickson & Roberts, 1997), that were found to increase SA women's susceptibility to experiencing body dissatisfaction, following exposure to appearance-based media. These include, increased social comparison, belief that value of self comes from appearance, and low body esteem (Inman et al., 2016; Khasru, 2022). It is possible that these factors may influence the relationship between media appearance pressures and overweight preoccupation in this sample of SA women.

Mechanisms influencing the relationship between media appearance pressures on overweight preoccupation have not been specifically identified in the current study. However, the observed relationship between media appearance pressures and overweight preoccupation in this study, supports the hypothesis that idealised bodies are internalised by watching visual appearance-based media (Khasru, 2022). It could be suggested that this type of visual exposure to idealised bodies is more persuasive and enduring than family and peer pressures around weight and shape.

It has been argued that social media may also promote a positive body image through offering content with a wider range of body types (Grogan, 2021). However, this continues to place value on weight and shape which may reinforce this preoccupation, regardless of the positive lens. This study did not ask participants the genre of media they consume, what dominant culture of media they follow or the frequency of their media usage. Thus, it is not possible to explore specific influential aspects of the media and its usage, that may impact on overweight preoccupation.

A novel aspect of social media is the presence of algorithms, which rank content based on what the user is viewing and interacting with (Gabor, 2023). This will then consistently expose the user to their 'preferred' content to increase engagement. If this content includes idealised bodies, research has suggested that this may intensify the relationship between social media and body dissatisfaction (Harriger et al., 2022). Findings from a study of mostly 'Asian' women living in Australia, revealed that body positive content on social media was associated with higher body satisfaction, demonstrating the benefits of this genre of content (Stevens & Griffiths, 2020).

There has been a recent call for researchers, policy makers and educators to consider the impact of modern social media on body image (Harriger et al., 2023). Harriger et al (2023) also highlighted the current bias in the research area, whereby the impact of social media has been predominately researched with young White women, resulting in a lack of understanding around the impact on People of the Global Majority.

The multiple regression model explained around a quarter of the variance, accounted for by the predictors in all three models. This suggests that marriage and media appearance pressures are key factors influencing overweight preoccupation in women with SA heritage in the UK.

In summary, it is likely that the impact of marriage and media appearance pressures, result in overweight preoccupation in women with SA heritage in the UK. The mechanisms behind the relationship between these sociocultural predictors, overweight preoccupation and eating behaviour difficulties have been hypothesised, but remain unknown.

6.2.3 Body Image: Body Areas Satisfaction

The current study suggests that pressures from the media, family and peers, marriage pressures and cultural identity conflict have little impact on the dissatisfaction of different areas of the body in SA women. These findings suggest that sociocultural pressures do not influence overall appearance satisfaction. Previous research has suggested women with SA heritage feel dissatisfied with specific aspects of appearance, such as skin colour (Craddock et al., 2023) and weight (Goel et al., 2021). Therefore, it could be possible that certain aspects of appearance are influenced by different sociocultural factors. However, in the current study, the different areas of the body were not independently analysed in relation to the sociocultural influences.

In addition, it is important to note that BMI was not controlled for in the analysis between sociocultural influences and body areas satisfaction. Research has suggested that SA children in the UK who are living in bigger bodies from a young age experience increased body dissatisfaction (Pallan et al., 2011). One explanation for this could be due to increased 'teasing' due to being perceived by others as 'overweight' (Reddy & Crowther, 2007). However, the context that the women in this study have grown up in, the size and shape of their bodies and the frequency and nature of commentary they may have experienced is unknown. This lack of context impacts on our understanding of the realities of the women in this study, meaning the findings are to be interpreted with caution and are presented as generalised associations.

6.2.4 The Impact of Self-Compassion

These results suggest that the strength and size of the relationship between peer pressures and body areas satisfaction was influenced by the women's level of self-compassion. This implies that self-compassion may help to moderate the impact of societal narratives around weight and shape from peers, leading to them feeling more satisfied with areas of their body.

Appearance-based commentary from peers (positive or negative) has been shown to increase vulnerability to body dissatisfaction in women with SA heritage (Goel et al., 2021; Khasru, 2022). The research around peer pressures impacting on body image often suggests an aspect of 'teasing', which has been shown to impact on body dissatisfaction and eating attitudes (Reddy & Crowther, 2007). However, this finding is limited as Reddy and Crowther (2007) did not identify the nature and types of comments women were experiencing, or the heritage and gender of the peers sharing them. It is also unknown to what extent comments are internalised, what responses women have to them and what characteristics may be protective against positive or negative comments around weight and shape.

The current study has found that self-compassion moderates the relationship between peer pressures and body satisfaction. To understand why this might be, proposed questions and hypotheses will be explored further.

Do some SA women care less about what their peers think or say about them? The level of self-compassion they experience may help them to fend off pressures around weight and shape from peers, but perhaps not from family and the media. Does this suggest that family and media appearance pressures are more pervasive and more difficult to challenge despite their level of self-compassion? This finding may suggest that friends are often chosen and their attitudes can be ignored more easily than the influx of societal narratives and

images on social media (Harriger et al., 2022) and the commentary and beliefs from family (Goel et al., 2021).

It has been suggested that self-compassion may influence the relationship between body appreciation and body-related pressures (Homan & Tylka, 2015). Although this link has not been established in women with SA heritage in the UK. Exploring the idea that increased self-compassion helps resist the peer pressures around weight and shape is important in understanding how to promote positive body image in women with SA heritage.

In addition, it is important to consider that this research did not individually explore the three dimensions of self-compassion proposed by the SCS scale, consisting of self-kindness, common humanity and mindfulness (Neff, 2003a). It may be that differing aspects of self-compassion moderate the relationships between other sociocultural influences on body image and eating behaviour.

6.2.5 Overall Summary of Thesis Results

This thesis found that women with SA heritage living in the UK who experience cultural identity conflict, are more likely to experience eating behaviour difficulties. Alongside this, increased marriage and media appearance pressures, may increase the likelihood of women with SA heritage experiencing overweight preoccupation.

In addition, this thesis found that self-compassion may help to moderate the impact of societal narratives around weight and shape from peers, leading to feeling more satisfied with areas of their body.

6.3 Researchers Reflective Position

At the beginning of this thesis, the awareness of the researcher's position was stated and actively considered at each stage of the research process. It is acknowledged that the results described above have been interpreted through the researcher's lens based on their gender, ethnicity, age and class, amongst other characteristics. Hence, the perspective of the field supervisor for this thesis, an expert by experience, was sought to offer an informed view on the findings and interpretations. Their influence helped to shape ideas around the need for tailored culturally sensitive interventions for this population, alongside acknowledging the influence of public health campaigns.

In noting my position and the ethical issues that arise from a White researcher researching the experiences of an ethnic group that they are not part of. I welcome the thoughts and perspectives of those this research hopes to support, to widen the sphere of understanding around this topic.

6.4 Strengths of the Research

To the knowledge of the author this is the first UK quantitative study to explore the impact of multiple evidence-based sociocultural influences, on body image and eating behaviour, moderated by self-compassion, in women with SA heritage.

This thesis has helped to build on the foundations of the limited research in this field with a quantitative lens and will hopefully encourage in-depth future research to further explore the observed relationships. Additionally, it has highlighted the need for increased understanding around the potential mechanisms influencing body image and problematic eating in this group, to tailor more insightful and considered interventions, to support SA women in the UK.

A strength of the thesis was that it achieved a sample size that was large enough to satisfy the planned statistical analysis. The range of measures were able to capture the targeted constructs described in the research aims, based on past qualitative research. The multiple linear regression analysis was used to explore the relationships between the predictor and outcome variables. This method of analysis allowed for the predictors to be inputted in blocks, demonstrating the contribution each group of predictors made within the model. Therefore, the findings offer a more reliable indication of the strength of the relationships.

Another strength of this thesis is the presence of a reflective stance within quantitative research. With an aim to encourage researchers to explore and state their position, to create more transparency and self-awareness. This level of reflexivity is expected within qualitative studies, but often disregarded in quantitative studies. Despite the researcher's position influencing every aspect of the research process.

This thesis has expanded on not only the methodology and findings in the research field, but also the need for transparency around researcher's reflective position and epistemological stance in quantitative academic writing.

6.5 Limitations of the Research

There are various factors which influence the outcomes of studies, even when they are well designed. Therefore, the following issues can be considered when interpreting the findings.

6.5.1 Design

This thesis has prioritised the need to build on a foundational understanding, based on existing qualitative research using quantitative methods, with a sample of women with SA heritage in the UK. However, this study has a cross-sectional design analysing relationships

between variables. Therefore, a common criticism is that it considers a snap-shot view of someone's experience and is unable to conclude on the stability of outcomes or causation.

6.5.2 Participants and Recruitment

Those recruited into the study were described as women with SA heritage and included anyone who identified as a woman. Due to the limited research in this area, it was felt most appropriate to build on the findings from qualitative research with women and not include males at this stage. However, it would be interesting to build upon this research to understand the experiences of males with SA heritage in the UK, in relation to weight and shape pressures. In addition, this thesis and the research field more generally, perpetuates the gender binaries represented in society and doesn't account for those who were assigned female at birth who no longer identify as a female.

Recruitment was optimised through the use of social media and University students. Community groups were contacted with the hope to collaborate on the development of the research and to expand recruitment opportunities. To help to increase the participation from community groups, relationships with varying organisations could have been developed over a longer period, with more discussions around the utility of the research and offers to support the services in an unrelated capacity.

6.5.3 Methodology and Measures

The researcher's unconscious bias may inadvertently perpetuate stereotypical experiences of SA women due to creating hypotheses based on the current generalised literature and using this to partly structure the current study. This is a particular challenge due to the nature of quantitative methodology. This method can overgeneralise a group of women

with SA heritage, who encompass diverse experiences and differing intersections of class, sexuality, religion, geography and other individual characteristics.

Although it would have been interesting to measure multiple sociocultural influences on body image and eating behaviour. This study chose to focus on fewer evidence-based variables, to establish a foundation of quantitative research to build on. Therefore, the external influences of racial discrimination and religion on body image and eating behaviour were not considered in this study. These are incredibly important factors which add to the context of a developing ED and of which this study was unable to consider. It is hoped that future research can incorporate these aspects into a broader picture and develop a better understanding of the role of these factors in relation to body image and eating behaviour.

In addition, there are a multitude of influential factors that were not included in this study due to feasibility and the focus being on sociocultural influences. These may include personality traits such as perfectionism and impulsivity, neurological processes such as cognitive flexibility (Culbert et al., 2015), demographics such as social class and education and psychological distress (Cooper & Fairburn, 2011; Mason et al., 2019).

The quantitative measures used have been selected due to being validated or used consistently with SA populations. However, many have been developed in the US and do not align with UK culture or the more recent cultural values and beliefs of second-generation women with SA heritage. An example of this is the CVCS, which was developed in the US and references American culture (Inman et al., 2001), hereby reducing its useability with UK populations.

Validated quantitative measures only offer information based on what is asked in a numerical form, this limits the richness of the information and can mean important details are missed. For example, it is unknown what ethnic heritage the category of ‘peers’ have in the

SATAQ-4R and the nature of the comments, meaning this measure is unable to capture the presence of colourism, body discrimination or positive commentary amongst peers in SA ethnic groups. Alongside this, the validity of most online measures is questionable due to the priming effects of the titles, information in the PIS and the potential presence of social desirability. Although, it is hoped this was minimised with it being an anonymous survey.

A broad criticism of social sciences research is the limits statistical models have within the academic and research context. For example, the method of multiple linear regression is not good at explaining the relationship of predictor variables to the outcome variable, if the relationships are not linear. Therefore, this analysis would not highlight if there were variables demonstrating a curved trend in the data. Multicollinearity is also a limit with this type of analysis, as highly correlated variables can result in high standard errors, meaning it was important in this study to obtain less intercorrelated data. Despite these limitations, within this study multiple linear regression has been utilised to the best of its capacity in the current research context.

6.5.4 Additional Sociocultural Influences

The wider context of people's lives is important to consider when interpreting these results. There will be many differing experiences impacting on eating behaviour and body image that have not been measured or considered in this research. The wider societal factors, often known as the exosystem in Bronfenbrenner's ecological model, such as government policies and campaigns are important influences impacting on eating behaviour and body image (Bronfenbrenner, 2000).

The National Health Service (NHS) campaigns promoting healthy living such as 'Better Health' often demonise being 'overweight' and put the blame on the individual, rather

than considering the impact of external influences (Talbot & Branley-Bell, 2022; Theis & White, 2021). Campaigns of this kind reinforce weight stigma and have been shown to result in increased shame, which may result in eating behaviour difficulties and body dissatisfaction (Talbot & Branley-Bell, 2022). It is also possible that during the pandemic, weight stigma and pressures to lose weight increased due to press coverage around obesity being a risk factor for COVID-19 (Brookes, 2022). Although it may be argued that COVID-19 increased focus on 'race-related' health disparities, which was a positive step towards tackling inequalities (Brookes, 2022).

In addition, research had identified the increased risk of diabetes for people with SA heritage in the UK (Iqbal, 2023). Hence, it is wondered if the national targeting of this health concern in relation to being overweight and 'cultural social stigma' (Kumar et al., 2016), increases fear and shame, impacting on body image and eating behaviour?

6.6 Implications for Eating Disorder Intervention

This research reflects the conflicting experiences of SA women in the UK caught between two pervasive societal narratives around the ideal weight and shape. Alongside the additional pressures of 'attractive' and 'marriageable' to a potential partner. The findings of this thesis directly inform the accessibility of ED services, content of assessments, focus of interventions, role of a psychologist and directions for future research.

6.6.1 Accessibility of NHS Eating Disorder Services

Research has identified that seeking treatment for eating behaviour difficulties is challenging for women with SA heritage due to stigma, shame, issues with confidentiality and a lack of training and understanding of cultural competence in health care professionals (Nazir, 2016). A better understanding around the experiences of SA women in relation to

their sociocultural context and the impact on body image and eating behaviour, could help to connect with communities to minimise stigma and shame and increase accessibility of services. Ultimately, this starts by expanding the research field to inform services and adapt training needs, acknowledge issues of confidentiality and work collaboratively with the communities they serve.

Most important is the need for the recognition of differences in the presentation of an ED and manifestation of this amongst different ethnic groups in the UK (Hoque, 2011). There needs to be an increased focus on the validation and exploration of SA women's experiences of the sociocultural influences impacting on body image and eating behaviour, to help to normalise these pressures and reduce the blame on the individual and feelings of shame.

A recent study shared that 'social stigma', the fear of social ostracization, was another barrier in accessing ED services in the US for those with SA heritage (Goel et al., 2023). Recommendations were made suggesting the facilitation of intergenerational conversations around mental health, collaboration with SA communities to develop targeted health campaigns and develop training in culturally sensitive care (Goel et al., 2023). This research would help to inform these recommendations for UK ED services.

6.6.2 Assessment of Sociocultural Influences, Body Image and Eating Behaviour

The assessment of sociocultural influences, body image and eating behaviour is often based on a White Western perspective due to the biases in existing research. The need for culturally adapted measures has been highlighted, to address the inequality of underestimating EDs in marginalised groups and inform prevention and treatment programs (Alexander et al., 2024). The inclusion of such measures and acknowledgment of ethnic differences should be included in the assessment specifications as provided by the NICE

quality standards for EDs. It is hoped that by addressing this inequality within ED services, this will be reflected in the adaptation of eligibility criteria to include the diverse ways EDs can present. For example, adapting the use of BMI within the criteria, which discriminates against Black and Asian individuals (Halbeisen et al., 2022).

6.6.3 Interventions for Body Dissatisfaction and Eating Behaviour Difficulties

Past research has often offered recommendations for addressing ED treatment with People of the Global Majority within the US (Acle et al., 2021). These recommendations include; using and developing culturally sensitive interventions, identifying barriers to treatment, exploring culturally contextual factors, explore ethnic identity and acculturation and involve family/social supports in treatment (Acle et al., 2021). All of these themes align with the findings presented in this study, reinforcing the need for increased focus on SA women's conflicting cultural context and adapting treatment to their needs. Interventions are not only offered by the NHS, but also through community and voluntary services, research grants and schools. The current focus is on both prevention and intervention, to consider the impact of the sociocultural context in childhood and how the implementation of education around weight stigma, positive body-image perspectives, social media awareness and family work may help to buffer the influence on body image and eating behaviour.

This thesis offers some thoughts around intervention when considering psychological input into services or community spaces offering support to those with body dissatisfaction or eating behaviour difficulties. Firstly, the thesis findings would recommend interventions around self-compassion, in managing the impact of societal pressures on weight and shape in the UK. Despite the NICE recommended model of therapy being Cognitive Behaviour Therapy (CBT) to treat eating disorders (NICE, 2017), the use of Compassion Focus Therapy (CFT) has increasingly been suggested as an alternative model (Goss & Allan, 2012; Steindl

et al., 2017). Alongside other models such as Dialectical Behavioural Therapy (DBT) that require more research to understand efficacy (Bankoff et al., 2012). However, the use of compassion-based interventions in relation to eating behaviour difficulties with SA communities in the UK have not been documented in the literature.

Alongside this, interventions that include the system around the individual would be indicated due to the recognition of the importance of family and community, in relation to the presence of cultural identity conflict and marital pressures. Past research has offered guidance in encouraging family support for someone suffering from an eating disorder, as the lack of acceptance from family can feel very isolating (Hoque, 2011). Systemic interventions would welcome the participation of anyone of importance in the person's life, to understand their meaning making of body image and eating behaviour and what aspects of society might impact on this. The current findings emphasise the importance of recognising cultural values and beliefs in the SA community, how family might work together to understand and reduce the impact of marriage pressures and explore cultural identity conflict.

Research has discussed the advances in family-based treatment, the adaptation to family needs and efficacy of these interventions with individuals with AN and BN (Gorrell et al., 2019; Lock & Le Grange, 2019). However, there was no mention of the use of these intervention with individuals and families of different ethnic groups. There is an obvious gap in the research field exploring the benefits of family interventions for those with SA heritage, specifically in the UK. Useful recommendations have been suggested from a rare study considering the use of family-based interventions for engaging SA families in the US (Sharma et al., 2020). Despite this study not specifically discussing family intervention in the context of an ED, there are potential implications. One suggestion is to facilitate the navigation of a middle path to help to culturally integrate the individual's sense of self. It is

hoped this work would lead to reduced parental guilt, increased parental empathy and understanding, and independent empathetic communication in the family (Sharma et al., 2020).

However, earlier research has suggested that a more 'psychoeducational' approach is seen as more suitable due to research suggesting a reluctance to participate in psychological 'treatment' for fear of bringing shame to the family (Kempa & Thomas, 2000). The implications for this gap in research are that services lack evidence and understanding in working with individuals and families with SA heritage, resulting in the inequality of interventions offered.

6.6.4 The Role of Clinical Psychologists

In 2021 the British Psychological Society published guidelines for Clinical Psychologists working in ED services (BPS, 2021). The responsibilities described include direct therapy skills with individuals, in group and with families, teaching and training, service development, supervision, clinical leadership, evaluation and research. Clinical Psychologists should consider distinct approaches to working with cultural identity conflict. Research has suggested psychological work around developing the self-concept, self-esteem and psychological wellbeing (Rahim et al., 2021). However, there is very little research sharing the efficacy of such interventions.

These guidelines also advise on specific competencies essential for those working into ED services, one of which described "understanding the influences of diversity in the development and maintenance of eating disorders". It is important that Clinical Psychologists use their role to develop their understanding around the experiences and needs of women with SA heritage in the UK struggling with eating behaviour difficulties, and disseminate this

at an organisational, community and societal level to reduce current inequalities. An example of could be by developing and circulating relevant resources for the population as a whole, via social media and to appropriate nationwide services.

6.7 Future Research Directions

Research uncovering the inequalities experienced by People of the Global Majority, has argued for more proactive diversity-orientated research (Halbeisen et al., 2022). The focus of recent research with People of the Global Majority has been on understanding ED presentations, sociocultural influences on body image and eating behaviour and validating culturally appropriate measures. Most qualitative studies have explored the experiences of women with SA heritage in relation to the impact of sociocultural influences on body image and eating behaviour (Goel et al., 2021; Javier & Belgrave, 2019; Mishra et al., 2023). However, there is a lack of research testing these findings with larger samples using quantitative methods in the UK.

This thesis aimed to investigate hypotheses around the experiences of a community sample, to build on the awareness of the contributing factors leading to body dissatisfaction and eating behaviour difficulties in women with SA heritage in the UK. The design of this study has allowed for the gathering of a breadth of SA women's experiences. However, it is noted that the unique experiences contributing to the women's feelings about themselves, others and the world can get lost. Therefore, it is hoped that this research will add to the picture of the experiences of the SA women in the UK, to guide further research and inform nationwide healthcare services.

The experiences of racial discrimination, 'teasing' and religion have been mentioned in this thesis as key factors to further explore to better understand the impact on body image and eating behaviour for women with SA heritage. Alongside the need for increased

exploration of sociocultural factors, it is also important to understand the differences based on migration generation and age within the SA population. The role of protective sociocultural influences should be considered in future research, as these influences are key in understanding what may protect women with SA heritage against eating behaviour difficulties, including religion and ethnic identity (Castle et al., 2011; Inman et al., 2016).

An important future focus would be to expand on the understanding of changing beauty ideals, e.g., thin ideal and muscular ideal, and the impact these conflicting beauty standards have on women with SA heritage. Due to the changing nature of these ideals, it is crucial that research continues to review these changes to inform services supporting individuals with an ED.

Lastly, future research should consider the impact of weight stigma in society and government and NHS campaigns focussing on individualised responsibility for weight loss, on women with SA heritage in the UK.

6.8 Overall Conclusions of the Thesis

In conclusion, the findings from this thesis build on the themes presented in existing research around sociocultural influences, impacting on body image and eating behaviour in women with SA heritage. This study found that those in the sample who experience cultural identity conflict were more likely to experience eating behaviour difficulties. Those who experience marriage and media appearance pressures also have an increased likelihood of experiencing overweight preoccupation. This study also chose to explore the protective factor of self-compassion and found that this may help to moderate the impact of societal narratives around weight and shape from peers, leading to feeling more satisfied with areas of their body.

This novel research underscores the imperative for more extensive studies and offers important recommendations for future exploration. It presents significant implications for clinical practice, guiding professionals, services, organisations, and researchers to holistically address mental health inequalities among women with SA heritage in the UK.

References

Abbas, S., Damani, S., Malik, I., Button, E., Aldridge, S., & Palmer, R. (2010). A comparative study of South Asian and non-Asian referrals to an eating disorders service in Leicester, UK. *European Eating Disorders Review, 18*(5), 404-409. https://doi.org/10.1002/erv.1033

Abraham, N. K., & Birmingham, C. L. (2008). Is there evidence that religion is a risk factor for eating disorders? *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity, 13*, e75-e78. https://doi.org/10.1007/BF03327508

Acle, A., Cook, B. J., Siegfried, N., & Beasley, T. (2021). Cultural Considerations in the Treatment of Eating Disorders among Racial/Ethnic Minorities: A Systematic Review. *Journal of Cross-Cultural Psychology*, 52(5), 468-488. https://doi.org/10.1177/00220221211017664

Agyeman, G. S. (2008). White researcher-black subjects: Exploring the challenges of researching the marginalised and 'invisible,'. *In Proceedings of the 7th European Conference on Research Methodology for Business and Management Studies: ECRM2008* (p. 267). Academic Conferences Limited.

Ahmad, S., Waller, G., & Verduyn, C. (1994). Eating attitudes among Asian schoolgirls: the role of perceived parental control. *Int J Eat Disord,* 15(1), 91-97. https://doi.org/10.1002/1098-108X(199401)15:1<91::AID-EAT2260150111>3.0.CO;2-7

Alexander, T., Burnette, C. B., Cory, H., McHale, S., & Simone, M. (2024). The need for more inclusive measurement to advance equity in eating disorders prevention. *Eating disorders,* 1-19. https://doi.org/10.1080/10640266.2024.2328460

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Bahji, A., Mazhar, M. N., Hudson, C. C., Nadkarni, P., MacNeil, B. A., & Hawken, E. (2019). Prevalence of substance use disorder comorbidity among individuals with eating disorders: A systematic review and meta-analysis. *Psychiatry Res, 273,* 58-66. https://doi.org/10.1016/j.psychres.2019.01.007

Bankoff, S. M., Karpel, M. G., Forbes, H. E., & Pantalone, D. W. (2012). A Systematic Review of Dialectical Behavior Therapy for the Treatment of Eating Disorders. *Eating disorders, 20*(3), 196-215. https://doi.org/10.1080/10640266.2012.668478

Becker, A., & Fay, K. (2006). Sociocultural issues and eating disorders. Annual Review of *Eating Disorders: Part 2,* 35-63.

Beutler, L. E., Brown, M. T., Crothers, L., Booker, K., & Seabrook, M. K. (1996). The dilemma of factitious demographic distinctions in psychological research. *J Consult Clin Psychol, 64*(5), 892-902. https://doi.org/10.1037//0022-006x.64.5.892

Bhatti, N. (2018). *The impact of beauty, body image, and health discourses on eating disorder risk in South Asian-Canadian women* (Master's thesis, The University of Western Ontario (Canada)) https://ir.lib.uwo.ca/etd/5206

BPS. (2021). Good Practice Guidelines: Trainee clinical psychologists and qualified clinical psychologists working with people with eating disorders For UK Clinical Psychology Training Providers. The British Psychological Society.

Brady, J. L., Kaya, A., Iwamoto, D., Park, A., Fox, L., & Moorhead, M. (2017). Asian American Women's Body Image Experiences: A Qualitative Intersectionality Study. *Psychology of Women Quarterly, 41*(4), 479-496. https://doi.org/10.1177/0361684317725311

Braun, T. D., Park, C. L., & Gorin, A. (2016). Self-compassion, body image, and disordered eating: A review of the literature. *Body Image, 17*, 117-131. https://doi.org/10.1016/j.bodyim.2016.03.003

Bronfenbrenner, U. (1992). *Ecological systems theory.* Jessica Kingsley Publishers.

Bronfenbrenner, U. (2000). *Ecological systems theory.* Oxford University Press.

Brookes, G. (2022). 'Lose weight, save the NHS': Discourses of obesity in press coverage of COVID-19. *Critical Discourse Studies, 19*(6), 629-647. https://doi.org/10.1080/17405904.2021.1933116

Brown, M., Cachelin, F. M., & Dohm, F.-A. (2009). Eating disorders in ethnic minority women: A review of the emerging literature. *Current Psychiatry Reviews, 5*(3), 182-193. https://doi.org/10.2174/157340009788971119

Brown, T. A., Cash, T. F., & Mikulka, P. J. (1990). Attitudinal body-image assessment: Factor analysis of the Body-Self Relations Questionnaire. *Journal of personality assessment, 55*(1-2), 135-144. https://doi.org/10.1080/00223891.1990.9674053

Burke, N. L., Schaefer, L. M., Karvay, Y. G., Bardone-Cone, A. M., Frederick, D. A., Schaumberg, K., Klump, K. L., Anderson, D. A., & Thompson, J. K. (2021). Does the tripartite influence model of body image and eating pathology function similarly across racial/ethnic groups of White, Black, Latina, and Asian women? *Eating*

behaviors: an international journal, 42, 101519-101519. https://doi.org/10.1016/j.eatbeh.2021.101519

Calogero, R. M., Herbozo, S., & Thompson, J. K. (2009). Complimentary weightism: The potential costs of appearance-related commentary for women's self-objectification. *Psychology of Women Quarterly, 33*(1), 120-132. https://doi.org/10.1111/j.1471-6402.2008.01479.x

Calugi, S., El Ghoch, M., Conti, M., & Dalle Grave, R. (2018). Preoccupation with shape or weight, fear of weight gain, feeling fat and treatment outcomes in patients with anorexia nervosa: A longitudinal study. *Behaviour Research and Therapy, 105*, 63-68. https://doi.org/https://doi.org/10.1016/j.brat.2018.04.001

Cash, T. F. (2000). The multidimensional body-self relations questionnaire (MBSRQ) users' manual. *Norfolk, VA: Old Dominion University*. https://doi.org/10.1037/t08755-000

Castle, H., Knight, E., & Watters, C. (2011). Ethnic identity as a protective factor for looked after and adopted children from ethnic minority groups: A critical review of the literature. *Adoption Quarterly, 14*(4), 305-325. https://doi.org/10.1080/10926755.2011.628266

Catina, A., & Joja, O. (2001). Emerging markets: Submerging women. *Eating disorders and cultures in transitions,* 111-119.

Chadderton, C. (2012). Problematising the role of the white researcher in social justice research. *Ethnography and Education, 7*(3), 363-380. https://doi.org/10.1080/17457823.2012.717203

Chan, J., & Hurst, M. (2022). South Asian women in the United Kingdom: The role of skin colour dissatisfaction in acculturation experiences and body dissatisfaction. *Body Image, 42*, 413-418. https://doi.org/10.1016/j.bodyim.2022.07.007

Cheng, Z. H., Perko, V. L., Fuller-Marashi, L., Gau, J. M., & Stice, E. (2019). Ethnic differences in eating disorder prevalence, risk factors, and predictive effects of risk factors among young women. *Eating behaviours, 32,* 23-30. https://doi.org/10.1016/j.eatbeh.2018.11.004

Chin Evans, P., & McConnell, A. R. (2003). Do racial minorities respond in the same way to mainstream beauty standards? Social comparison processes in Asian, Black, and White women. *Self and Identity, 2*(2), 153-167. https://doi.org/10.1080/15298860309030

Chong, W. W. (2020). *The Stress-buffering Effects of Social Support and Self-compassion on Subjective Well-being on Asian Americans: Generational Differences*. University of Missouri-Kansas City.

Chowbey, P., Salway, S., & Ismail, M. (2012). Influences on diagnosis and treatment of eating disorders among minority ethnic people in the UK. *Journal of Public Mental Health*. https://doi.org/10.1108/17465721211236363

Clarke, C., Peach, C., & Vertovec, S. (1990). *South Asians overseas: migration and ethnicity*. Cambridge University Press.

Cooper, Z., & Fairburn, C. G. (2011). The evolution of "enhanced" cognitive behavior therapy for eating disorders: Learning from treatment nonresponse. *Cognitive and behavioral practice, 18*(3), 394-402. https://doi.org/10.1016/j.cbpra.2010.07.007

Craddock, N., Gentili, C., Phoenix, A., White, P., Diedrichs, P. C., & Barlow, F. K. (2023). Investigating the role of perceived ingroup and outgroup colourism on body image and wellbeing among Black, Asian, and other racialised/ethnic minority groups living in the UK. *Body Image, 46*, 246-255. https://doi.org/10.1016/j.bodyim.2023.06.010

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review, 43*(6), 1241-1299. https://doi.org/10.2307/1229039

Culbert, K. M., Racine, S. E., & Klump, K. L. (2015). Research Review: What we have learned about the causes of eating disorders - a synthesis of sociocultural, psychological, and biological research. *J Child Psychol Psychiatry, 56*(11), 1141-1164. https://doi.org/10.1111/jcpp.12441

Cummins, L. H., Simmons, A. M., & Zane, N. W. (2005). Eating disorders in Asian populations: a critique of current approaches to the study of culture, ethnicity, and eating disorders. *Am J Orthopsychiatry, 75*(4), 553-574. https://doi.org/10.1037/0002-9432.75.4.553

de Zoysa, P., Kumar, S., Amarasuriya, S. D., & Mendis, N. S. (2022). Cultural validation of the Self-Compassion Scale and the Subjective Happiness Scale and the influence of gender on self-compassion and subjective happiness in a Sri Lankan undergraduate population. *Asian Journal of Social Psychology, 25*(3), 421-432. https://doi.org/10.1111/ajsp.12505

Demmler, J. C., Brophy, S. T., Marchant, A., John, A., & Tan, J. O. A. (2020). Shining the light on eating disorders, incidence, prognosis and profiling of patients in primary and

secondary care: national data linkage study. *Br J Psychiatry, 216*(2), 105-112. https://doi.org/10.1192/bjp.2019.153

Dimitrov, D., & Kroumpouzos, G. (2023). Beauty perception: A historical and contemporary review. *Clinics in Dermatology, 41*(1), 33-40. https://doi.org/10.1016/j.clindermatol.2023.02.006

Dixon, A. R., & Telles, E. E. (2017). Skin color and colorism: Global research, concepts, and measurement. *Annual Review of Sociology, 43,* 405-424. https://doi.org/10.1146/annurev-soc-060116-053315

Doris, E., Shekriladze, I., Javakhishvili, N., Jones, R., Treasure, J., & Tchanturia, K. (2015). Is cultural change associated with eating disorders? A systematic review of the literature. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity, 20,* 149-160. https://doi.org/10.1007/s40519-015-0189-9

Emmer, C., Bosnjak, M., & Mata, J. (2020). The association between weight stigma and mental health: A meta-analysis. *Obesity Reviews, 21*(1), e12935. https://doi.org/10.1111/obr.12935

Fahiz, M. F. (2019). A cross cultural study of body image among adolescents and young adults. *Indian Journal of Health and Wellbeing, 10*(7-9), 205-216.

Fairburn, C. G., & Brownell, K. D. (2005). *Eating disorders and obesity: A comprehensive handbook.* Guilford Press.

Ferreira, C., Pinto-Gouveia, J., & Duarte, C. (2013). Self-compassion in the face of shame and body image dissatisfaction: Implications for eating disorders. *Eating behaviors, 14*(2), 207-210. https://doi.org/10.1016/j.eatbeh.2013.01.005

Fidan, T. (2022). *Is self-compassion relevant to the pathology and treatment of eating and body image concerns?* University of Sheffield. https://etheses.whiterose.ac.uk/31461/

Franko, D. L. (2007). Race, ethnicity, and eating disorders: considerations for DSM-V. *Int J Eat Disord, 40,* S31-34. https://doi.org/10.1002/eat.20455

Frederick, D. A., Kelly, M. C., Latner, J. D., Sandhu, G., & Tsong, Y. (2016). Body image and face image in Asian American and white women: Examining associations with surveillance, construal of self, perfectionism, and sociocultural pressures. *Body Image, 16,* 113-125. https://doi.org/10.1016/j.bodyim.2015.12.002

Fredrickson, B. L., & Roberts, T.-A. (1997). Objectification theory: Toward understanding women's lived experiences and mental health risks. *Psychology of Women Quarterly, 21*(2), 173-206. https://doi.org/10.1111/j.1471-6402.1997.tb00108.x

Furnham, A., & Adam-Saib, S. (2001). Abnormal eating attitudes and behaviours and perceived parental control: a study of white British and British-Asian school girls. *Social psychiatry and psychiatric epidemiology, 36*(9), 462-470. https://doi.org/10.1007/s001270170025

Furnham, A., & Patel, R. (1994). The eating attitudes and behaviours of Asian and British schoolgirls: A pilot study. *International Journal of Social Psychiatry, 40*(3), 214-226. https://doi.org/10.1177/002076409404000307

Furnham, A., & Shiekh, S. (1993). Gender, generational and social support correlates of mental health in Asian immigrants. *International Journal of Social Psychiatry, 39*(1), 22-33. https://doi.org/10.1177/002076409303900103

Gabor, J. (2023). The TikTok Algorithm Is Good, But Is It Too Good? Exploring the Responsibility of Artificial Intelligence Systems Reinforcing Harmful Ideas on Users. *Catholic University Journal of Law and Technology, 32*(1), 109-144.

Garner, D. M., & Garfinkel, P. E. (1979). The Eating Attitudes Test: An index of the symptoms of anorexia nervosa. *Psychological medicine, 9*(2), 273-279. https://doi.org/10.1017/S0033291700030762

Garner, D. M., Olmsted, M. P., Bohr, Y., & Garfinkel, P. E. (1982). The eating attitudes test: psychometric features and clinical correlates. *Psychological medicine, 12*(4), 871-878. https://doi.org/10.1017/S0033291700049163

Gilbert, P. (2010). *Compassion focused therapy: Distinctive features.* Routledge. https://doi.org/10.4324/9780203851197

Gilbert, P. (2014). The origins and nature of compassion focused therapy. *British journal of clinical psychology, 53*(1), 6-41. https://doi.org/10.1111/bjc.12043

Goel, N. J. (2019). Conceptualization of body image and eating disorders among South Asian American women: A qualitative investigation.

Goel, N. J., Thomas, B., Boutté, R. L., Kaur, B., & Mazzeo, S. E. (2021). Body Image and Eating Disorders Among South Asian American Women: What Are We Missing? *Qualitative Health Research, 31*(13), 2512-2527. https://doi.org/10.1177/10497323211036896

Goel, N. J., Thomas, B., Boutté, R. L., Kaur, B., & Mazzeo, S. E. (2023). "What will people say?": Mental health stigmatization as a barrier to eating disorder treatment-seeking for South Asian American women. *Asian American Journal of Psychology, 14*(1), 96. https://doi.org/10.1037/aap0000271

Gordon, R. A. (2001). Eating disorders East and West: A culture-bound syndrome unbound. *Eating disorders and cultures in transition, 1,* 16.

Gorrell, S., Loeb, K. L., & Le Grange, D. (2019). Family-based Treatment of Eating Disorders: A Narrative Review. *Psychiatr Clin North Am, 42*(2), 193-204. https://doi.org/10.1016/j.psc.2019.01.004

Goss, K., & Allan, S. (2012). An introduction to compassion-focused therapy for eating disorders (CFT-E). *Eating and its disorders,* 303-314. https://doi.org/10.1002/9781118328910.ch20

Gowers, S. G., & Green, L. (2009). *Eating disorders: cognitive behaviour therapy with children and young people.* Routledge.

Grogan, S. (2021). *Body image: Understanding body dissatisfaction in men, women and children.* Routledge.

Halbeisen, G., Brandt, G., & Paslakis, G. (2022). A Plea for Diversity in Eating Disorders Research. *Front Psychiatry, 13,* 820043. https://doi.org/10.3389/fpsyt.2022.820043

Hamilton, A., Mitchison, D., Basten, C., Byrne, S., Goldstein, M., Hay, P., Heruc, G., Thornton, C., & Touyz, S. (2022). Understanding treatment delay: perceived barriers preventing treatment-seeking for eating disorders. *Australian & New Zealand Journal of Psychiatry, 56*(3), 248-259. https://doi.org/10.1177/0004867421102010

Harriger, J. A., Evans, J. A., Thompson, J. K., & Tylka, T. L. (2022). The dangers of the rabbit hole: Reflections on social media as a portal into a distorted world of edited bodies and eating disorder risk and the role of algorithms. *Body Image, 41,* 292-297. https://doi.org/https://doi.org/10.1016/j.bodyim.2022.03.007

Harriger, J. A., Thompson, J. K., & Tiggemann, M. (2023). TikTok, TikTok, the time is now: Future directions in social media and body image. *Body Image, 44*, 222-226. https://doi.org/https://doi.org/10.1016/j.bodyim.2023.01.005

Hausenblas, H. A., Campbell, A., Menzel, J. E., Doughty, J., Levine, M., & Thompson, J. K. (2013). Media effects of experimental presentation of the ideal physique on eating disorder symptoms: A meta-analysis of laboratory studies. *Clinical psychology review, 33*(1), 168-181. https://doi.org/10.1016/j.cpr.2012.10.011

Hayes, A. F., & Rockwood, N. J. (2017). Regression-based statistical mediation and moderation analysis in clinical research: Observations, recommendations, and implementation. *Behav Res Ther, 98,* 39-57. https://doi.org/10.1016/j.brat.2016.11.001

Herbozo, S., Stevens, S. D., Moldovan, C. P., & Morrell, H. E. (2017). Positive comments, negative outcomes? The potential downsides of appearance-related commentary in ethnically diverse women. *Body Image, 21*, 6-14. https://doi.org/10.1016/j.bodyim.2017.01.008

Homan, K. J., & Tylka, T. L. (2015). Self-compassion moderates body comparison and appearance self-worth's inverse relationships with body appreciation. *Body Image, 15,* 1-7. https://doi.org/https://doi.org/10.1016/j.bodyim.2015.04.007

Hoque, S. (2011). *An exploration into the experience of an eating disorder and journey into treatment for British South-Asian women: What can we learn?* (Doctoral dissertation, University of Leicester).

Huang, H., Liu, Z., Xiong, H., Herold, F., Kuang, J., Chen, E., Taylor, A., Yeung, A., Sun, J., Hossain, M. M., Kramer, A., Guo, T., & Zou, L. (2023). Validation of sociocultural attitudes towards appearance questionnaire and its associations with body-related outcomes and eating disorders among Chinese adolescents. *Front Psychiatry, 14,* 1088769. https://doi.org/10.3389/fpsyt.2023.1088769

Inman, A. G. (2006). South Asian women: Identities and conflicts. *Cultural Diversity and Ethnic Minority Psychology, 12*(2), 306. https://doi.org/10.1037/1099-9809.12.2.306

Inman, A. G., Ladany, N., Constantine, M. G., & Morano, C. K. (2001). Development and preliminary validation of the cultural values conflict scale for South Asian women. *Journal of Counseling Psychology, 48*(1), 17-27. https://doi.org/10.1037/0022-0167.48.1.17

Inman, M., Snyder, A., & Peprah, K. (2016). Religious-body affirmations protect body esteem for women who base self-worth on appearance or others' approval. *Mental Health, Religion & Culture, 19*(1), 98-111. https://doi.org/10.1080/13674676.2015.1124634

Iqbal, S. (2023). Cultural factors influencing the eating behaviours of type 2 diabetes in the British South-Asian population: a scoping review of the literature. *Journal of Global Health Reports, 7,* e2023050. https://doi.org/10.29392/001c.84191

Jaccard, J., & Turrisi, R. (2003). *Interaction Effects in Multiple Regression* https://doi.org/10.4135/9781412984522

Jakobsen, J. C., Gluud, C., Wetterslev, J., & Winkel, P. (2017). When and how should multiple imputation be used for handling missing data in randomised clinical trials – a practical guide with flowcharts. *BMC Medical Research Methodology, 17*(1), 162. https://doi.org/10.1186/s12874-017-0442-1

Jamieson, M. K., Pownall, M., & Govaart, G. H. (2022). Reflexivity in quantitative research: a rationale and beginner's guide. *Social and Personality Psychology Compass*, *17*(4), e12735. https://doi.org/10.1111/spc3.12735

Javier, S. J., & Belgrave, F. Z. (2015). An examination of influences on body dissatisfaction among asian American college females: Do family, media, or peers play a role? *Journal of American College Health, 63*(8), 579-583. https://doi.org/10.1080/07448481.2015.1031240

Javier, S. J., & Belgrave, F. Z. (2019). "I'm not White, I have to be pretty and skinny": A qualitative exploration of body image and eating disorders among Asian American women. *Asian Am J Psychol, 10*(2), 141-153. https://doi.org/10.1037/aap0000133

Johns, G., Taylor, B., John, A., & Tan, J. (2019). Current eating disorder healthcare services – the perspectives and experiences of individuals with eating disorders, their families and health professionals: systematic review and thematic synthesis. *BJPsych Open, 5*(4), e59, Article e59. https://doi.org/10.1192/bjo.2019.48

Jose, P. E. (2013). *Doing statistical mediation and moderation.* Guilford Press.

Kang, H. (2013). The prevention and handling of the missing data. *Korean J Anesthesiol, 64*(5), 402-406. https://doi.org/10.4097/kjae.2013.64.5.402

Kawamura, K. Y. (2011). Asian American body images.

Kawamura, K. Y. (2015). Cross-Cultural and Ethnicity Issues in Diagnosis. *In The Wiley handbook of eating disorders* (pp. 197-208). https://doi.org/https://doi.org/10.1002/9781118574089.ch16

Kempa, M. L., & Thomas, A. J. (2000). Culturally sensitive assessment and treatment of eating disorders. *Eating disorders, 8*(1), 17-30. https://doi.org/10.1080/10640260008251209

Khasru, I. (2022). Cover Girls: South Asian American Women's Vulnerability to Body Dissatisfaction, Arising from Cultural Differences and Western Appearance-Based Media. *The Columbia Journal of Asia, 1*(1), 49-61.

Kirschner, M. V. (2011). *The relationship of acculturative stress and family cohesion to body dissatisfaction and eating disorder symptomatology among Asian and Hispanic women.* Alliant International University, Los Angeles.

Klump, K. L., McGue, M., & Iacono, W. G. (2003). Differential heritability of eating attitudes and behaviors in prepubertal versus pubertal twins. *International Journal of Eating Disorders, 33*(3), 287-292. https://doi.org/10.1002/eat.10151

Kumar, K., Greenfield, S., Raza, K., Gill, P., & Stack, R. (2016). Understanding adherence-related beliefs about medicine amongst patients of South Asian origin with diabetes and cardiovascular disease patients: a qualitative synthesis. *BMC Endocrine Disorders, 16*(1), 24. https://doi.org/10.1186/s12902-016-0103-0

Kumari, N. (2004). South Asian women in Britain: Their mental health needs and views of services. *Journal of Public Mental Health*, *3*(1), 30-38. https://doi.org/10.1108/17465729200400005

Layard, R. (2012). Mental illness loses out in the NHS. *British Politics and Policy at LSE.* http://eprints.lse.ac.uk/id/eprint/48405

Li, P., Stuart, E. A., & Allison, D. B. (2015). Multiple Imputation: A Flexible Tool for Handling Missing Data. *Jama, 314*(18), 1966-1967. https://doi.org/10.1001/jama.2015.15281

Lim, D. (2016). *Sociocultural Attitudes Towards Appearance Questionnaire-4-Revised in Asian Americans* (Master's thesis, Loma Linda University).

Linardon, J. (2021). Positive body image, intuitive eating, and self-compassion protect against the onset of the core symptoms of eating disorders: A prospective study. *International Journal of Eating Disorders, 54(*11), 1967-1977. https://doi.org/10.1002/eat.23623

Liu, S., Li, C.-I., Wang, C., Wei, M., & Ko, S. (2020). Self-compassion and social connectedness buffering racial discrimination on depression among Asian Americans. *Mindfulness, 11*(3), 672-682.

Lock, J., & Le Grange, D. (2019). Family-based treatment: Where are we and where should we be going to improve recovery in child and adolescent eating disorders. *International Journal of Eating Disorders, 52*(4), 481-487. https://doi.org/10.1002/eat.22980

Mason, T. B., Mozdzierz, P., Wang, S., & Smith, K. E. (2021). Discrimination and Eating Disorder Psychopathology: A Meta-Analysis. *Behavior Therapy, 52*(2), 406-417. https://doi.org/10.1016/j.beth.2020.05.003

Mason, T. B., Smith, K. E., & Lavender, J. M. (2019). Stigma control model of dysregulated eating: A momentary maintenance model of dysregulated eating among marginalized/stigmatized individuals. *Appetite, 132,* 67-72. https://doi.org/https://doi.org/10.1016/j.appet.2018.09.017

Mateer, E. M., Jin, J., Taone, T., Duffield, C., & Foster, M. (2023). Does self-compassion buffer against stigma among Asian Americans? *Stigma and Health.* https://doi.org/10.1037/sah0000455

McCourt, J., & Waller, G. (1996). The influence of sociocultural factors on the eating psychopathology of Asian women in British society. *European Eating Disorders Review: The Professional Journal of the Eating Disorders Association, 4(*2), 73-83. https://doi.org/10.1002/(SICI)1099-0968(199606)4:2<73::AID-ERV147>3.0.CO;2-2

McLaren, L., Kuh, D., Hardy, R., & Gauvin, L. (2004). Positive and negative body-related comments and their relationship with body dissatisfaction in middle-aged women. *Psychology & Health, 19*(2), 261-272. https://doi.org/10.1080/0887044031000148246

Mcleod, S. (2023). Social Identity Theory In Psychology (Tajfel & Turner, 1979). *Retrieved from Simply Psychology: https://www.simplypsychology. org/social-identity-theory. html.*

Mehrotra, G. R. (2016). South Asian Women and Marriage: Experiences of a Cultural Script. *Gender Issues, 33*(4), 350-371. https://doi.org/10.1007/s12147-016-9172-7

- Milner, A., & Jumbe, S. (2020). Using the right words to address racial disparities in COVID-19. *The Lancet. Public Health, 5*(8), e419. https://doi.org/ 10.1016/S2468-2667(20)30162-6

Mishra, A., Craddock, N., Chan, J., Elwyn, R., Cerea, S., Tan, W. Q., Haamed, H. B., & Turk, F. (2023). " You Can't Be Too Skinny. You Can't Be Too Fat. I Don't Know What You Are Supposed To Be.": A qualitative focus group study exploring body image experiences of South Asian women in the UK. *Body Image, 46,* 123-138. https://doi.org/10.1016/j.bodyim.2023.05.005

Mishra, P., Pandey, C. M., Singh, U., Gupta, A., Sahu, C., & Keshri, A. (2019). Descriptive statistics and normality tests for statistical data. *Ann Card Anaesth, 22(*1), 67-72. https://doi.org/10.4103/aca.ACA_157_18

Montgomery, D. C., Peck, E. A., & Vining, G. G. (2021). *Introduction to linear regression analysis.* John Wiley & Sons.

Mujtaba, T., & Furnham, A. (2001). A cross-cultural study of parental conflict and eating disorders in a non-clinical sample. *International Journal of Social Psychiatry, 47*(1), 24-35. https://doi.org/10.1177/002076400104700103

Mumford, D. B. (1993). Eating disorders in different cultures. *International review of psychiatry, 5*(1), 109-114. https://doi.org/10.3109/09540269309028299

Mumford, D. B., Whitehouse, A. M., & Platts, M. (1991). Sociocultural correlates of eating disorders among Asian schoolgirls in Bradford. *The British Journal of Psychiatry, 158*(2), 222-228. https://doi.org/10.1192/bjp.158.2.222

Mustafa, N., Zaidi, A. U., & Weaver, R. R. (2017). Conspiracy of silence: cultural conflict as a risk factor for the development of eating disorders among second-generation Canadian South Asian women. *South Asian Diaspora, 9*(1), 33-49. https://doi.org/10.1080/19438192.2016.1199421

Naqvi, I., & Kamal, A. (2017). Translation and validation of multidimensional body self-relation questionnaire-appearance scale for young adults. *Pakistan Journal of Psychological Research, 32,* 465-485.

Nazir, B. (2016). *Improving understanding and access to treatment for Eating Disorders among British South Asian females.* The University of Manchester (United Kingdom).

Neff, K. (2003a). The development and validation of a scale to measure self-compassion. *Self and Identity, 2*(3), 223-250. https://doi.org/10.1080/15298860309027

Neff, K. (2003b). Self-compassion: An alternative conceptualization of a healthy attitude toward oneself. *Self and Identity, 2*(2), 85-101. https://doi.org/10.1080/15298860309032

Neff, K. D., & Vonk, R. (2009). Self-compassion versus global self-esteem: Two different ways of relating to oneself. *Journal of personality, 77*(1), 23-50. https://doi.org/10.1111/j.1467-6494.2008.00537.x

Negi, S., Benau, E. M., Strowger, M., Grammer, A. C., & Timko, C. A. (2022). Internalization of Appearance Ideals and Not Religiosity Indirectly Impacts the Relationship Between Acculturation and Disordered Eating Risk in South and Southeast Asian Women Living in the United States. *Front Psychol, 13,* 843717. https://doi.org/10.3389/fpsyg.2022.843717

NICE. (2017). *National Institute for Health and Care Excellence: Guidelines. In Eating Disorders: Recognition and Treatment. National Institute for Health and Care Excellence (NICE).* Copyright © National Institute for Health and Care Excellence, 2017.

NICE. (2019). Eating Disorders: What is it? https://cks.nice.org.uk/topics/eating-disorders/background-information/definition/

Pallan, M. J., Hiam, L. C., Duda, J. L., & Adab, P. (2011). Body image, body dissatisfaction and weight status in south asian children: a cross-sectional study. *BMC Public Health, 11,* 1-8.

Perera, H., Wickramasinghe, V., Wanigasinghe, K., & Perera, G. (2002). Anorexia nervosa in early adolescence in Sri Lanka. *Annals of tropical paediatrics, 22(*2), 173-177.

Pike, K. M., & Dunne, P. E. (2015). The rise of eating disorders in Asia: a review. *J Eat Disord, 3*, 33. https://doi.org/10.1186/s40337-015-0070-2

Prathikanti, S. (1997). *East Indian American families. Working with Asian Americans: A guide for clinicians,* 79100.

Preti, A., Rocchi, M. B. L., Sisti, D., Camboni, M. V., & Miotto, P. (2011). A comprehensive meta-analysis of the risk of suicide in eating disorders. *Acta Psychiatrica Scandinavica, 124*(1), 6-17. https://doi.org/10.1111/j.1600-0447.2010.01641.x

Rahim, H. F., Mooren, T. T., van den Brink, F., Knipscheer, J. W., & Boelen, P. A. (2021). Cultural identity conflict and psychological well-being in bicultural young adults: do self-concept clarity and self-esteem matter? *The Journal of Nervous and Mental Disease, 209*(7), 525-532. https://doi.org/ 10.1097/NMD.0000000000001332

Reddy, S. D., & Crowther, J. H. (2007). Teasing, acculturation, and cultural conflict: psychosocial correlates of body image and eating attitudes among South Asian women. *Cultural Diversity and Ethnic Minority Psychology, 13*(1), 45. https://doi.org/10.1037/1099-9809.13.1.45

Relojo, D. (2016). Moderating Effects of Dietary Restraint and Self-Compassion in an Expressive Writing Intervention in Southeast Asian Population. *Journal of Behavioural Sciences, 26*(2).

Richards, P. S., Weinberger-Litman, S., Berrett, M. E., & Hardman, R. K. (2020). Spirituality, religion, and eating disorders. *In Handbook of spirituality, religion, and mental health* (pp. 99-118). Elsevier. https://doi.org/10.1016/B978-0-12-816766-3.00006-9

Robinson, L., Prichard, I., Nikolaidis, A., Drummond, C., Drummond, M., & Tiggemann, M. (2017). Idealised media images: The effect of fitspiration imagery on body satisfaction and exercise behaviour. *Body Image, 22,* 65-71. https://doi.org/10.1016/j.bodyim.2017.06.001

Rodgers, R. F., Berry, R., & Franko, D. L. (2018). Eating Disorders in Ethnic Minorities: an Update. *Current Psychiatry Reports, 20*(10), 90. https://doi.org/10.1007/s11920-018-0938-3

Rome, E. S., & Ammerman, S. (2003). Medical complications of eating disorders: an update. *Journal of Adolescent Health, 33*(6), 418-426. https://doi.org/10.1016/j.jadohealth.2003.07.002

Rounsefell, K., Gibson, S., McLean, S., Blair, M., Molenaar, A., Brennan, L., Truby, H., & McCaffrey, T. A. (2020). Social media, body image and food choices in healthy young adults: A mixed methods systematic review. *Nutrition & Dietetics, 77*(1), 19-40. https://doi.org/10.1111/1747-0080.12581

Royal College of Psychiatrists. (2019). Position statement on early intervention for eating disorders. In: Royal College of Psychiatrists London.

Rudiger, J. A., & Winstead, B. A. (2013). Body talk and body-related co-rumination: Associations with body image, eating attitudes, and psychological adjustment. *Body Image, 10*(4), 462-471. https://doi.org/https://doi.org/10.1016/j.bodyim.2013.07.010

Runfola, C. D., Von Holle, A., Trace, S. E., Brownley, K. A., Hofmeier, S. M., Gagne, D. A., & Bulik, C. M. (2013). Body dissatisfaction in women across the lifespan: results of the UNC-SELF and Gender and Body Image (GABI) studies. *Eur Eat Disord Rev, 21*(1), 52-59. https://doi.org/10.1002/erv.2201

Sahi Iyer, D., & Haslam, N. (2003). Body image and eating disturbance among south Asian-American women: The role of racial teasing. *International Journal of Eating Disorders, 34*(1), 142-147. https://doi.org/10.1002/eat.10170

Schaefer, L. M., Burke, N. L., Thompson, J. K., Dedrick, R. F., Heinberg, L. J., Calogero, R. M., Bardone-Cone, A. M., Higgins, M. K., Frederick, D. A., Kelly, M., Anderson, D. A., Schaumberg, K., Nerini, A., Stefanile, C., Dittmar, H., Clark, E., Adams, Z., Macwana, S., Klump, K. L., . . . Swami, V. (2015). Development and validation of the Sociocultural Attitudes Towards Appearance Questionnaire-4 (SATAQ-4). *Psychol Assess, 27*(1), 54-67. https://doi.org/10.1037/a0037917

Schaefer, L. M., Harriger, J. A., Heinberg, L. J., Soderberg, T., & Kevin Thompson, J. (2017). Development and validation of the sociocultural attitudes towards appearance questionnaire-4-revised (SATAQ-4R). *International Journal of Eating Disorders, 50*(2), 104-117. https://doi.org/https://doi.org/10.1002/eat.22590

Seekis, V., Bradley, G., & Duffy, A. L. (2020). Does a Facebook-enhanced Mindful Self-Compassion intervention improve body image? An evaluation study. *Body Image*, *34*, 259-269. https://doi.org/10.1016/j.bodyim.2020.07.006

Segal, U. A. (1991). Cultural variables in Asian Indian families. *Families in society, 72*(4), 233-242. https://doi.org/10.1177/10443894910720040

Shaikh, M. (2017). *Struggling to Escape Colorism: &Skin Color Discrimination Experiences of South Asian Americans* (Doctoral dissertation).

Sharma, N., Shaligram, D., & Yoon, G. H. (2020). Engaging South Asian youth and families: A clinical review. *International Journal of Social Psychiatry, 66*(6), 584-592. https://doi.org/10.1177/0020764020922881

Sharpe, H., Griffiths, S., Choo, T.-H., Eisenberg, M. E., Mitchison, D., Wall, M., & Neumark-Sztainer, D. (2018). The relative importance of dissatisfaction, overvaluation and preoccupation with weight and shape for predicting onset of disordered eating behaviors and depressive symptoms over 15 years. *International Journal of Eating Disorders, 51*(10), 1168-1175. https://doi.org/https://doi.org/10.1002/eat.22936

Simone, M., Telke, S., Anderson, L. M., Eisenberg, M., & Neumark-Sztainer, D. (2022). Ethnic/racial and gender differences in disordered eating behavior prevalence trajectories among women and men from adolescence into adulthood. *Soc Sci Med, 294*, 114720. https://doi.org/10.1016/j.socscimed.2022.114720

Sinha, S., & Warfa, N. (2013). Treatment of eating disorders among ethnic minorities in western settings: a systematic review. *Psychiatria Danubina, 25*(suppl 2), 295-299.

Slater, A., & Tiggemann, M. (2015). Media exposure, extracurricular activities, and appearance-related comments as predictors of female adolescents' self-objectification. *Psychology of Women Quarterly, 39*(3), 375-389. https://doi.org/10.1177/0361684314554606

Smart, R., Tsong, Y., Mejía, O. L., Hayashino, D., & Braaten, M. E. T. (2011). Therapists' experiences treating Asian American women with eating disorders. *Professional Psychology: Research and Practice, 42*(4), 308. http://doi.org/ 10.1037/a0024179

Smart, R. S. (1999). *Role of ethnicity, body dissatisfaction, and stressful life events in disordered eating among Asian-American, Chicana/Latina, and European American college females.* University of Southern California.

Soh, N. L.-W., & Walter, G. (2013). Publications on cross-cultural aspects of eating disorders. *Journal of Eating Disorders, 1*(1), 1-4. https://doi.org/10.1186/2050-2974-1-4

Solmi, F., Hatch, S. L., Hotopf, M., Treasure, J., & Micali, N. (2014). Prevalence and correlates of disordered eating in a general population sample: the South East London Community Health (SELCoH) study. *Social psychiatry and psychiatric epidemiology, 49*(8), 1335-1346. https://doi.org/10.1007/s00127-014-0822-3

Solmi, F., Hotopf, M., Hatch, S., Treasure, J., & Micali, N. (2016). Eating disorders in a multi-ethnic inner-city UK sample: prevalence, comorbidity and service use. *Social*

psychiatry and psychiatric epidemiology, 51, 369-381. https://doi.org/10.1007/s00127-015-1146-7

Sotiriou, E. G. (2021). *Cultural components of body dissatisfaction in ethnically diverse women: moving beyond weight focused body image.* The University of Texas at Austin.

Stam, V. (2021). Working through and with whiteness in fieldwork practice: activating an ethic of solidarity in race research in the Netherlands. *Whiteness and Education, 6*(2), 182-199. https://doi.org/10.1080/23793406.2021.1929427

Stefanile, C., Nerini, A., Matera, C., Schaefer, L. M., & Thompson, J. K. (2019). Validation of an Italian version of the Sociocultural Attitudes Towards Appearance Questionnaire-4-Revised (SATAQ-4R) on non-clinical Italian women and men. *Body Image, 31*, 48-58. https://doi.org/10.1016/j.bodyim.2019.08.005

Steindl, S. R., Buchanan, K., Goss, K., & Allan, S. (2017). Compassion focused therapy for eating disorders: A qualitative review and recommendations for further applications. *Clinical Psychologist, 21*(2), 62-73. https://doi.org/10.1111/cp.12126

Stevens, A., & Griffiths, S. (2020). Body Positivity (# BoPo) in everyday life: An ecological momentary assessment study showing potential benefits to individuals' body image and emotional wellbeing. *Body Image, 35,* 181-191. https://doi.org/10.1016/j.bodyim.2020.09.003

Striegel-Moore, R. H., & Bulik, C. M. (2007). Risk factors for eating disorders. *American psychologist, 62*(3), 181.

Stuart, J., & Ward, C. (2011). Predictors of Ethno-Cultural Identity Conflict Among South Asian Immigrant Youth in New Zealand. *Applied Developmental Science, 15*(3), 117-128. https://doi.org/10.1080/10888691.2011.587717

Swami, V., Airs, N., Chouhan, B., Amparo Padilla Leon, M., & Towell, T. (2009). Are there ethnic differences in positive body image among female British undergraduates? *European Psychologist, 14*(4), 288-296.

Szabó, Á., & Ward, C. (2022). Development and validation of a short form version of the Ethno-Cultural Identity Conflict Scale (EICS-SF). *Assessment, 29*(5), 1020-1032. https://doi.org/10.1177/10731911211000108

Talbot, C. V., & Branley-Bell, D. (2022). #BetterHealth: A qualitative analysis of reactions to the UK government's better health campaign. *Journal of health psychology, 27*(5), 1252-1258. https://doi.org/10.1177/1359105320985576

Tareen, A., Hodes, M., & Rangel, L. (2005). Non-fat-phobic anorexia nervosa in British South Asian adolescents. Int J Eat Disord, 37(2), 161-165. https://doi.org/10.1002/eat.20080

Theis, D. R., & White, M. (2021). Is obesity policy in England fit for purpose? Analysis of government strategies and policies, 1992–2020. *The Milbank Quarterly, 99*(1), 126-170. https://doi.org/10.1111/1468-0009.12498

Thomas, J. J., Lee, S., & Becker, A. E. (2016). Updates in the epidemiology of eating disorders in Asia and the Pacific. *Current opinion in psychiatry, 29*(6), 354-362. https://doi.org/10.1097/YCO.0000000000000288

Tsong, Y., & Smart, R. (2015). The role of cultural beliefs in disordered eating among Asian-American women. *Asian American Journal of Psychology, 6*(4), 342.

Tuomainen, H., McGowan, R., Williams-Ridgway, A., Guy, K., & McNeil, S. (2024). Protocol for a scoping review to identify research reporting on eating disorders in minority ethnic populations in the UK, Canada, Australia and New Zealand. *BMJ Open, 14*(2), e075034. http://doi.org/10.1136/bmjopen-2023-075034

Tylka, T. L., & Kroon Van Diest, A. M. (2015). Protective factors. *The Wiley handbook of eating disorders,* 430-444. https://doi.org/10.1002/9781118574089.ch33

Tylka, T. L., Russell, H. L., & Neal, A. A. (2015). Self-compassion as a moderator of thinness-related pressures' associations with thin-ideal internalization and disordered eating. *Eating behaviors, 17*, 23-26. https://doi.org/10.1016/j.eatbeh.2014.12.009

Udo, T., & Grilo, C. M. (2018). Prevalence and correlates of DSM-5–defined eating disorders in a nationally representative sample of US adults. *Biological psychiatry, 84*(5), 345-354. https://doi.org/10.1016/j.biopsych.2018.03.014

Ulfvebrand, S., Birgegård, A., Norring, C., Högdahl, L., & von Hausswolff-Juhlin, Y. (2015). Psychiatric comorbidity in women and men with eating disorders results from a large clinical database. *Psychiatry Research, 230*(2), 294-299. https://doi.org/https://doi.org/10.1016/j.psychres.2015.09.008

Vaidyanathan, S., Kuppili, P. P., & Menon, V. (2019). Eating Disorders: An Overview of Indian Research. *Indian J Psychol Med, 41*(4), 311-317. https://doi.org/10.4103/ijpsym.Ijpsym_461_18

Van Alsten, S. C., & Duncan, A. E. (2020). Lifetime patterns of comorbidity in eating disorders: An approach using sequence analysis. *European Eating Disorders Review, 28(*6), 709-723. https://doi.org/10.1002/erv.2767

VanVoorhis, C. W., & Morgan, B. L. (2007). Understanding power and rules of thumb for determining sample sizes. *Tutorials in quantitative methods for psychology, 3*(2), 43-50.

Varghese, A., & Rae Jenkins, S. (2009). Parental overprotection, cultural value conflict, and psychological adaptation among Asian Indian women in America. *Sex roles, 61*(3), 235-251. https://doi.org/10.1007/s11199-009-9620-x

Wales, J., Brewin, N., Raghavan, R., & Arcelus, J. (2017). Exploring Barriers to South Asian Help-Seeking for Eating Disorders. *Mental Health Review Journal, 22.* https://doi.org/10.1108/MHRJ-09-2016-0017

Waller, G., Schmidt, U., Treasure, J., Emanuelli, F., Alenya, J., Crockett, J., & Murray, K. (2009). Ethnic origins of patients attending specialist eating disorders services in a multiethnic urban catchment area in the United Kingdom. *International Journal of Eating Disorders, 42*(5), 459-463. https://doi.org/10.1002/eat.20631

Ward, C., Stuart, J., & Kus, L. (2011). The construction and validation of a measure of ethno-cultural identity conflict. *Journal of personality assessment, 93*(5), 462-473. https://doi.org/10.1080/00223891.2011.558872

Wei, M., Liu, S., Ko, S. Y., Wang, C., & Du, Y. (2020). Impostor feelings and psychological distress among Asian Americans: Interpersonal shame and self-compassion. *The Counseling Psychologist, 48*(3), 432-458. https://doi.org/10.1177/0011000019891992

Wildes, J. E., Emery, R. E., & Simons, A. D. (2001). The roles of ethnicity and culture in the development of eating disturbance and body dissatisfaction: A meta-analytic review. *Clinical psychology review, 21*(4), 521-551. https://doi.org/10.1016/S0272-7358(99)00071-9

Winter, V. R., Danforth, L. K., Landor, A., & Pevehouse-Pfeiffer, D. (2019). Toward an Understanding of Racial and Ethnic Diversity in Body Image among Women. *Social Work Research, 43*(2), 69-80. https://doi.org/10.1093/swr/svy033

World Health Organization. (2018). International classification of diseases for mortality and morbidity statistics (11th Revision).

Yoo, W., Mayberry, R., Bae, S., Singh, K., He, Q. P., & Lillard Jr, J. W. (2014). A study of effects of multicollinearity in the multivariable analysis. *International journal of applied science and technology, 4*(5), 9.

Yu, E. A., & Chang, E. C. (2020). Depressive symptoms and life satisfaction in Asian American college students: Examining the roles of self-compassion and personal and

relational meaning in life. *Asian American Journal of Psychology, 11*(4), 259. https://doi.org/10.1037/aap0000214

Appendices

Appendix 1. Search Strategy Matrix and Results

Search No.	South asian, asian,	Women, female*, girl*	Women, female*, girl*,	Eating disorder*, disordered eating, eating pathology, eating psychopathology, dietary restraint, eating behaviour, eating, eating symptoms, eating symptomatology, problematic eating	Body image, body dissatisfaction, weight consciousness, eating disturbance, body satisfaction, body ambivalence, self-image, appearance,	Sociocultural, Discourse, Narratives, Attitudes, influence*, Culture, Perspective, Values, Beliefs, Stigma, Stigmatisation, Stigmatization,	Media, Online, Internet, Fitspiration, peer*, Teasing, Bullying, racial teasing, Family, parent*, generation*,	Self compassion, self-compassion, Compassion, self-kindness, self-compassionate, self-warmth,	cultural conflict, cultural values, cultural identity, Acculturation, Identity, cultural beliefs, Marriage, Marital,
1.	X	X	X	X					
2.	X	X		X	X	X			
3.	X	X	X		X	X			
4.	X	X		X			X		
5.	X	X	X				X		
6.	X	X					X		

7.	X	X		X		X
8.	X	X	X			X
9.	X				X	

Research terms used for the scoping review, each ‘,’ indicates the use of “OR”, meaning any of those truncated keywords is enough for eligibility. The asterisk is used to include any words that begin with this word. Each search number includes multiple groups of truncated research terms the groups highlighted in the table were searched by using the ‘AND’ function to ensure results included one of the terms within each group.

Search No.	Number of papers	Number excluded (duplicates, not relevant population)	Total number of papers
1.	67	Duplicates = 44, Not SA pop (East Asian) = 2	21
2.	14	Duplicates = 10, Not SA pop (Chinese) = 2	2
3.	9	Duplicates = 7	2
4.	0	N/A	0
5.	0	N/A	0
6.	0	N/A	0
7.	15	Duplicates = 7	8
8.	18	Duplicates = 8	10
9.	29	Duplicates = 10 Not SA pop (East Asian, Asian Pacific Islander American) = 2	17
		Total number of papers:	60
		Total minus total duplicates:	50

Appendix 2. Ethical Approval

The Secretariat
University of Leeds
Leeds, LS2 9JT
Email: fmhunihethics@leeds.ac.uk

UNIVERSITY OF LEEDS

Beth Pearson
Leeds Institute of Health Sciences
Faculty of Medicine & Health
University of Leeds
Leeds, LS2 9JT

12 June 2024

Dear Beth

MREC 22-062 – The impact of sociocultural weight and shape values on body dissatisfaction and eating behaviour difficulties, moderated by self-compassion in women with South Asian heritage

NB: All approvals/comments are subject to compliance with current University of Leeds and UK Government advice regarding the Covid-19 pandemic.

The above research ethics application has been reviewed by the School of Medicine Research Ethics Committee (SoMREC) and I can confirm a conditional favourable ethical opinion based on the documentation received at date of this letter and *subject to the following condition/s which must be fulfilled prior to the study being implemented:*

1. **Consent Form – The statement, *"I agree to take part in the above research project"* needs to be added back in at the end of the consent form. It was requested that that the applicant remove the statement about the participant consenting to updating their email for the prize draw, but the statement "I agree to take part in the above research project" was also removed in error as well.**

2. **Section C22 - The applicant has now clarified that only the PI has access to the data, therefore they need to untick here that they will submit the research data to a journal to support publication, and untick submit to institutional repository.**

The study documentation must be amended where required to meet the above conditions and submitted for file and possible future audit. *Once you have addressed the conditions and submitted for file/future audit, you may implement the study and further confirmation of approval is not provided. Please note*, failure to comply with the above conditions will be considered a breach of ethics approval and may result in disciplinary action.

Please retain this letter as evidence of approval. Once you have met the conditions and submitted for file/audit, the study may be implemented with immediate effect.

The above conditions of the approval have been fully met and therefore full ethics approval has been given.

Appendix 3. Outcome Measures

Demographics

Age _____	
Please tick the box of the answer that applies to you.	
Ethnic Group Heritage:	Pakistani Bangladeshi Indian Nepalese Maldivian Sri Lankan Mixed heritage, please describe……. Other Asian heritage, please describe…..
Marital Status:	Single Married Civil Partnership Widowed Divorced Separated
SA Migrant Generation:	First Second Third

Sociocultural Attitudes Towards Appearance Questionnaire – 4R (SATAQ-4R)

Directions: Please read each of the following items carefully and indicate the number that best reflects your agreement with the statement.

No.	Item.	Definitely Disagree	Mostly Disagree	Neither Agree Nor Disagree	Mostly Agree	Definitely Agree
1	It is important for me to look muscular	1	2	3	4	5
2	It is important for me to look good in the clothes I wear	1	2	3	4	5
3	I want my body to look very thin	1	2	3	4	5
4	I think a lot about looking muscular	1	2	3	4	5
5	I think a lot about my appearance	1	2	3	4	5

6	I think a lot about looking thin	1	2	3	4	5
7	I want to be good looking	1	2	3	4	5
8	I want my body to look muscular	1	2	3	4	5
9	I don't really think much about my appearance	5	4	3	2	1
10	I don't want my body to look muscular	5	4	3	2	1
11	I want my body to look very lean	1	2	3	4	5
12	It is important to me to be attractive	1	2	3	4	5
13	I think a lot about having very little body fat	1	2	3	4	5
14	I don't think much about how I look	5	4	3	2	1
15	I would like to have a body that looks very muscular	1	2	3	4	5
16	I feel pressure from family members to look thinner	1	2	3	4	5
17	I feel pressure from family members to improve my appearance.	1	2	3	4	5
18	Family members encouraged me to decrease my level of body fat	1	2	3	4	5
19	Family members encourage me to get in better shape	1	2	3	4	5
20	My peers encourage me to get thinner.	1	2	3	4	5
21	I feel pressure from my peers to improve my appearance	1	2	3	4	5
22	I feel pressure from my peers to look in better shape.	1	2	3	4	5
23	I get pressure from my peers to decrease my level of body fat.	1	2	3	4	5
24	Significant others encourage me to get thinner.	1	2	3	4	5

25	I feel pressure from significant others to improve my appearance.	1	2	3	4	5
26	I feel pressure from significant others to look in better shape.	1	2	3	4	5
27	I get pressure from significant others to decrease my level of body fat.	1	2	3	4	5
28	I feel pressure from the media to look in better shape.	1	2	3	4	5
29	I feel pressure from the media to look thinner.	1	2	3	4	5
31	I feel pressure from the media to improve my appearance.	1	2	3	4	5
31	I feel pressure from the media to decrease my level of body fat.	1	2	3	4	5

Ethno-Cultural Identity Conflict Scale (EICS)

Directions: Please read each of the following items carefully and indicate the number that best reflects your agreement with the statement.

No.	Item.	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
1	No matter what the circumstances are, I have a clear sense of who I am	5	4	3	2	1
2	I have difficulties fitting into the wider society because of my cultural background	1	2	3	4	5
3	In general, I do not think that people from my ethnic group know the real me.	1	2	3	4	5
4	I sometimes do not know where I belong	1	2	3	4	5
5	I am an outsider in both my own ethnic group and the wider society	1	2	3	4	5
6	Because of my cultural heritage, I	1	2	3	4	5

	sometimes wonder who I really am					
7	I experience conflict over my identity	1	2	3	4	5
8	I find it impossible to be part of both my cultural group and the wider society	1	2	3	4	5
9	I am uncertain about my values and beliefs	1	2	3	4	5
10	I have serious concerns about my identity	1	2	3	4	5
11	People tend to see me as I see myself	5	4	3	2	1
12	I do not know what culture I belong to	1	2	3	4	5
13	I find it hard to maintain my cultural identity	1	2	3	4	5
14	I sometimes question my cultural identity	1	2	3	4	5
15	I am confused about the different demands placed on me by my family and other people	1	2	3	4	5
16	Sometimes I do not know myself	1	2	3	4	5
17	I find it easy to maintain my traditional culture and to be part of the larger society	5	4	3	2	1
18	I feel confident moving between cultures	5	4	3	2	1
19	I have difficulties fitting in with members of my ethnic group.	1	2	3	4	5
20	I am sometimes confused about who I really am	1	2	3	4	5

Cultural Value Conflict Scale (Marriage Subscale) (CVCS-M)

If you are already married or in a civil partnership, please answer this question based on how you felt prior to this time.

Directions: Please read each of the following items carefully and indicate the number that best reflects your agreement with the statement.

No.	Item.	Strongly Agree	Somewhat Agree	Neither Agree nor Disagree	Somewhat Disagree	Strongly Disagree
1	I experience anxiety at the thought of having an arranged marriage	1	2	3	4	5
2	I struggle with the value attached to needing to be married by age 25.	1	2	3	4	5
3	I struggle with the pressure to be married and the lack of option to remain single within my own culture.	1	2	3	4	5

Multidimensional Body Self Relations Questionnaire–Appearance Scales (MBSRQ–AS).

Directions: Please read each of the following items carefully and indicate the number that best reflects your agreement with the statement.

No.	Item.	Definitely Disagree	Mostly Disagree	Neither Agree nor Disagree	Mostly Agree	Definitely Agree
1	Before going out in public, I always notice how I look	1	2	3	4	5
2	I am careful to buy clothes that will make me look my best	1	2	3	4	5
3	My body is sexually appealing	1	2	3	4	5
4	I constantly worrying worry about being or becoming fat	1	2	3	4	5
5	I like my looks just the way they are	1	2	3	4	5
6	I check my appearance in a mirror whenever I can	1	2	3	4	5
7	Before going out, I usually spend a lot of time getting ready	1	2	3	4	5

8	I am very conscious of even small changes in my weight	1	2	3	4	5
9	Most people would consider me good-looking	1	2	3	4	5
10	It is important that I always look good	1	2	3	4	5
11	I use few grooming products	5	4	3	2	1
12	I like the way I look without clothes on	1	2	3	4	5
13	I am self-conscious if my grooming isn't right.	1	2	3	4	5
14	I usually wear whatever is handy without caring how it looks	5	4	3	2	1
15	I like the way my clothes fit me	1	2	3	4	5
16	I don't care what people think about my appearance	5	4	3	2	1
17	I take special care with my hair grooming	1	2	3	4	5
18	I dislike my physique	5	4	3	2	1
19	I am physically unattractive	5	4	3	2	1
20	I never think about my appearance	5	4	3	2	1
21	I am always trying to improve my physical appearance	1	2	3	4	5
22	I am on a weight-loss diet	1	2	3	4	5

Please indicate how dissatisfied or satisfied you are with each of the following areas or aspects of your body:

No.	Item.	Very Dissatisfied	Mostly Dissatisfied	Neither Satisfied nor Dissatisfied	Mostly Satisfied	Very Satisfied
23	Face (facial features, complexion)	1	2	3	4	5
24	Hair (colour, thickness, texture)	1	2	3	4	5

25	Lower torso (buttocks, hips, thighs, legs)	1	2	3	4	5
26	Mid torso (waist, stomach)	1	2	3	4	5
27	Upper torso (chest or breasts, shoulders, arms)	1	2	3	4	5
28	Muscle tone	1	2	3	4	5
29	Weight	1	2	3	4	5
30	Height	1	2	3	4	5
31	Overall appearance	1	2	3	4	5
32	I have tried to lose weight by fasting or going on crash diets	Never	Rarely	Sometimes	Often	Very often
33	I think I am…	Very underweight	Somewhat underweight	Normal weight	Somewhat overweight	Very overweight
34	From looking at me, most people would think I am…	Very underweight	Somewhat underweight	Normal weight	Somewhat overweight	Very overweight

Self-compassion Scale (SCS)

Please read each statement carefully before answering. Indicate how often you behave in the stated manner, using the following scale:

Item.	Almost never				Almost Always
1. I'm disapproving and judgmental about my own flaws and inadequacies.	5	4	3	2	1
2. When I'm feeling down, I tend to obsess and fixate on everything that's wrong.	5	4	3	2	1
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.	1	2	3	4	5
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.	5	4	3	2	1
5. I try to be loving towards myself when I'm feeling emotional pain.	1	2	3	4	5
6. When I fail at something important to me, I become consumed by feelings of inadequacy.	5	4	3	2	1
7. When I'm down and out, I remind myself that there are lots of other	1	2	3	4	5

	people in the world feeling like I am					
8.	When times are really difficult, I tend to be tough on myself.	5	4	3	2	1
9.	When something upsets me I try to keep my emotions in balance.	1	2	3	4	5
10.	When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.	1	2	3	4	5
11.	I'm intolerant and impatient towards those aspects of my personality I don't like.	5	4	3	2	1
12.	When I'm going through a very hard time, I give myself the caring and tenderness I need.	1	2	3	4	5
13.	When I'm feeling down, I tend to feel like most other people are probably happier than I am.	5	4	3	2	1
14.	When something painful happens, I try to take a balanced view of the situation.	1	2	3	4	5
15.	I try to see my failings as part of the human condition.	1	2	3	4	5
16.	When I see aspects of myself that I don't like, I get down on myself.	5	4	3	2	1
17.	When I fail at something important to me, I try to keep things in perspective.	1	2	3	4	5
18.	When I'm really struggling, I tend to feel like other people must be having an easier time of it.	5	4	3	2	1
19.	I'm kind to myself when I'm experiencing suffering.	1	2	3	4	5
20.	When something upsets me, I get carried away with my feelings.	5	4	3	2	1
21.	I can be a bit cold-hearted towards myself when I'm experiencing suffering.	5	4	3	2	1
22.	When I'm feeling down, I try to approach my feelings with curiosity and openness.	1	2	3	4	5
23.	I'm tolerant of my own flaws and inadequacies	1	2	3	4	5
24.	When something painful happens, I tend to blow the incident out of proportion.	5	4	3	2	1

25. When I fail at something that's important to me, I tend to feel alone in my failure.	5	4	3	2	1
26. I try to be understanding and patient towards those aspects of my personality I don't like.	1	2	3	4	5

Eating Attitudes Test – 26 (EAT-26)

Instructions: This is a screening measure to help you determine whether you might have an eating disorder that needs professional attention. This screening measure is not designed to make a diagnosis of an eating disorder or take the place of a professional consultation. Please fill out the form below as accurately, honestly and completely as possible. There are no right or wrong answers.

Check a response for each of the following statements:	Always:	Usually:	Often:	Some times:	Rarely:	Never:
1. I am terrified about being overweight.	3	2	1	0	0	0
2. I avoid eating when I am hungry.	3	2	1	0	0	0
3. I find myself preoccupied with food.	3	2	1	0	0	0
4. I have gone on eating binges where I feel that I may not be able to stop.	3	2	1	0	0	0
5. I cut my food into small pieces.	3	2	1	0	0	0
6. I am aware of the calorie content of foods that I eat.	3	2	1	0	0	0
7. I particularly avoid food with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	3	2	1	0	0	0
8. I feel that others would prefer if I ate more.	3	2	1	0	0	0
9. I vomit after I have eaten.	3	2	1	0	0	0
10. I feel extremely guilty after eating.	3	2	1	0	0	0
11. I am occupied with a desire to be thinner.	3	2	1	0	0	0
12. I think about burning up calories when I exercise.	3	2	1	0	0	0
13. Other people think that I am too thin.	3	2	1	0	0	0

14.	I am preoccupied with the thought of having fat on my body.	3	2	1	0	0	0
15.	I take longer than others to eat my meals.	3	2	1	0	0	0
16.	I avoid foods with sugar in them.	3	2	1	0	0	0
17.	I eat diet foods.	3	2	1	0	0	0
18.	I feel that food controls my life.	3	2	1	0	0	0
19.	I display self-control around food.	3	2	1	0	0	0
20.	I feel that others pressure me to eat.	3	2	1	0	0	0
21.	I give too much time and thought to food.	3	2	1	0	0	0
22.	I feel uncomfortable after eating sweets.	3	2	1	0	0	0
23.	I engage in dieting behaviour.	3	2	1	0	0	0
24.	I like my stomach to be empty.	3	2	1	0	0	0
25.	I have the impulse to vomit after meals.	3	2	1	0	0	0
26.	I enjoy trying new rich foods.	3	2	1	0	0	0

In the past 6 months have you:		Never	Once a month or less	2-3 times a month	Once a week	2-6 times a week	Once a day or more
A.	Gone on eating binges where you feel that you may not be able to stop?*	0	0	1	1	1	1
B.	Ever made yourself sick (vomited) to control your weight or shape?	0	1	1	1	1	1
C.	Ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?	0	1	1	1	1	1
D.	Exercised more than 60 minutes a day to lose or to control your weight?	0	0	0	0	1	1
E.	Lost 20 pounds or more in the past 6 months		1 YES			0 NO	

F.	Have you ever been treated for an eating disorder?	YES	NO

Appendix 4. Participant Information Sheet

Participant Information Sheet

The impact of sociocultural weight and shape values on body image, eating behaviours and self-compassion in women of South Asian heritage

---

Thank you for considering to take part in this research project. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please email the lead investigator, Beth (umbp@leeds.ac.uk) if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

What is the purpose of the project?
The aim of the study is to explore what factors might influence body image and eating behaviour in women with South Asian heritage. The study will also consider whether self-compassion is helpful in reducing the chance of experiencing difficulties with body dissatisfaction and eating behaviour difficulties

To participant in this study, you will be asked to complete one survey of six questionnaires at a time that is convenient for you. You will not be asked to participate in any further research following the completion of the survey.

Why have I been chosen?
We are looking to recruit over 100 participants who are **over 16 years of age** and are a **woman with South Asian heritage.**

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep (and be asked to sign a consent form) and you can still withdraw at any time without it affecting any benefits that you are entitled to in any way. You do not have to give a reason.

What do I have to do?/ What will happen to me if I take part?
You will be asked to complete one online questionnaire consisting of multiple choice questions which will take around 30 minutes to complete. If you are unable to access the online survey, please email umbp@leeds.ac.uk and this can be sent to you in the post with a return envelope.

What are the possible disadvantages and risks of taking part?
There are no foreseeable disadvantages to taking part. However, due to the nature of the questionnaires there is a chance they could bring up difficult feelings. At which point you are

free to withdraw from completing the survey at any time and there are support resources available at the end of the survey.

What are the possible benefits of taking part?
Following the completion of the survey you will be entered into a prize draw to win one of several £30 Love2Shop voucher! Alongside this, you will be helping to bridge a gap in the research understanding what factors influence difficulties with body image and eating behaviour in women with South Asian heritage. This study aims to better inform prevention and intervention strategies within communities and services.

Use, dissemination and storage of research data
The information from the completed survey will be used anonymously within the research data analysis, once the data has been used for analysis purposes, it will be deleted. This study will be completed with the view for future publishing.

What will happen to my personal information?
Participants will be asked to provide their email address in order to be entered into the prize draw, this is optional and you do not need to provide this information if you do not wish to be entered into the draw. Your email address will be the only partially identifiable information that will be held, it will be kept securely and will not be shared with anyone outside of the research team or used for any other purposes but this study. This data will be deleted following the completion of the research project.

What will happen to the results of the research project?
All the contact information that we collect about you during the course of the research will be kept strictly confidential and will be stored separately from the research data. We will take steps wherever possible to anonymise the research data so that you will not be identified in any reports or publications.
A publication of this research study aims to be disseminated in 2024 and a copy can be sent to your email address if you have requested this in your survey response.

Who is organising/ funding the research?
This research is conducted as part of a Doctorate in Clinical Psychology and is funded by the School of Medicine at the University of Leeds.

Contact for further information
Lead Investigator: Beth Pearson
Email: umbp@leeds.ac.uk Supervised by: Dr Fiona Trew

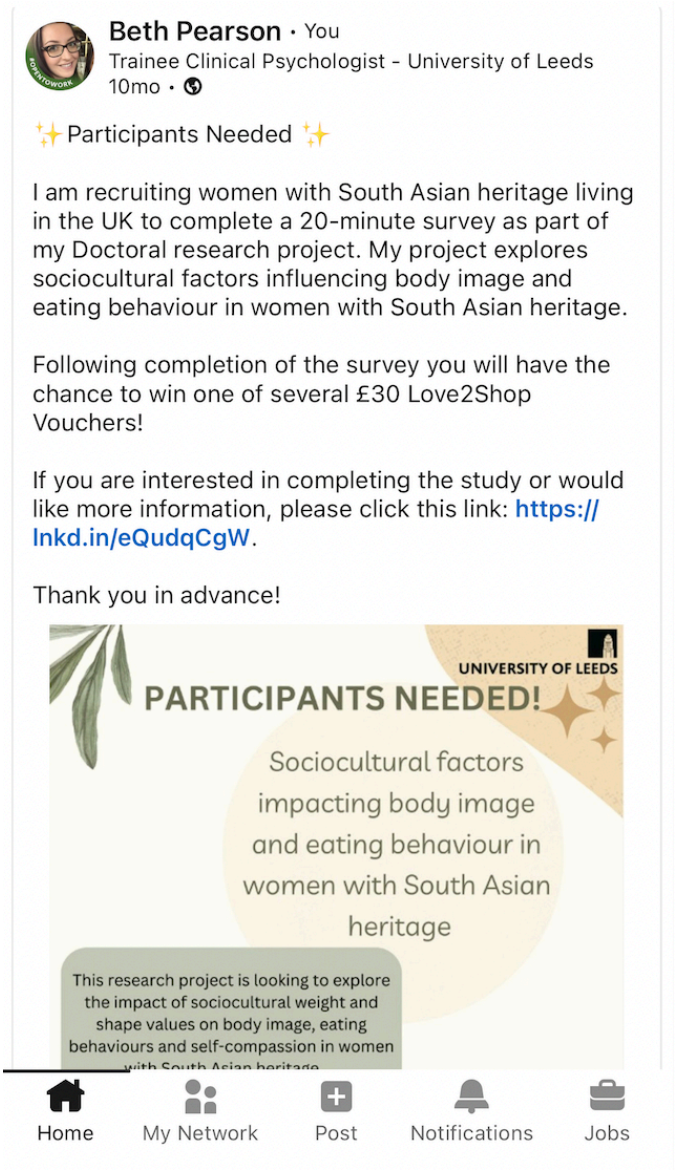
Thank you for taking the time to read this information sheet and we are grateful for your participation!

Appendix 5. Participant Consent Form

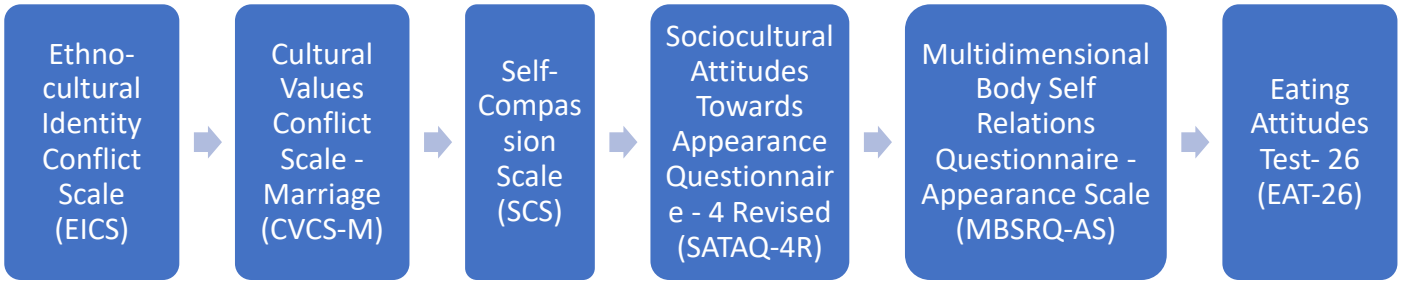
Consent to take part in: The impact of sociocultural weight and shape values on body image, eating behaviours and self-compassion in women with South Asian heritage	Add your initials next to the statement if you agree
I confirm that I have read and understand the information sheet explaining the above research project and can contact Beth Pearson (Principal Investigator) with any questions on umbp@leeds.ac.uk.	
I understand that my participation is voluntary and that I am free to withdraw at any time by exiting the webpage. In addition, should I not wish to answer any particular question or questions, I am free to decline. I understand that once I have clicked 'finish' I will no longer be able to withdraw my anonymous data.	
I understand that members of the research team may have access to my anonymised responses and that my email address will only be used if I have chosen to be entered into the prize draw to will a £30 amazon voucher. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research. I understand that my responses will be kept strictly confidential.	
I understand that the data I provide will be stored on the secure University of Leeds OneDrive.	
I understand that relevant sections of the data collected during the study, may be looked at by individuals from the University of Leeds or from regulatory authorities where it is relevant to my taking part in this research.	
I agree to take part in the above research project and if I have entered into the prize draw I will inform the lead researcher should my email address change.	

Appendix 6. Poster Advertisement

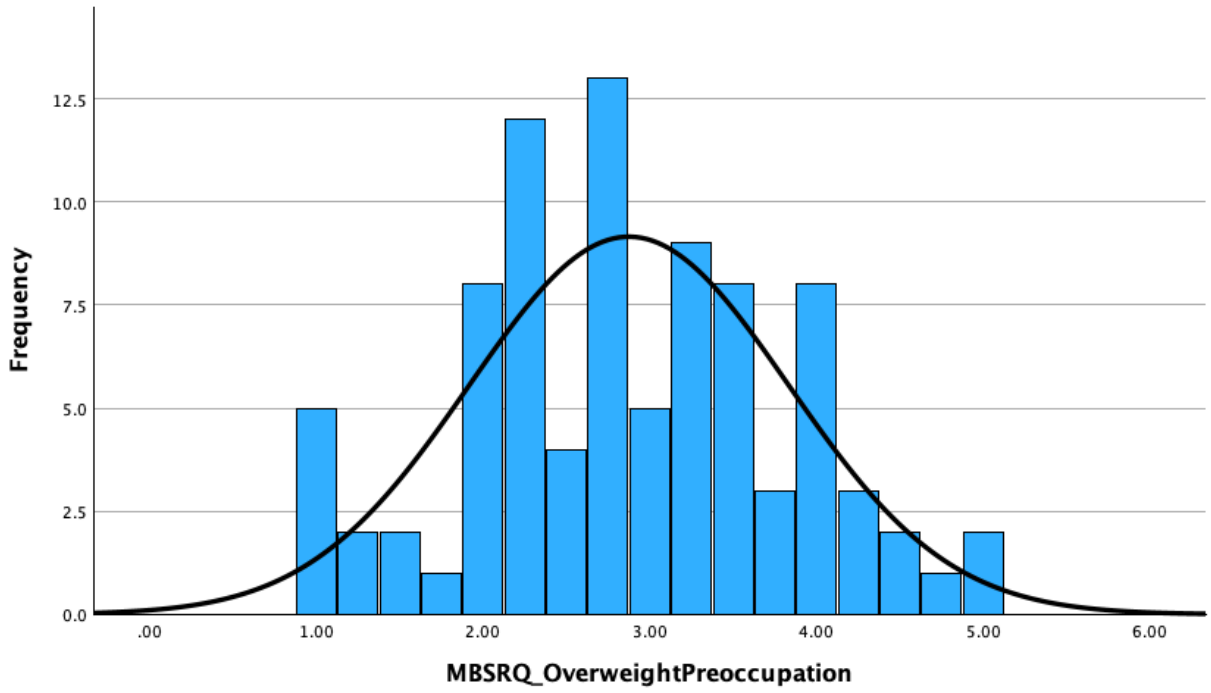
Appendix 8. LinkedIn Recruitment Advertisement

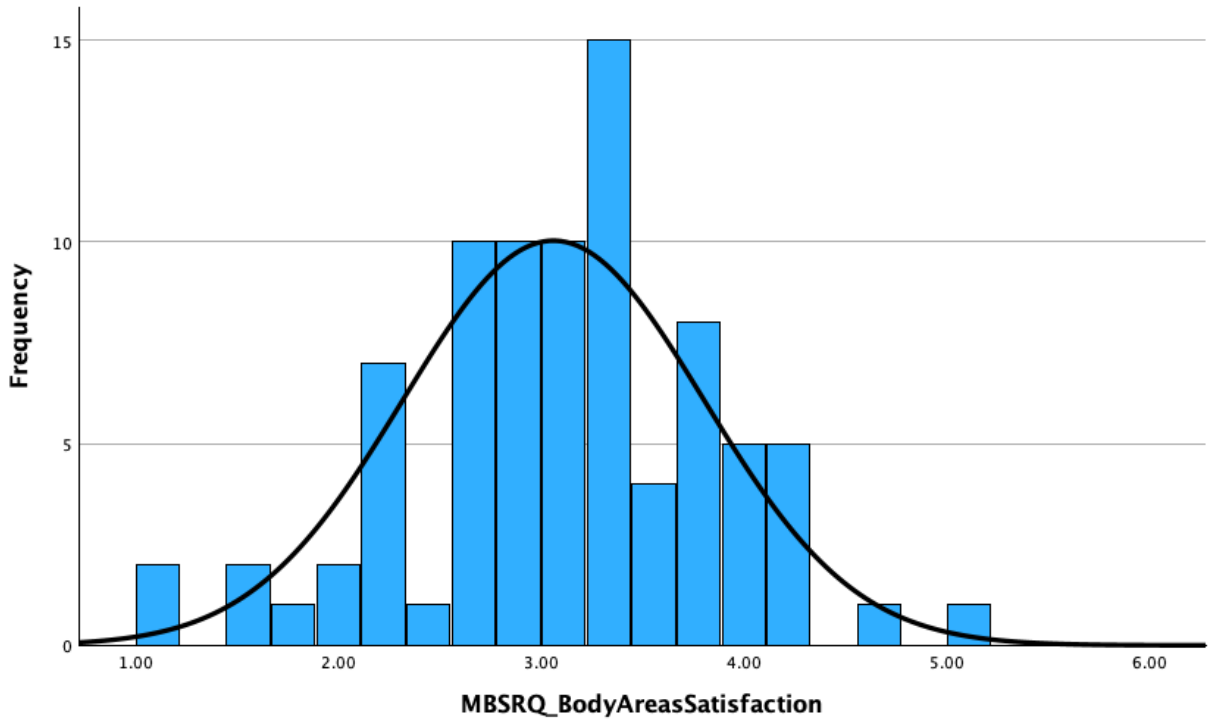


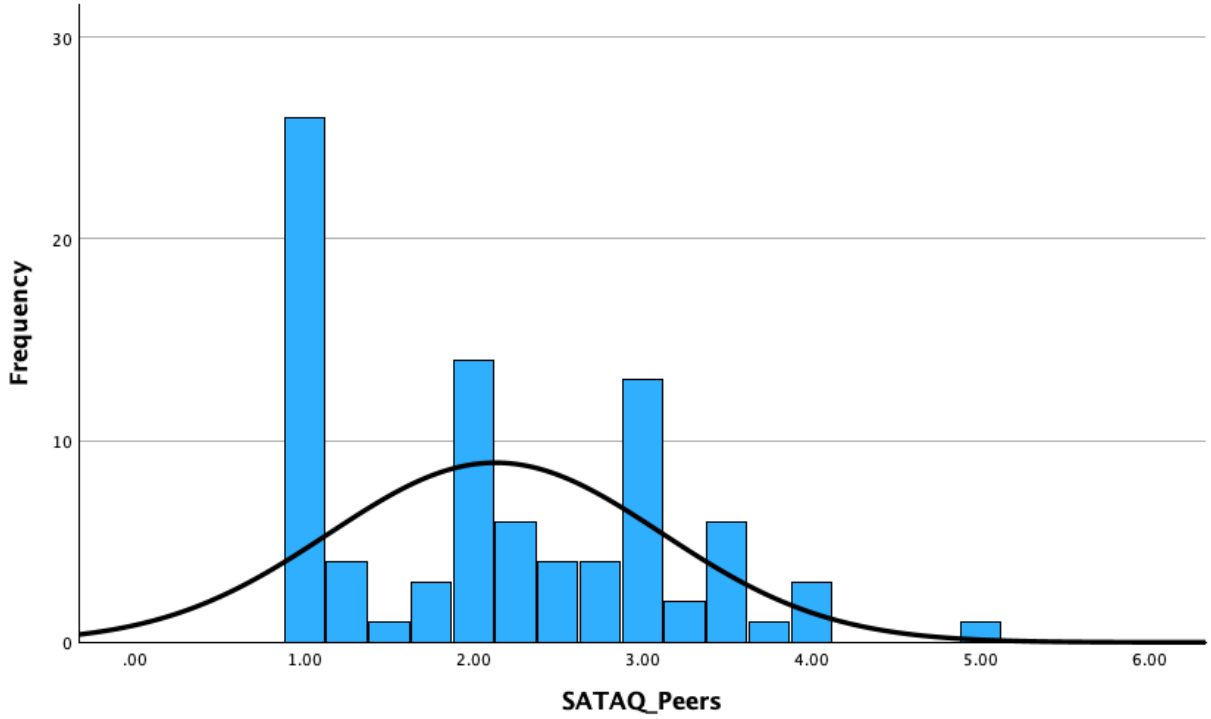
Appendix 9. Order of Measures in Online Survey

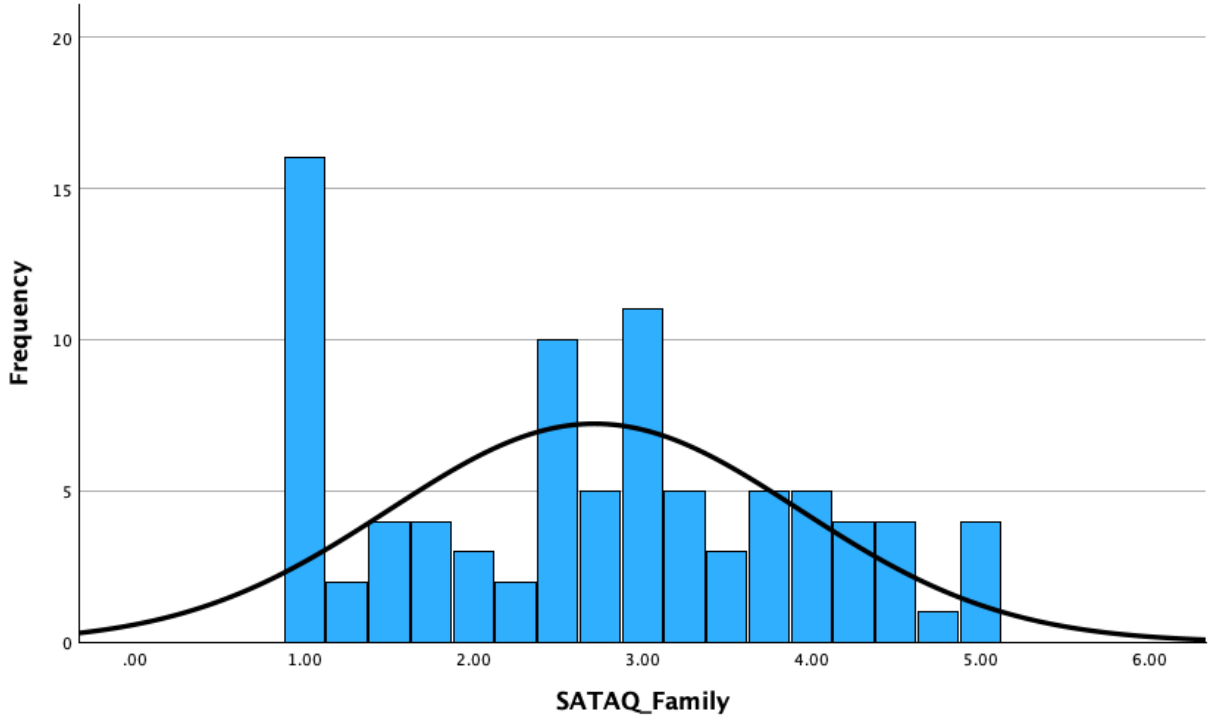


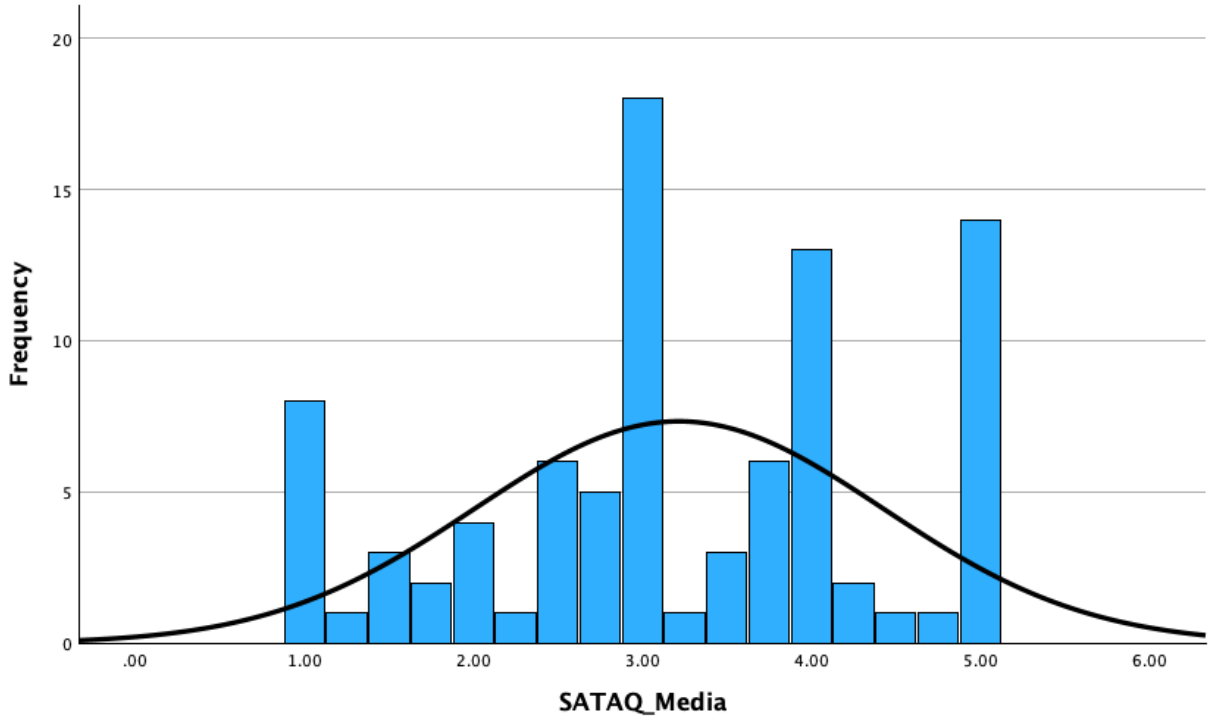
Appendix 10. Normality Histogram Plots

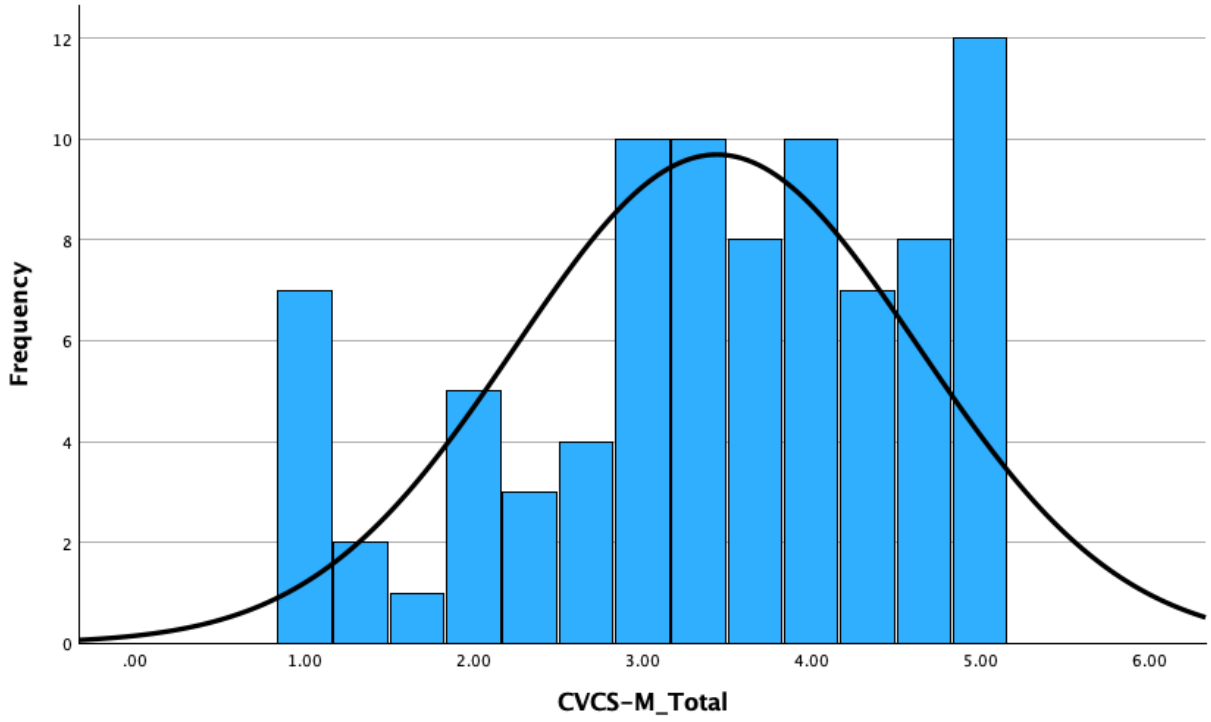


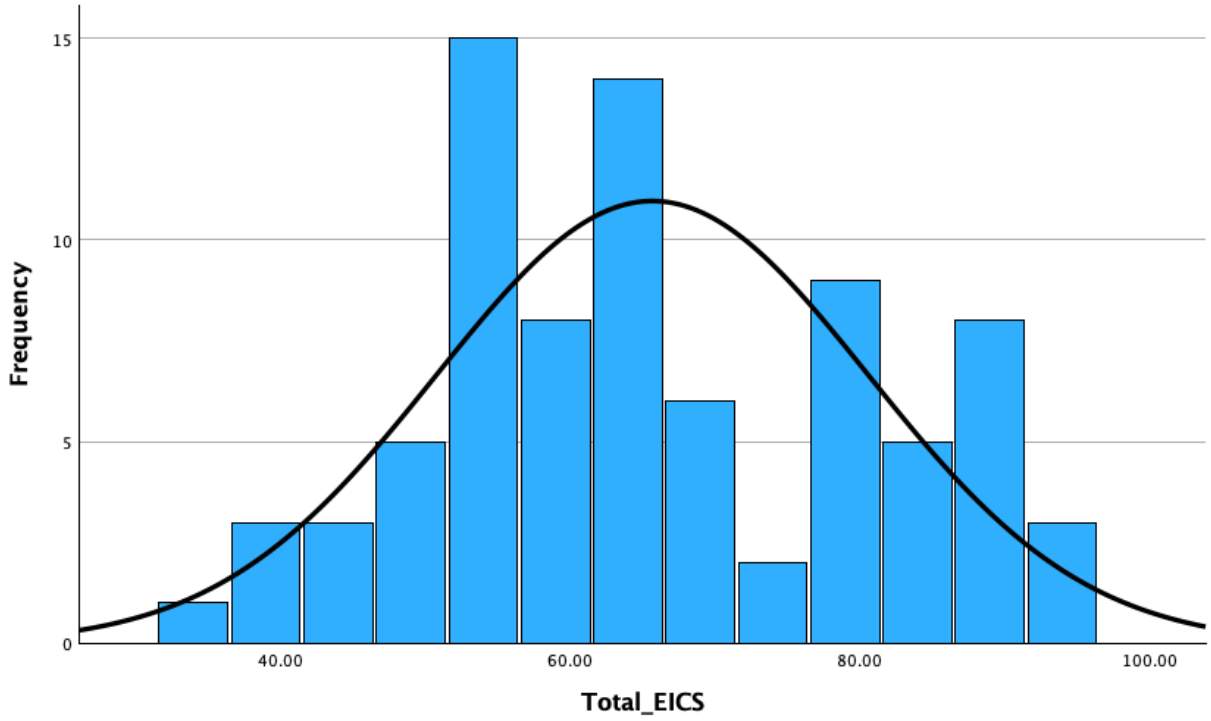


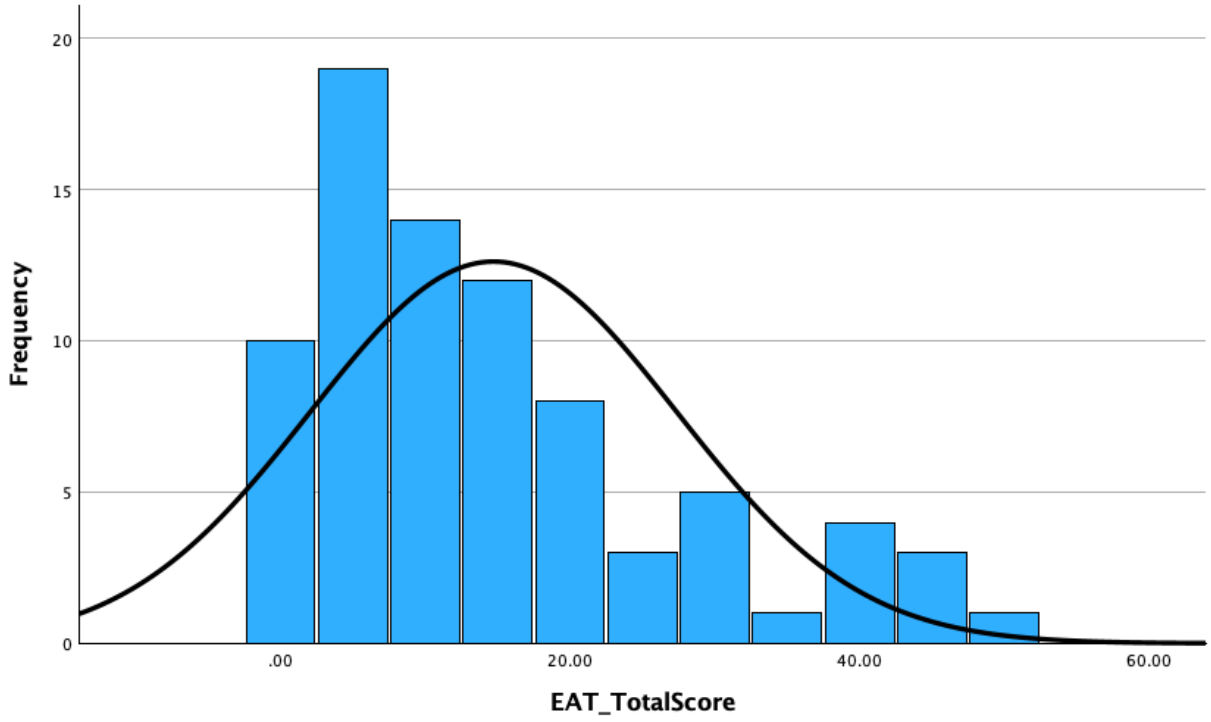

30
20
10
0
Frequency
.00
1.00
2.00
3.00
4.00
5.00
6.00
SATAQ_Peers

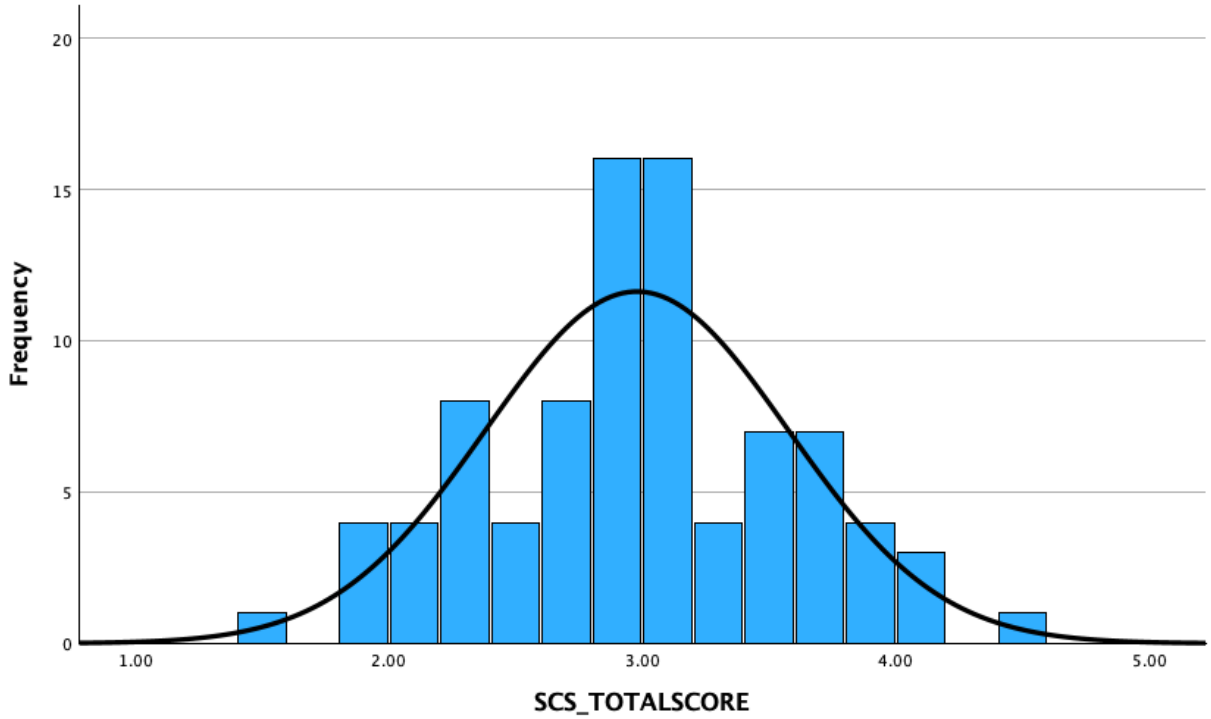

20
15
10
5
0
Frequency
.00
1.00
2.00
3.00
4.00
5.00
6.00
SATAQ_Family


Frequency
20
15
10
5
0
.00
1.00
2.00
3.00
4.00
5.00
6.00
SATAQ_Media


Frequency
12
10
8
6
4
2
0
.00
1.00
2.00
3.00
4.00
5.00
6.00
CVCS-M_Total


15
10
5
0
Frequency
40.00
60.00
80.00
100.00
Total_EICS


20
15
10
5
0
Frequency
.00
20.00
40.00
60.00
EAT_TotalScore



Appendix 11. Correlation Matrix of Predictors and Outcome Measures.

	SATAQ-M	SATAQ-F	SATAQ-P	CVCS-M	EICS	EAT-26	OP	BASS	SCS
SATAQ-M	-	0.425**	0.145	0.120	-0.177	0.017	0.377**	-0.134	0.416**
SATAQ-F	0.452**	-	0.506**	0.325**	-0.323**	0.148	0.457**	-0.222*	-0.402**
SATAQ-P	0.145	0.506**	-	0.066	-0.292**	0.166	0.203	-0.167	-0.115
CVCS-M	0.120	0.325**	0.066	-	-0.390**	0.250*	0.346**	-0.264*	-0.282**
EICS	-0.177	-0.323**	-0.292**	-0.390**	-	-0.522	-0.222*	0.273**	0.481**
EAT-26	0.011	0.139	0.181*	0.252**	-0.530**	-	0.337**	-0.500**	-0.220*
OP	0.393**	0.450**	0.198*	0.346**	-0.225*	0.333**	-	-0.222*	-0.406**
BASS	-0.134	-0.222*	-0.167	-0.264*	0.273**	-0.507**	-0.222*	-	0.355**
SCS	-0.416**	-0.402**	-0.115	-0.282**	0.481**	-0.224*	-0.405**	0.355**	-

Note: Analysis is based on pooled imputed data.
*Correlation is significant at the .05 level (2-tailed)
**Correlation is significant at the .01 level (2-tailed)