Portfolio Volume 1: Major Research Project

An Investigation of the Experience of Treatment Receiving Muslims with an Eating Disorder: An Interpretative Phenomenological Analysis

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Acknowledgments

I would like to thank my family and friends for the support. I would like to thank my participants for trusting me with their lived experiences and their generosity.

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List of Abbreviations

ED	Eating Disorder
UK	United Kingdom
NHS	National Health Service
CR	Critical realism
DSM-5	Diagnostic and Statistical Manual of Mental Disorders 5th Edition
ICD-11	International Classification of Disorders 11th Edition
WEIRD	Western, Educated, Industrial, Rich, Democracies
NICE	National Institute for Health and Care Excellence
MANTRA	Maudsley Model of Anorexia Treatment
CBT-E	Cognitive Behavioural Therapy adapted for eating disorders
EAT-26	Eating Attitudes Test-26
SSCM	Specialist Supportive Clinical Management
FPT	Focal Psychodynamic Therapy
IPA	Interpretative Phenomenological Analysis
GET	Group Experiential Theme
PET	Personal Experiential Theme
BMI	Body Mass Index

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Abstract

Background: In a post 9/11 context, there has been a growing inequality in health outcomes for minority Muslim populations in the United Kingdom (UK). The aim of the study is to better understand the experience of eating disorder (ED) treatment received by Muslims and consider what changes could be made to inform current treatment practices.

Methodology: A cross-sectional, qualitative study using semi-structured interviews was conducted. The study was interested in the personal accounts of Muslims who had experienced treatment for an ED, and for this reason an interpretative phenomenological approach (IPA) was chosen. Recruitment of participants took place in two adult community ED services in Luton and East London. Purposive sampling was used.

Findings: The final sample consisted of five, female participants with a pre-existing diagnosis of anorexia nervosa, with one participant having a comorbid diagnosis of anorexia nervosa and bulimia. Five group experiential themes (GETs) were developed, drawn from the double hermeneutic cycle of IPA. Key themes illustrated the influence of migration on perceptions of EDs, stigma of EDs within minority cultural, social and religious identities and experiences of marginalisation from mental health services. Changes for ED services to consider were within the realm of upskilling staff teams within cultural and religiously informed practice and offering Muslims peer support groups.

Implications: The participants in this study communicated the complexities of Muslim identity when in a Western healthcare service context where often the topic of religion was neglected. Further research is necessary to better meet the needs of this population.

Key Words Eating disorders, Muslims, intervention, interpretative phenomenological analysis, qualitative research

Chapter 1

Introduction

1.1 Overview

The present study explores the experiences of Muslims receiving treatment for an ED. In this chapter, the researcher will examine the personal and epistemic position in relation to the area of study, along with contextualising the topic of interest within the wider literature and discussing its relevance in clinical practice.

1.2 Researcher's Personal and Philosophical Position in Relation to the Area Under Study

1.2.1 Researcher's Personal Position

Positionality refers to where one locates themselves in relation to the topic of interest. It requires individuals to reflect on their own social identity and lived experiences and consider how these inform their processes of sense-making, assumptions, and beliefs.

My interest in this topic stems from my own lived experience as a British South Asian Muslim. Although I do not have an eating disorder (ED), I have struggled with disordered eating for most of my adolescent and adult life. Moreover, having previously worked in research focused on minority ethnic groups in the United Kingdom (UK), I learned that there is little recognition of minority religious groups within statutory mental healthcare services. A person's lived experience and their sense-making of life events can, for many, be understood through the lens of religion.

From my personal experience, I have found that culture has complicated my relationship with Islam. Cultural standards around idealized body types often drive ideas about the need to restrict food as a means of controlling weight. The scrutiny of female bodies is

often a topic of public conversation, which can contribute to preoccupation with body image and, subsequently, disordered eating habits. These experiences and the pressures to maintain an idealized body type fuelled much of my own struggles with problematic eating behaviours. Practices such as fasting for religious purposes can exacerbate these symptoms.

Furthermore, many assumptions are made regarding Muslim individuals. For instance, I have had conversations with people who held preconceived notions that Islamic religious viewpoints are regressive and outdated, believing they have little place in modern society. These attitudes are perhaps rooted in Islamophobia. In the post-9/11 context and the subsequent rise of Islamophobia, I feel that services could do more to consider the needs of Muslims accessing treatment for an ED.

I hope to highlight the nuanced needs of help-seeking Muslims. Through my personal experiences and the experiences of others, I aim to provide a platform for voices that often go unheard.

1.2.2 Researcher's Epistemic Position: Critical Realism

The philosophical position the researcher is taking in the present study is best described as critical realism (CR) (Bhaskar, 1975). According to CR, reality is not dependent on our knowledge and observation of it (Haigh, Kemp, Bazeley & Haigh, 2019). CR is a relatively new position representing the paradigm of realist ontology, that reality existing independent of our thoughts or interactions with it but also recognising a subjectivist epistemology (Bygstad & Munkvold, 2011).

CR asserts that ideologies informing our understanding and practice in public health can be modified and extended. Therefore, it is important to hold a certain flexibility in the assumption of the trustworthiness or adequacy of the knowledge we perceive (Haigh, Kemp, Bazeley & Haigh, 2019). In the context of EDs, our knowledge of assessment and current treatment approaches of these disorders is certainly not infallible. CR acknowledges the complexities and layered nature in the sphere of the social world we operate within and asks

us to focus on the 'tendencies' of the phenomenon that have been experienced (Haigh, Kemp, Bazeley & Haigh, 2019).

CR methodologies must take a pluralist approach that is adequate in its attempt to sense make, and that there is no possibility of a fundamentally 'settled' theory but a nature of constant change (Bygstad & Munkvold, 2011). For instance, the structural entities of power that activate mechanisms that cause effects, such as the paradigm between human rights and social determinants of health (Haigh, Kemp, Bazeley & Haigh, 2019). Arguably, the conceptualisation of human rights in the social determinants of health often fail to consider the structural factors and how these entities interact with each other (Haigh, Kemp, Bazeley & Haigh, 2019). Methodological approaches that draw on CR follows the aim to understand and explain the underlying mechanisms (Bygstad & Munkvold, 2011). In the context of Muslims receiving treatment for an ED, critical realism recognises the material reality of these mechanisms and structures but also holds space for evaluating how society constructs, interacts and understands the phenomenon.

1.3 Key Terms and Definitions

1.3.1 Eating Disorders

It is estimated that over 700,000 people in the UK are suggested to have an eating disorder (ED), with the majority reported to be female (National Institute for Health and Care Excellence [NICE] Clinical Knowledge Summaries, 2019). Anorexia nervosa has the highest mortality rate among mental health disorders (NICE Clinical Knowledge Summaries, 2019). EDs have been shown to be more prevalent in Western countries (Qjan et al., 2022). The literature hypothesizes that this may be due to Western cultural values concerning thinness, which may not be as present in non-Western societies. However, prevalence rates may also be underestimated, as individuals with EDs may not always access services (Soh, Touyz, & Surgenor, 2006).

The *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5) (American Psychiatric Association, 2013) recognizes EDs as five distinct categories: 1. Anorexia nervosa is characterized by extreme restriction of food intake leading to significantly low body weight. Patients with anorexia nervosa tend to exhibit a fear of gaining weight. 2. Bulimia nervosa is characterized by recurrent episodes of binge eating followed by compensatory behaviours such as purging, laxative use, or excessive exercise to counteract the binge eating (American Psychiatric Association, 2013). 3. Binge eating disorder involves recurring episodes of consuming large amounts of food in a short period, during which the person may feel a sense of lack of control. 4. Other specified feeding or eating disorder refers to individuals who experience significant distress due to symptoms similar to those of EDs but do not meet the thresholds for anorexia nervosa, bulimia nervosa, or binge eating disorder (American Psychiatric Association, 2013). 5. Avoidant/restrictive food intake disorder is associated with feeding disturbances, such as a lack of interest in eating or food, avoidance based on sensory characteristics, or concern about aversive consequences of eating.

There are minor discrepancies between the DSM-5 and the *International Classification of Disorders, 11th Edition* (ICD-11) regarding diagnostic criteria for EDs (Quadflieg, Voderholzer, Meule, & Fichter, 2023). This study will use the DSM-5 diagnostic classification.

The knowledge base that informs mental health diagnostic criteria predominantly relies on Western forms of knowledge, which can arguably create blind spots when studying under-researched populations (Henrich, Heine, & Norenzayan, 2010). The DSM-5 attempts to standardize methods for assessing and diagnosing mental illnesses, providing validity and shared definitions. However, the process of defining and diagnosing mental illness has limitations, and it is well known that human perspectives are often influenced by unconscious biases. For example, mental disorders are predominantly constructed through a lens shaped by individuals raised in Western, Educated, Industrialized, Rich, and Democratic (WEIRD) societies (Henrich, Heine, & Norenzayan, 2010).

Muslims are found worldwide; however, the majority are concentrated in northern and central Africa, the Middle East, and Southeast Asia (Pew Research Center, 2011). In academic research, most clinical trials are conducted and funded by high-income countries, with the United States leading in trial volume (World Health Organization, 2023). This highlights a disparity: the populations studied in mental health research often do not reflect the diversity of global populations. Therefore, in investigating a potentially under-researched population, it is essential to remain aware of potential gaps and biases in the existing literature and to approach the subject with openness and flexibility.

Cultural norms significantly influence perceptions of pathology. These norms are dynamic and shaped by factors such as race, class, religion, and culture (Burnham, 2018). For example, middle-class white females are often stereotyped as the typical demographic for ED diagnoses (Gordon, Perez, & Joiner, 2002). Such stereotypes risk alienating individuals who do not fit this mould, potentially discouraging them from seeking help (Gordon, Perez, & Joiner, 2002). Research has shown that ethnic disparities exist in healthcare: racial minority populations are at higher risk for non-detection of EDs in primary care services (Borowsky et al., 2000; Bignall, Jeraj, Helsby, & Butt, 2019). Furthermore, studies indicate that ethnic minority patients are less likely to be referred to ED services compared to their white counterparts (Waller et al., 2017).

There are also discrepancies in the instruments used to measure ED symptomatology in research and screening. For instance, the Eating Attitudes Test-26 (EAT-26), considered a valid tool for ED studies, produced cross-culturally inconsistent results when administered to Jewish, Muslim, and Christian populations in Israel (Spivak-Lavi et al., 2021). The findings suggest that cultural factors influence perceptions of disordered eating behaviours and that current standardized instruments may lack sensitivity in detecting these differences. Additionally, routine screening measures may not adequately identify ED symptoms in some populations (Spivak-Lavi et al., 2021). These lower detection rates and the underrepresentation of minority populations in ED services underscore the need to better

understand the experiences of these populations and assess whether current treatment practices meet their needs.

Historically, EDs have been predominantly diagnosed in female populations. Given the physical health implications of EDs, the illness has long been associated with risks to reproductive health (Holmes, 2018). While studies have quantitatively shown long- and short-term risks to fertility for ED sufferers, the evidence is often contradictory (Holmes, 2018; Chaer et al., 2020). A qualitative study revealed that fertility warnings are routinely given to female ED patients seeking treatment (Holmes, 2018). In some cases, participants reported that these warnings felt punitive and manipulative, describing them as a form of scaremongering from health professionals, which they perceived as unhelpful for their recovery (Holmes, 2018).

Such findings suggest that treatment experiences can involve elements of shaming. The topic of women with EDs and the associated risks to fertility can have wider cultural, societal, and religious implications, particularly in contexts where menstruation and fertility are deeply tied to notions of normative femininity and religious duty. These aspects of shaming, religious obligation, and normative femininity are important considerations for the researcher when reflecting on the topic of interest.

1.3.2 Religion: Islam

There have been many attempts to distinguish what constitutes a religion and what does not. Efforts to categorize theories that offer explanations have been described as wishful thinking, symbolist, and cognitive approaches to the sense-making of faith (Guthrie, 1996). Wishful-thinking theories tend to consider religious beliefs as providing a source of comfort but fail to explain aspects of religion that represent fears (Guthrie, 1996). Symbolism asserts that religious ideas and symbols sustain cohesion and order in society. However, despite this assertion of religion as a means for social unity, symbolist theories fail to address counterarguments, such as the role of religion in warfare (Guthrie, 1996). Cognitive theories

suggest that the motivation for religious thought is not only to explain the world but also to control or influence it. However, these theories do not satisfactorily explain why such religious beliefs are considered plausible (Guthrie, 1996).

Numerous approaches have been developed to create a framework for understanding religion and its function in society. However, many of these theories arguably do not withstand scrutiny and can be cursory in nature, as shown in the examples above.

Religion is enriched by its historical emergence but also intersects with the social, cultural, and political climate of society (Fitzgerald, 2015). Public discourse on religion can be conflicting—on one hand, religion is seen as concerned with spiritual life and promoting peace; on the other, it is perceived as a source of conflict and irrationality (Fitzgerald, 2015). Researchers, therefore, must navigate the intricacies of religion to fully capture its nuances and the varied individual relationships with God.

Moreover, religion has been shown to promote social support, community values, gratitude, moderation in life, and discouragement of risk-taking behaviors that may harm oneself, others, or the environment (Flannelly, Ellison & Strock, 2004). These attributes have become points of interest for researchers seeking to understand the role of religion in people's lives and how it informs behavior and well-being. However, conducting research on religion and health presents methodological challenges (Flannelly, Ellison & Strock, 2004). Scientific research typically emphasizes measurement and statistical controls, yet investigating the effects of religion on health outcomes involves unique complexities (Flannelly, Ellison & Strock, 2004).

In the context of religion, socio-cultural changes can significantly impact how individuals practice their faith and respond to health. Thus, evidence-based research on public health must be critically evaluated, even after undergoing rigorous peer review (Flannelly, Ellison & Strock, 2004).

For instance, understanding how Muslims navigate, define, and practice their faith brings numerous complexities to research. Many Muslims originate from northern and central Africa, the Middle East, and Southeast Asia (Pew Research Centre, 2011). There are

significant implications regarding colonial influence on how Muslims are perceived and navigate their identity in the West (Pew Research Centre, 2006). The categorization of Muslims often comes with negative stereotypes, such as the perception that Muslims are regressive in their views toward modern society and intolerant of Western cultural lifestyles (Pew Research Centre, 2006). Additionally, Muslims' identities are frequently clustered into a cultural core that sets them apart from Western society (Qureshi, 2020). Nonetheless, Muslims are diverse in culture, generational history, and lived experience.

The practice and opinions of what it means to be Muslim can vary significantly. Practicing Islam, for instance, which for some is integral to every aspect of life, may be measured by how closely one adheres to divine law, encompassing beliefs, deeds, and character in relation to Islam's code of life. However, this varies from person to person, influenced by numerous factors (Al-Faruqi, 2012).

Although Islam is a religion, an inherent cultural force is associated with this identity, and the construction of this culture can sometimes complicate understanding and practicing Islam (Al-Faruqi, 2012). While Islam is defined by the five pillars of core belief and practice (profession of faith, prayer, almsgiving, fasting, and pilgrimage), there is also a socio-political and cultural construction of what it means to exist as a Muslim in modern society (Al-Faruqi, 2012).

1.4 Current Treatment Options and Frameworks for Eating Disorders

Currently as it stands, NICE guidelines recommend for most ED presentations to receive a course of Cognitive Behavioural Therapy adapted for eating disorders (CBT-E) in the form of group, or individual guided self-help, or therapy of up to 20 sessions and for presentations of Anorexia nervosa of up to 40 sessions of CBT-E or Maudsley Model of Anorexia Treatment (MANTRA) or Specialist Supportive Clinical Management (SSCM) or Focal Psychodynamic Therapy (FPT) of similar length (2017, updated 2020).

Treatment for anorexia nervosa usually combines weight management plan with talking therapy. CBT-E, if offered, typically comes with a focus on managing emotions, thoughts and behaviour concerning eating habits and self-opinion (NICE, 2017). The difference between Cognitive Behavioural Therapy and CBT-E is the focus on establishing better control overeating habits and reducing the preoccupation of this, these symptoms ED patients often report (Dalle, 2022). The treatment also focusses on rules related to eating, food and managing distressing life events that may have led to the development of the ED (Dalle, 2022). Treatment may also focus on perfectionistic traits, low self-esteem and interpersonal or intrapersonal problems (Dalle, 2022). MANTRA as a recommended treatment option, draws on psychological and neurobiological research. MANTRA is usually delivered across 20 sessions and involves understanding what may be causing the ED and then working collaboratively with the patient to address this, which can also include family or carers to support patients in their treatment and recovery (NHS, 2021). SSCM focuses on alleviating the symptoms of anorexia nervosa, with a focus on weight gain and the return to normal eating habits whilst offering psychotherapeutic support to the patient (NHS, 2017). Similarly, for binge eating disorder, CBT-E may be the treatment that is routinely offered in statutory ED services. Medication for mood can be offered, however it is recommended that it is not offered as the only treatment for binge eating disorder or anorexia (NHS, 2023).

The information and NICE guidance available to clinicians for the treatment of EDs does not consider religion, despite theoretical perspectives offering insight into mental illness interacting with other parts of the individual's identity such as culture, race, gender, or class (Burnham, 2018). One example of this, in the context of EDs, religion, and the female gender, is the idea that for women their body has traditionally and historically been used for religious expression (Lelwica, 2011). Particularly in Islam, modesty for women may be outwardly expressed through garments that cover the body and is recognised as an act of their devotion to God (Lelwica, 2011). However, in a society where the female body is often culturally sanctioned, the individual may show behaviours related to using the body as a vessel of expressing suffering whilst simultaneously a tool used to show religious commitment to God

(Lelwica, 2011). Therefore, it could be hypothesised that the intersection of conflicting belief systems may arise when fasting is enacted as an obligatory act of devotion, but also stirring up internalised beliefs around thinness, social acceptance, and desirability. It is these interactions between religion and the ED that can be valuable for the patient to explore during treatment and of interest to the research question in the understanding and making sense of the nuanced experience of Muslims receiving treatment for an ED.

As the present study is investigating the experience from a religious perspective on treatment, it is of interest to describe alternative forms of approaches to understanding an ED through the lens of spirituality and religion. One form of sense making is discussed in "The Revival of the Sciences of the Faith" that presents the divided human psyche into intellect, self, soul, and heart (Ghazali, 1986). According to Ghazali, these elements interconnect, and it is through the developmental process where the instilling of healthy behaviours, cognitive thinking styles and spiritual activities that promote good health (1986). When this process is disturbed, a spiritual guide can facilitate the exploring of the inner self of the individual's psyche before working towards restabilising a healthier equilibrium within the self, soul, heart, and intellect (Ghazali, 1986). This is done through processes of cognitive restructuring to aid the person towards engaging in healthier behaviours (Keshavarzi & Ali, 2019). This being similar to treatment models for ED, such as CBT-E, where clinicians will guide the ED patient through a process of building awareness around unhelpful cognitions and disentangling what may be upholding these beliefs, to then gently challenge this with the aim of creating shifts towards healthier eating behaviours (Galle, 2022). These concepts certainly have parallels to what we may identify in current treatment practices and perhaps offer early ideas to the reader on how religion could be integrated into treatment for religious individuals.

1.5 Eating Disorders and Islam

The present study was conducted in England and with an increasingly diversifying population in the UK is it important to understand the influential forces on the interaction

between religion and mental health, where religion can play a significant role in illness perception, recovery and shape lived experiences. Research has revealed conflicting outcomes, suggesting that religion may be both a protective factor but also considered a risk factor for the development of an ED for religious patients, this further complicating the role of religion in psychological treatment and recovery (Abraham & Birmingham, 2008).

Many religions have traditions of fasting as a form of showing devotion to God. Fasting in Islam is obligatory for Muslims during the Holy month of Ramadan however there are exemptions such as sickness, pregnancy, or if you are travelling (Islamic Relief, 2023). For Muslim who suffer from an ED, during Ramadan there may be considerable health related risks in the expectation to refrain from drinking and eating from sunrise to sunset for the 30 days (Jay, 2022). In addition, religious celebrations such as Eid may be challenging, as food often becomes a cultural source of celebration during these events (Jay, 2022). The Association of UK Dieticians website recently published an article discussing some of the risk factors associated with fasting for people with an ED, namely fasting as a potential trigger for relapse, fasting masking an ED, and the emphasis of communal eating during this time exacerbating anxieties related to eating and social judgment (Jay, 2022). However, in contrast, an earlier study found that Ramadan fasting restrictions did not seem to have a clinically significant effect on eating behaviours for participants with an ED diagnosis (Erol, Baylan & Yazici, 2008). This conflicting evidence perhaps suggest that for some, religion and EDs may interact with other internalised belief systems. For example, it is important to make a distinction between fasting and dieting and that different value systems may be activated (Geertz, 1973). The act of fasting can be considered relevant to a person's spiritual journey, whereas social, cultural views of physical aesthetics may be the motivation and belief system driving behaviours towards dieting (Geertz, 1973), and it is these underlying belief systems possibly activated that may risk being unnoticed and subsequently not addressed for Muslims in treatment for an ED.

The theoretical underpinnings of an ED can be key in understanding this phenomenon. The development of EDs have been associated with self-esteem theory, interpersonal theory,

emotion regulation theory, executive function theory, social neuroscience theories, theory of mind, and trans-diagnostic theory (Zanella & Lee, 2022). ED patients often present with cognitions and behaviours that are markers of physiological, psychological and neurological processes (Harrison et al., 2010). For example, a recent review found that ED patients reported higher sensitivity to punishment compared to the healthy control group with no ED (Harrison et al., 2010). The association between ED and the reward/punishment paradigm can be linked to the dysregulation of the psychological and physiological systems in an ED patient due to prolonged behavioural inhibition to food (Harrison et al., 2010). This tendency of punishment and in turn self-harm through restriction of food can cause further complications on a person's sense of self. In the context of religion and in relation to the researcher's topic of interest, the body in Islam is considered the creation of God and is therefore a "gift" from God, hence the individual does not possess ownership of his or her body (Aramesh, 2009). Islamic legislation considers it unlawful for a Muslim to cause harm to themselves or to other people which may give rise to spiritual conflicts for an individual (Aramesh, 2009). It could be argued that these internal conflicts perhaps go unnoticed in a clinical setting where there is little training and knowledge on religion.

These examples illustrate the complex nature of Islam and its interaction with EDs and provide context to some of the existing ideas in the literature of the possible conflicts that may arise for Muslims with an ED. The researcher hopes that the present study will offer further detail in the nuanced nature between this interaction and provide valuable insight into how Muslim individuals perceive and make sense of their ED during their time in treatment.

1.6 Mental Health Service Usage by Muslim Minorities

When investigating Muslim experiences, it is important to acknowledge the socio-political context in a post 9/11 climate and how this has influenced the perception of Muslim identity. Evidence has shown negative stereotyping and discrimination of Muslims subsequently impacting the physical and mental wellbeing of help-seeking for Muslim patients

(Laird et al, 2007). Alarmingly, studies have shown increasing inequalities in the quality of care for treatment receiving Muslim minorities in the UK. This may be related to the longstanding marginalisation of minority populations and "faith-blind" policies continuing to impact access to culturally appropriate care for Muslim patients (Laird et al, 2007). Therefore, it is essential that mental healthcare services do more to understand and address existing and growing healthcare inequalities for this population.

Government policies such as the *Prevent* strategy have been proposed as colour-blind policies, however and arguably, these policies have key influence on the systematic surveillance and alienation of Muslims in the UK (Awan, 2012). *Prevent* strategy was set up as a counter-terrorism programme with an aim to stop people both from becoming a terrorist or supporting terrorism (GOV.UK, 2011). Key government documents state that whilst the purpose of *Prevent* is to address all forms of terrorism or threats to national security, at the time of its conception it was stated that the majority of resources and efforts will be devoted to preventing people from supporting or joining Al Qaida, its affiliates, related groups or individuals who share violent Islamist ideology associated with it (GOV.UK, 2011). The initial implementation of this strategy as a response to the issue of terrorism came with criticism (Awan, 2012). One criticism being that *Prevent* is a political tool that enables and perpetuates a problematic narrative around Muslim identity, that being the characterisation of Muslims as vulnerable to radicalisation in comparison to other faith or ethnic groups (Awan, 2012; Bonino, 2013). Another accusation, which has been denied, is that the *Prevent* programmes were used to facilitate spying on communities, subsequently harming the trust people had in the strategy (Awan, 2012). There were further reports of the Government admitting that groups who are now considered to support extremist ideology having had received funding from *Prevent* related grants (GOV.UK, 2011), again further evidencing the policy as flawed and ineffective.

Prevent related government documents suggest that radicalisation occurs from people in search for identity, meaning and community (GOV.UK, 2011). These theories go further into suggesting that particularly second or third generation Muslims in Europe experiencing discrimination and socio-economic disadvantage are at increased risk of finding a value

system within the terrorist community (GOV.UK, 2011). These reports further concluding that vulnerabilities in a sense of belonging and identity are essential factors to consider when identifying potential radicalisation (Bonino, 2013, GOV.UK, 2011). These ideas around the profiling of individuals at risk of radicalisation becomes the drivers of associating radicalisation as rooted in migration and race, asserting a distinction between who is most likely and least likely to become a terrorist (Bonino, 2013). With this hypothesis, there is a stereotypical profile presented to the public where many Muslims residing in Europe are likely to have experienced discrimination, as they are set apart from the rest of the population as likely to engage in violence extremist ideology, legitimising the disproportionate increase on surveillance of Muslim individuals (Bonino, 2013). Furthermore, the Citizenship Survey conducted in 2010 looked at personal and individual vulnerability factors (Citizenship Survey: 2010-11 (April 2010-March 2011), England, 2012), the survey revealed that factors such as being young and of a lower socioeconomic and income group were common risk factors in individuals who had engaged in terrorist activities. Moreover, people who show to have a mistrust of Parliament, or hold negative views of policing were also considered as key factors to consider when profiling individuals at risk of radicalisation (GOV.UK, 2011).

Whilst strategies like *Prevent* claim to not suppress an individual's freedom to practice their faith in the UK, these policies can inadvertently have criminalising effects on the practice of Islam, raising public paranoia and suspicion towards Muslims. When we develop frameworks based on rhetoric that explicitly state a significant proportion of people who have engaged in terrorism in the UK have come from overseas, and particularly countries that are of Muslim-majority and affected by conflict, it becomes near impossible to disentangle the negative stereotypes (Awan, 2012). It is therefore in the opinion of the researcher, difficult to separate whether this is a war on terrorism or a targeted attack on Muslims in the UK as the social-political landscape arguably fuels a perceived mistrust towards statutory services within the Muslim community.

The socio-political climate concerning Muslims is significant to the research question. The researcher considers these events important for understanding the lived experiences of

Muslims receiving treatment for an ED as it illustrates the underlying structures and mechanisms that influence the realities of Muslims in the UK. The prejudices at the macro-(state) level and meso/micro (community and individual) level can have ripple effects on the help-seeking tendencies and willingness for Muslims to explore their own religious identity in relation to illness and recovery in a Western healthcare context (Bonino, 2013). This is significant for the study in that this may perhaps impact a participant's level of readiness to disclose. These events act as key reminders in the sensitivities of the topic under investigation and therefore essential the researcher is mindful of this when approaching the subject.

1.7 Socio-political Status of Muslims in Society

When we think about Islamophobia, the reader may consider this type of hate to exist as overt forms of hostility. Policies such as *Prevent* arguably place pressure on clinicians to act on racist logic, as these policies compel individuals to unconsciously act and survey their Muslim counterparts through a socially reinforced Islamophobic lens (Bonino, 2013).

Islamophobia and racism are different concepts, though as mentioned earlier majority of Muslims originate from ethnic minority groups (Al-Farugi, 2012), and therefore these entities often intersect when discussing the lived experiences of Muslims. Moreover, the predominant image of Muslims in the West is usually presented as minority ethnic (Bonino, 2013). Dr Tarek Younis discusses this intersection of race and Islam in relation to the phenomenon of the liberal racist (Qureshi, 2020). Liberal racism draws from a subset of criteria of which helps determine the good Muslims from the bad Muslims (Qureshi, 2020). This developed in popularity post 9/11 where there was the dominant narrative of bad Muslims as terrorists and good Muslims as not terrorists which led to Muslims being characterised as a threat to modern society (Qureshi, 2020). These ideas were deeply ingrained into the social consciousness of the global West and as a result, we now witness what has originated from racist logic the need for good Muslims to condemn the bad (Qureshi, 2020). This condemnation complex (Qureshi, 2020) which carries racist implications positions Muslims into condemning terrorism forcing

Muslims to legitimise the racist logic in order to have a voice and be accepted into the conversation.

Political, psychological and social structures arguably play a role in perpetuating social discrimination by reinforcing ideas of Muslims as a threat to the safety of society. To illustrate this point, *Prevent* training promotes the idea that there is a psychological and emotional vulnerability that can be considered a risk factor for potential radicalisation, and therefore used to determine who is good and who may be susceptible to committing bad (Qureshi, 2020). Clinicians are asked to draw on their own gut instinct to determine who may warrant a *Prevent* referral, however what these processes fail to acknowledge is the unconscious and problematic racist logic that informs the gut instinct of professionals and counter-terrorist policies, for instance, popular signifiers such as skin colour, beard, or hijab (Bonino, 2013).

These structural forces may not explicitly be identified within the personal accounts of the participants when investigating the present topic. Nonetheless, it is important to make these distinctions regarding Muslim populations, as the researcher feels it is essential the reader understands the macro level influences that may impact individual lived experiences.

1.8 Access to Eating Disorder Services

To the author's knowledge there is no current NICE guidance on making cultural or religious adaptations for the treatment of an ED to date (NICE, 2020). From the researcher's perspective, there is sparse research available for clinicians to draw on an evidence base in how best to make religiously informed adjustments in treatment of an ED.

Typically, minority religious identity is rarely separately investigated within health disparity research and the inequalities experienced by Muslim minority patients still largely go unspoken or unacknowledged in clinical practice (Laird et al., 2007). In a review investigating the barriers Muslims face when accessing support for mental health, language barriers, stigma, family honour, misconceptions of mental illness and preferences to seek help from traditional healers (Basit & Hamid, 2010). Furthermore, other factors such as lack of cultural

understanding, suspicion and mistrust of therapies were key factors impacting help seeking in Muslims for mental health difficulties (Inspirited Minds, 2021).

During the assessment and treatment period, clinicians may routinely check religion only in the context of a protective factor, but neglect recognising the complexities of being Muslim in the West and how this may shape their sense of safety within secular mainstream services (Laird et al., 2007). What might become a blind spot for some clinicians are the internalised biases towards Muslim people as discussed earlier, where the clinician may reenact prejudices towards the individual conscious or unconsciously. This may influence how Muslim individuals interact with services and therefore, the researcher must also be aware of the impact unconscious biases can have within research and proactively consider methods to ensure individuals feel safe when they recount their experiences of receiving treatment for an ED. Nevertheless, the documented mistrust Muslims have towards services and considering what it must take to overcome these suspicions to receive treatment, alongside the low representation of Muslim minorities in mental health research, provide further grounds in the value and importance of the present investigation.

Chapter 2

Systematic literature review on religion-based interventions for treatment of eating disorders.

2.1 Background for Literature Review

There has been substantial progress over the years in the development of effective treatments for eating disorders (EDs). However, despite this, a significant number of individuals with EDs remain treatment-resistant, relapse, or continue to be at high risk (Miskovic-Wheatley et al., 2023). EDs are complex diseases characterised by abnormal eating behaviours and distorted attitudes toward body image and weight. The *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (American Psychiatric Association, 2013) classifies feeding and EDs, with anorexia nervosa and bulimia nervosa considered the classic ED types (Qian et al., 2021).

Due to the physical health implications of EDs, the medical model remains an essential part of treatment. However, there has been a growing emphasis on acknowledging the importance of a multifaceted approach. Currently, the National Institute for Health and Care Excellence (NICE) guidelines recommend 16 or more sessions of cognitive behavioural therapy for eating disorders (CBT-E) (2020).

Studies have shown that religiousness and spirituality can play significant roles in the onset and maintenance of EDs, yet these factors are often neglected in current assessment processes and treatment approaches. Religion and spirituality are concepts related to systems of belief that often involve acts of worship and devotion to a God or supernatural being (Koenig, 2012). Growing evidence reveals differences in the theoretical constructs of EDs between religious individuals and non-religious individuals (Marsden, Karagianni & Morgan,

2007). Treatment-seeking religious patients often bring complex ED schemas that are entangled with their religious and cultural identities. For instance, many faiths involve the common practice of traditional fasting (Trabelsi et al., 2022). While evidence in the literature conflicts regarding whether fasting is a risk factor for developing EDs, it can, for some ED patients, become a way of disguising their illness (Erol, Baylan & Yazici, 2008; Trabelsi et al., 2022). Moreover, individuals who can no longer fast due to their ED may experience identity issues related to their faith (Jay, 2022). While faith can aid in an individual's recovery, for example prayer offering a sense of control and comfort, it could be argued that some may experience a loss of faith during treatment.

Research has explored the theoretical underpinnings of the relationship between religion and mental health issues (Masters, 2010). For example, emerging studies have highlighted the importance of attachment theory in understanding the connection between religion and EDs. These studies emphasize the integral role of family culture and social environment in the development of early childhood attachment styles (Latzer, Hochdorf, Bachar & Canetti, 2002; Tasca, Ritchie & Balfour, 2011; Strenger, Schnitker & Felke, 2016). Attachment theory identifies three major patterns, each with subtypes (Ainsworth et al., 1978). Attachment styles illustrate how individuals navigate social relationships and regulate their emotions (Ainsworth et al., 1978). The most common attachment style is secure, followed by avoidant, and finally ambivalent or resistant attachment (Ainsworth et al., 1978). One study revealed that avoidant attachment types were commonly associated with anorexia nervosa and bulimia nervosa, while the healthy control group was more likely to present with secure attachment styles (Latzer, Hochdorf, Bachar & Canetti, 2002). Similarly, another study found anxious attachment styles associated with bulimic behaviours, while individuals with avoidant attachment styles were more likely to present with anorexic behaviours (Tasca, Ritchie & Balfour, 2011).

In the context of EDs, religion, and attachment styles, patterns emerge in which individuals exhibiting ED symptomatology also display anxious attachment styles toward God. These individuals typically fear that God does not love or accept them, while those with avoidant attachment styles distance themselves and evade closeness with their God (Strenger, Schnitker & Felke, 2016). Conversely, a secure attachment style with God has been found to promote well-being and reduce body dissatisfaction and dieting behaviours (Homan & Boyatzis, 2010; Strenger, Schnitker & Felke, 2016). However, there is still a lack of clarity and understanding regarding why or how this phenomenon occurs.

Findings from a review suggest that religious beliefs, when coupled with a secure relationship with God, are associated with lower levels of disordered eating, psychopathology, and body image concerns (Akrawi et al., 2015). Despite examples of the benefits of religious and spiritual practice, one reason for the lack of integration of religion into mainstream treatment models may be the insufficient empirical evidence regarding the effectiveness and acceptability of religion-based practices. Standard recommendations often involve drawing on community resources and religious leaders for counsel, in parallel with encouraging private forms of religious practice, such as prayer.

2.1.1 Rationale and Aim

There has been a growth in the acknowledgment and acceptance of the influential force of culture and religion in treatment and recovery processes for mental health issues (Masters, 2010). Furthermore, religion is a protected characteristic under the Equality Act 2010 and therefore important for service providers to routinely recognise it as a common ground for discrimination. Despite this, it is arguable that little efforts have been made to resource clinicians in current mainstream mental health treatment services to address complex identity issues related to faith and promote recovery through the integration of religion. Religiously informed treatment for ED patients can provide clinicians with increased

sensitivity to this aspect of identity, opening a platform to explore how religion may interact with the ED.

The review will aim to investigate the available literature on religion-based interventions for treatment of EDs. The present review will also consider the impact of religion on the process of recovery from EDs and use this to inform whether these interventions are effective for current services and healthcare providers to consider.

The distinctions between religion and spirituality are still contested where in some cases religion and spirituality are used interchangeably. Therefore, the review will accept studies that use either term in reference to the belief of a God or Higher Power. Furthermore, there are huge variations in the definition of what it looks like or means to practice religion, therefore any implementation of religious practice within treatment for an ED the authors have considered to be a form of intervention to ensure relevant studies are not excluded in the final review search. The review predicts the possibility of variations in definitions of religion and religious practice in the literature which may bring methodological differences. If so, this will be examined in the literature and addressed in the discussion.

To the authors knowledge, there are no systematic literature reviews of this nature.

2.2 Method

2.1.1 Preregistration

The review protocol was designed, developed, and registered with the International Prospective Register of Systematic Reviews PROSPERO (CRD42023457431). The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) was adopted to ensure methodological rigour and global best practice for systematic review in the health discipline (Sideri, Papageorgiou & Eliades, 2018). The study used Boland, Cherry, and Dickson's (2017) model of review protocol to outline the inclusion/exclusion criteria and propose specific methods of analyses in advance of undertaking the study. To further ensure data is

systematically well-managed, all records were collated on RefWorks. This is a bibliographic tool used in research to develop and manage personalised databases.

2.2.2 Search Method

The Population, Phenomenon of Interest and Context (PICO) model was adopted to formulate the review strategy.

Table 1.

PICO Table

PICO	
Population	Religion
Intervention	Religious-based treatment of eating disorders (ED)
Context	EDs
Outcomes	Effectiveness of religion-based intervention on ED

Eight databases were searched for published articles between August 1990 and January 2024. Relevant studies were identified by searching titles and abstracts in the following bibliographic databases: CINAHL, PsycINFO, PsycARTICLES, Cochrane Controlled Trials Register, ProQuest Central, Medline and Web of Science (WOS), and Google Scholar.

Search terms: ((Religion OR Spirituality OR Faith OR God OR Buddhi* OR Christian* OR Jew* OR Hindu* OR Muslim OR Islam* OR Worship OR Church OR Catholic* OR Evangelic*) AND Eating disorder OR Anorexia OR Bulimia OR Bing eating OR OSFED OR Other specified feeding or eating disorder OR EDNOS OR eating disorder not otherwise specified OR Disordered eating OR Eating Disturbance OR Eating pathology) AND (Recovery OR Therapy OR Intervention OR Program* OR Treatment OR Journey OR Healing OR Lived

experience OR Rehabilitat* OR Surviv* OR Reclaim* OR Conquer* OR Remission OR Cope OR Coping).

2.2.3 Inclusion and Exclusion Criteria

Inclusion: (i) 70% of participants aged above 16 years old (ii) Any measure of eating disorder or disordered eating whether through a validated scale or existing diagnosis (iii) eating disorder as the primary outcome measure in the study (iv) belonging to a religious or spiritual group or belief in a Higher Power or God. Exclusion: (i) Majority of the sample under the age of 16 years old (ii) No diagnosis or validated measure to determine the presence of an eating disorder or eating disorder symptomology.

Only published studies were included if they met the following inclusion: (i) studies that have provided religiously informed interventions for the treatment of an eating disorder/s (ii) studies which involved a sample of over 70% of participant with an eating disorder (iii) case studies, review articles, qualitative and quantitative studies, randomised and non-randomised controlled trials.

Exclusion: (i) studies involving interventions which do not focus on the treatment of an eating disorder (ii) studies with an emphasis on the prevalence of eating disorder only and without the provision of an intervention (iii) study protocols.

2.2.4 Screening and Selection

An initial search using a combination of key terms on Google Scholar had been conducted. These earlier searches supported in the conceptualisation of the review topic, providing the researcher with an idea of the literature available in the field. During this process of conducting superficial searches, the researcher was also able to decide on whether there was sufficient available data for the feasibility of a systematic literature review on the topic of interest.

Moving forward, once a topic and title had been confirmed along with a list of relevant search terms, the titles and abstracts were screened out according to inclusion/exclusion criteria, and studies not fulfilling the criteria were excluded. If it was uncertain whether the study met the inclusion/exclusion criteria, the study was retained for the next stage. In the second stage, full-text articles were screened out based on inclusion-exclusion criteria. All records were collected on RefWorks, a bibliographic tool used in research to develop personalised databases. In addition to the databases mentioned above, literature searches were supplemented by checking the reference lists of relevant systematic literature reviews and included papers reference lists for potentially relevant papers and the reference list of studies relevant to the topic of interest.

During an early scoping review of the available literature, studies such as Hoque (2011) were initially reviewed. This study investigated British South Asian women's experiences of ED treatment. The findings detailed the impact of culture on ED symptomatology and help-seeking behaviours, the parental impact on the journey into treatment for an ED—with some families preferring to seek support from a religious clergy—and how receiving support from clinicians was validating in contrast to the invalidating responses received from participants' families (Hoque, 2011).

Although the study briefly mentioned the experience of religion in its analysis, it generally lacked a robust focus on specific religion-based interventions. As a result, it met the exclusion criteria for the present review. However, studies like Hoque (2011) provided valuable insights into relevant literature that helped inform the present study and demonstrated a strong methodological approach in this area of research.

Another example of an excluded study was a qualitative paper investigating the need for cultural adaptations to health interventions for African American women with binge eating disorder (Scott, Gil-Rivas & Cachelin, 2019). While the study abstract was screened, it was excluded from the final dataset because it did not implement a religiously informed intervention. Nonetheless, the study offered valuable guidance in informing the method for using thematic analysis in the review.

The data screening was done in two phases by two independent reviewers, and any discrepancies were resolved through discussion with a third reviewer.

2.2.5 Quality Assessment

Included qualitative and quantitative studies were assessed using the Critical Appraisal Skills Programme (CASP) tool for quality appraisal. Each domain was assessed as “yes” or “no”, “somewhat” or “can’t tell”. A final risk of bias assessment for each study was a combination of assessment on each domain as per instruction given in the tool. An overview of the quality checklist for each study can be found in Table 4 and 5.

The modified CASP tool for qualitative reports (see Appendix G) was used to allows the assessor to choose between the options “yes”, “no” and “can’t tell” with an additional option of “somewhat” for a greater degree of nuance (Long et al., 2020). The “somewhat” indicates where authors have made a reasonable attempt in fulfilling a particular domain (Long et al., 2020). The adapted CASP tool for qualitative reports (Long et al., 2020) was used to assess the following studies, Pivarunas, 2016, Hertz, Addad & Ronel, 2012, Richard et al., 2018, Richards et al., 1998, Berrett Hardman, O’Grady & Richards, 2007. The CASP case control study checklist (2023) was used to appraise Spangler, 2010, the CASP randomised controlled trial checklist (2023) was used to appraise Richards, Berrett, Hardman & Eggett, 2006, and the CASP cohort study checklist (2023) was used to appraise the following studies, Smith, Hardman, Richards & Fischer, 2003, Davis et al., 2014, Brytek-Matera & Schilz, 2013, Tonkin, 2005 and Angelova & Utermohlen, 2013.

Assessment of potential risk of bias was made independently by two reviewers. One independent reviewer had a master’s level degree in clinical psychology who was recruited as the project expert by experience consultant and the second reviewer in the appraisal process was the researcher on the project completing training at a doctoral level in clinical psychology. Discrepancies were resolved through discussion between themselves and with a third peer reviewer training at a doctoral level qualification in clinical psychology who had shown interest

in the research topic and held previous experience in conducting systematic literature reviews. The researcher's role was to rate the quality for all included studies and completed the write-up of the appraisal.

2.2.6 Data Extraction

Quantitative and qualitative data was extracted independently by two reviewers and any discrepancies were resolved through discussion with the third reviewer. Quantitative information was extracted independently by at least two reviewers using a data extraction spreadsheet. Extracted information included study characteristics, study design, sample characteristics, intervention characteristics, and results. There was sufficient literature on the topic of religion-based interventions with a focus on a range of EDs that our search picked up. If there was limited information on content of intervention or if it was unclear in the title and abstract whether religion or spirituality was covered, the study was included in the full text review. Meta-analysis and systematic literature reviews findings and references were checked for any relevant studies that met the inclusions criteria. Any disagreements were resolved after discussion among the research team members.

The primary outcome was to systematically review literature on religion-based interventions for the treatment of EDs. The secondary outcome was to synthesis and analysis data to address the effectiveness of religion-based interventions.

2.2.7 Strategy for Data Synthesis

Due to the high heterogeneity in study design, intervention characteristics and outcomes in the included literature a meta-analysis was not feasible. The review will consolidate descriptive information on intervention characteristics and outcomes using a qualitative method of data synthesis.

Thematic analysis (Braun & Clarke, 2006; Clarke, Braun & Hayfield, 2015) was applied, and the review inductively extracted and summarised the data on religion-based interventions through a phased approach: 1) Data familiarisation 2) Generating codes (identifying religiously informed approaches to ED treatment in most basic form) 3) Searching for themes (identifying common areas of interventions repeated across studies and combine into themes and subthemes 4) Reviewing themes 5) Defining and naming themes, 6) Write-up. One of the benefits of thematic analysis is the flexibility and a method of analysis that can be applied across a range of theoretical and epistemological approaches (Braun & Clarke, 2006; Clarke & Braun, 2013).

The first step was reading and re-reading of the included studies, where notes and early impressions were noted. During the second stage, initial codes were generated where the analysis was guided by the research question. Open coding was used where codes were developed and modified as the researcher worked through the coding process, these codes were logged using NVivo, a qualitative data analytic software. The development of themes was characterised by their significance to the topic of interest. Codes were fitted together into a theme and some themes were combined where there were overlaps.

Each theme that seemed to say something about the research question was then in step 4 reviewed (Braun & Clarke 2006). Questions such as do they make sense? Does this say something in response to the research question? Does the evidence support each theme? Are there themes within themes (subthemes)? Were questions used to guide the data synthesis. The researcher then reviewed the themes in the context of the entire data set before moving to stage 5 which was refining what each theme is saying (Braun & Clarke 2006, p. 92), before moving to the final stages of writing-up. Throughout this process the project expert by experience consultant supported in offering critical reflections on the researchers coding processes, defining of themes and subthemes.

2.3 Results

2.3.1 Summary of Findings

The search yielded *n* = 7906 records, of which duplicates were *n* = 14. Two reviewers screened the available titles and abstracts by applying the inclusion/exclusion criteria and found *n* = 47 records. A review of the full texts (*n* = 47) resulted in the screening out of studies with no data related to religion-based interventions for EDs. Accordingly, *n* = 12 met the present study's inclusion criteria and therefore selected for the systematic review (See Figure 1).

Majority of the studies were excluded for reasons such as no standardised measurements to confirm an ED if the participants had not prior to the study received an ED diagnosis, the intervention had no religion-based element or focused only on the prevalence or risk factors of EDs. All discrepancies between the two reviewers were resolves through discussion with the wider research team.

Figure 1. PRISMA Flow Diagram

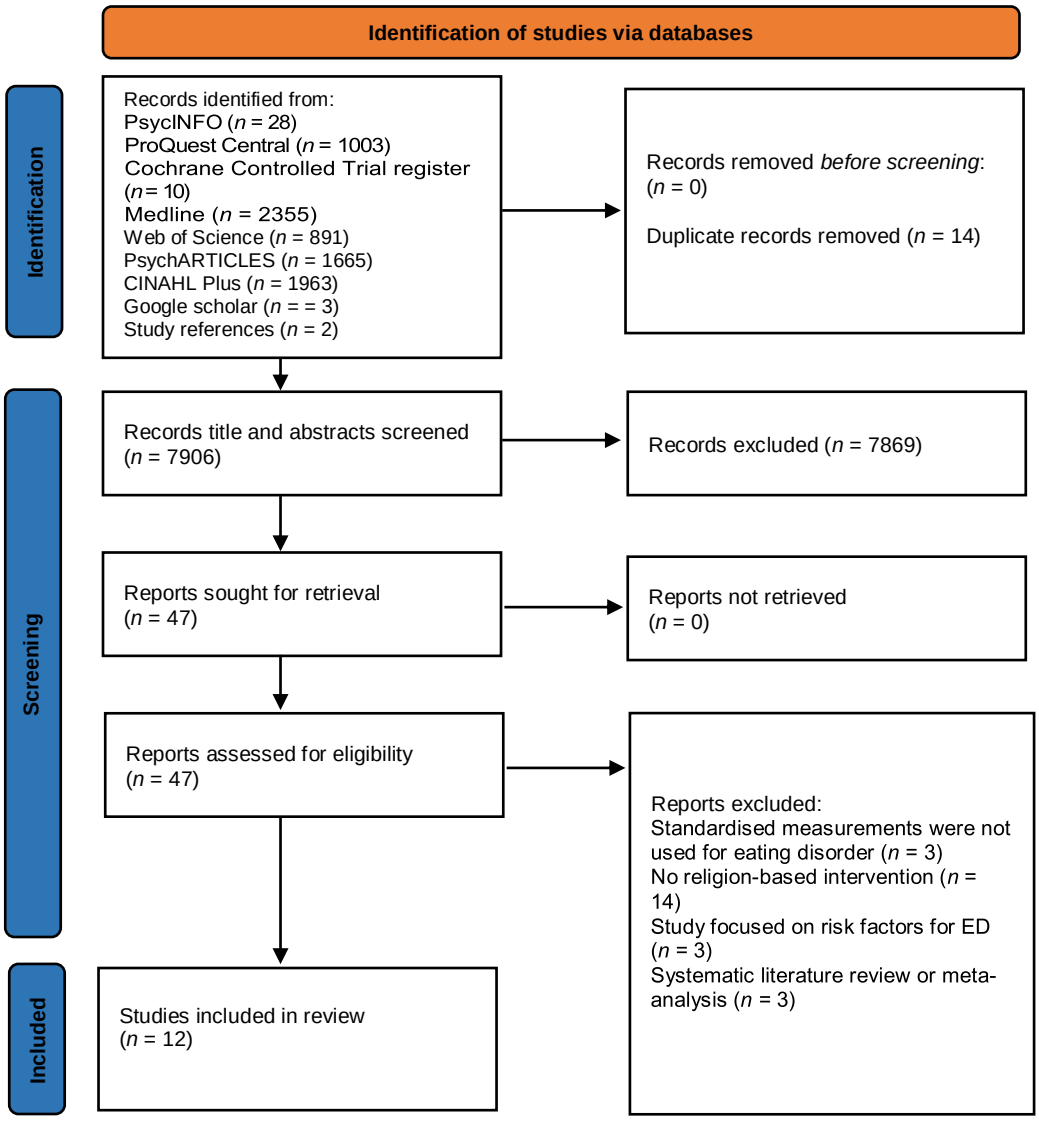

Table 2.

Study Characteristics

Author, Year And Country	Study Design	Sample Size	Religion	Measures
Spangler, 2010. America.	Cross-sectional case report.	Single case report.	Christianity.	None administered.
Richards et al., 1998. America.	Cross-sectional qualitative study.	Not stated.	Christianity.	None administered.
Richard et al., 2018. America.	Cross-sectional qualitative study using thematic analysis.	83 participants.	48% of the participants identified as Latter-Day Saint (LDS or Mormon), 20% as Protestant, 9% as Roman Catholic, 3% as Jewish, and 20% as non-affiliated though spiritually oriented.	The surveys consisted of open-ended questions that inquired about the role that faith and spirituality played in treatment and recovery. This included: • How did your eating disorder hurt your spirituality and/or relationship with Higher Power? • In what ways did your faith and spirituality help you during your treatment? (c) What role has your

				spirituality and faith played in the overall progress you have made in recovering from your eating disorder? • What did your therapist or other members of the treatment staff to assist you in using the resources of your faith and spirituality during treatment?
Hertz, Addad & Ronel, 2012. Israel.	A qualitative phenomenological study.	20 participants.	Jewish. Half of the participants defined themselves as secular, the other half were connected to Orthodox Judaism in varied degrees of religiosity.	Semi-structured interview which consisted of open-ended questions that inquired about childhood experiences, onset of overeating tendencies, experiences of the support programme, and emotional state.
Pivarunas, 2016. America.	A qualitative Interpretative Phenological Analysis study.	5 participants.	Non-denominational Christianity.	All participants included in the study scored above the clinical cut-off on the Eating Disorders Examination Questionnaire (Fairburn 7 Beglin, 1994). Semi-structured interview questions included: Struggles with food, eating and/or body image, participants hope to gain from the group? Group questions included: struggles with food, eating, and/or body image, recalling their intentions when they started participating in the group; whether the group helpful and what was particularly helpful, not so helpful? and is there hope in the midst of this struggle?
Davis et al., 2014.	Cross-sectional quantitative design.	13 participants.	Faith of participant group not specified.	The study administered: • The Yale Food Addiction Scale (YFAS)

New York, America.				• The Eating Disorder Examination-Self-Report Questionnaire (EDE-Q) • The Centre for Epidemiological Studies Depression Scale (CES-D) • The Brief Multidimensional Measure of Religiousness/ Spirituality (BMMRS)
Richards, Berrett, Hardman & Eggett, 2006. America.	A randomized, pre-test- post-test control group design.	122 participants.	The majority of participants were LDS (*n* = 84, 68.9%), 6.5% were Protestant (*n* = 8), 5.7% were Catholic (*n* = 7), 1.6% were Jewish (*n* = 2), 7.4% said they were affiliated with some other religious denomination but did not specify which one (*n* = 9), and 7.4% of the participants were not affiliated with a religious affiliation, but viewed themselves are having their own spiritual beliefs (*n* = 9).	Outcome measures that were administered weekly during treatment included: • Symptom Distress Subscale of the OQ-45 • Eating Disorder Self-Monitoring Scale (EDSMS; Richards, 1996) • Theistic Spiritual Outcome Survey (TSOS; Richards, Smith, Schowalter, Richard, Berrett, & Hardman, 2005)
Brytek-Matera & Schilz, 2013. Poland.	Pre-test- post-test control group design.	107 participants.	Faith of participant group not specified.	The study administered: • Brief Coping Orientation to Problems Experienced Scale (Brief COPE; Carver 1997) • The Stress Coping Questionnaire (SVF-120; Janke et al. 1997)

Tonkin, 2005. America.	Pre-test- post-test control group design.	18 participants.	Christianity.	The study administered: • The Eating Disorder Inventory-2 (EDI-2) • Binge Eating Scale (BES) • Paffenbarger Physical Activity Questionnaire (PPAQ) • Degree of Spirituality, Multidimensional Measurement of Religiousness/Spirituality, Religious/Spiritual Coping (RCOPE)
Smith, Hardman, Richards & Fischer, 2003. America.	Cross-sectional quantitative study.	251 participants.	The majority of participants were Latter-Day Saints (LDS) (*n* = 162, 64.5%), 4.4% were Protestant (*n* = 11), 4.0% were Catholic (*n* = 10), 1.2% were Jewish (*n* = 3), 8.0% said they were affiliated with some other religious denomination but did not specify which one (*n* = 20), and 5.6% of the participants were not affiliated with a religious affiliation, but viewed themselves are having their own spiritual beliefs (N = 14).	The measures that were used to assess the outcomes of treatment included: • The Eating Attitudes Test (EAT; Garner & Garfinkel, 1979) • Body Shape Questionnaire (BSQ; Cooper, Taylor, Cooper, & Fairburn, 1987) • Outcome Questionnaire (OQ-45.2; Lambert, Okiishi, Finch, & Johnson, 1998) • Therapist Outcome Evaluation Scale (TOES; Richards, 1996) • The religious well-being subscale of the Spiritual Well-Being Scale (SWBS; Paloutzian & Ellison, 1991).
Angelova & Utermohlen, 2013.	Cross-sectional mixed methods survey design.	205 participants.	Faith of participant group not specified.	• Faith (i.e., the depth of one's spiritual belief) and dietary restraint behaviours were assessed using single-item categorical measures.

Bulgaria.				• The Socio-Cultural Attitudes Towards Appearance Questionnaire (SATAQ) (Thompson, & Stormer, 1995) • The Contour Drawing Rating Scale (CDRS) by (Thompson & Gray, 1995) • A Bulgarian version (Boyadjieva & Steinhausen, 1996) of the Eating Attitudes Test (EAT-40) by Garner and Garfinkel (1979).
Berrett, Hardman, O'Grady, & Richards, 2007. America.	Cross-Sectional qualitative study.	Not stated.	Faith of participant group not specified.	None administered.

Table 3.

Study Outcomes and Intervention Characteristics

Author and Year	Aims and Objectives	Intervention Characteristics	Sample Characteristics	Outcome	Limitations
Spangler, 2010.	The study offers methods of integrating religious concepts, practices, and resources into CBT treatment for EDs.	Support via religious community, clergy encouragement, prayer, hope, religious texts, and religious value and belief systems in the treatment of those with eating disorders. Cognitive behavioural treatments for clients with held religious schemata regarding such issues as inherent worth, joy, charity, divinity, gratitude, repentance, and forgiveness as alternatives to	27-year-old female with a diagnosis of depression and Eating Disorder Not Otherwise Specified.	Acceptable treatment for religious informed adapted CBT.	• Case study may not be generalisable to the wider population. • Outcome measures were not applied to determine whether treatment was effective.

		maladaptive eating disordered schemata.			
Richards et al., 1998.	This article examines the roles of religion and spirituality in the aetiology and treatment of eating disorders for latter-day saint patients.	Intervention for the treatment of ED used religious coping strategies as follows: (a) teaching spiritual concepts (b) assigning religious-spiritual bibliotherapy (c) encouraging prayer (d) encouraging spiritual imagery and meditation (e) encouraging forgiveness (f) encouraging patients to seek spiritual direction from their religious leaders (g) encouraging clients to be involved in their religious community.	Latter-Day Saints.	Acceptable treatment for ED. Identified religious and spiritual issues that patients with eating disorders struggle with: (a) negative images or perceptions of God (b) feelings of spiritual wellness and shame (c) fear of abandonment by God, (d) lack of acceptance of sexuality (e) reduced capacity to love and serve (f) difficulty of surrendering and having faith	• Long term effectiveness of religiously informed treatment not reported. • No demographic information on patient population and therefore may not be generalisable to the wider public.

				(9) dishonesty and deception.	
Richard et al., 2018. America.	Study 1, study explored the following research questions: (a) How do women believe their eating disorder affected their faith and spirituality? (b) How do women believe that their faith and spirituality helped them during and after treatment? (c) What spiritual interventions do women believe were most helpful during treatment? Study 2, explored the following research questions: (a) What are the experiences of women whose eating disorder treatment incorporated spirituality? (b) How do	A treatment facility for women with eating disorders located in Utah. Treatment approaches are from a multidimensional, multidisciplinary perspective with an ecumenical (nondenominational) spiritual emphasis. All participants successfully completed 60–90 days of inpatient and/or residential treatment.	Thirty-five percent of participants had been diagnosed with anorexia nervosa, 40% with bulimia nervosa, and 25% with eating disorder not otherwise specified. Female. The ages of the participants ranged from 18 to 45 years old.	The analysis from both studies revealed that a significant portion of women believed religion/ spirituality is an indispensable support in eating disorder treatment. Results from Study 1 were: Theme 1: Eating disorder undermined spirituality. Theme 2: Recovery of spirituality facilitated treatment and recovery from eating disorders. Theme 3: Treatment staff supported the spiritual beliefs of	• Study 1 and Study 2 did not include the eating disorder illnesses of binge eating disorder or avoidant/restrictive intake disorder. • A number of different religions were represented, approximately 50% of the participants were members of the Latter-Day Saints church. Thus, sample does not represent the religious demographics of the general population. • Data for Study 1 was collected over 10 years ago and so questions might be raised about whether its findings are dated.

	women believe spirituality affected their eating disorder? (c) In what ways do women believe their faith and spirituality helped them during treatment and recovery? (d) In what ways do women believe religion may have negatively impacted their treatment and recovery?			patients during treatment. Theme 4: Treatment staff supported the spiritual beliefs of patients during treatment. Results from Study 2 were consistent with Study 1 but added additional perspectives of how religion/ spirituality can negatively impact women during the development and treatment of their eating disorder.	
Hertz, Addad & Ronel, 2012.	Study focused on the emotional recovery of overeaters anonymous members was conducted.	12-step self-help program for compulsive overeaters, binge eating disorder. Tools for spiritual emotional work implemented.	Female. Their ages ranged from 26 to 62. All participants had at least one year	It was found that the tools used for spiritual and emotional work at OA are essential to recovery.	• The participants were chosen according to specific qualities and characteristics and so, as is common in qualitative research, it is not possible to

			membership of overeater anonymous. Women were considered to be compulsive overeaters.		generalize to the population at large. • The current findings are based on subjective accounts of members that were taken "as is" by the research team. However, triangulation of different sources might increase their trustworthiness. • The presence of an active participant researcher and the unique type of relationship built between the primary researcher and the interviewees could have influenced the data.
Pivarunas, 2016.	The present study qualitatively explored the experience of faith-based support group participation for five	Finding Balance with Food, a curriculum for groups, was utilized as the faith-based intervention (Rhodes, 2003). This Christian curriculum	20-28 years old. Caucasian. All participants scored above the clinical cut-off	Acceptable treatment for ED.	• A homogeneous sample of young, Caucasian, non-denominational Christian-identifying women was utilized.

	women with an eating disorder.	features two resources: first, an autobiographical account of the author's recovery from an eating disorder and second, a 12-week workbook intended to supplement weekly readings with home practice activities, reflection questions, discussion questions, and relevant Bible passages. The curriculum assumes a Protestant Christian worldview. Change is understood as occurring through a personal relationship with Jesus Christ. To this end, negative religious coping is reframed as thoughts and beliefs antithetical to biblical truth and, consequently, as originating in the devil (referred to in the	on the Eating Disorders Examination Questionnaire (Fairburn and Beglin, 1994), which was used as a screening tool. Three participants had previously been diagnosed by a mental health professional with an eating disorder (1 Anorexia Nervosa, 1 Bulimia Nervosa, 1 Eating Disorder Not Otherwise Specified).	• Sample does not accurately represent the diversity of those who struggle with disordered eating. • No formal assessment of religious coping.

		curriculum as the Stealer, based on the biblical passage John 10:10). The curriculum encourages readers to adopt a biblical view of their identities in Christ and to trust that Jesus can heal.			
Davis et al., 2014. America.	The purpose of the study is to describe characteristics of an urban community sample attracted to a spiritually based, weight loss intervention.	Spiritual Self-Schema Therapy (3S) is a manual-guided, empirically validated treatment.	38.5% were identified as African American (*n* = 5), 15.4% Caucasian (*n* = 2), 15.4% Multiracial (*n* = 2), and 30.8% Hispanic (*n* = 4). Male (*n* = 5 38.5%). Age (*M* = 42.46 *SD* = 9.54)	Mean baseline scores of the EDE-Q, YFAS, and the CES-D revealed clinically meaningful levels of eating disordered pathology and depression, respectively. The overall attrition rate was quite low for interventions targeting obesity.	• Small sample size makes it difficult to draw conclusions about the population.
Richards, Berrett, Hardman & Eggett, 2006.	The purpose of the present study was to evaluate the effectiveness of a	Patients who participated in the Emotional Support group received regular inpatient treatment	The ages of the participants ranged from 13 to 52 years (*M* =21.2; *SD* =6.6). 80% of	The findings indicate that the Spirituality group did enhance the overall	• The sample sizes in the three treatment groups were relatively small

	spiritual group intervention for eating disorder inpatients. The study compared the effectiveness of a Spirituality group with Cognitive and Emotional Support groups using a randomized, control group design.	program, with the addition of one hour per week of group discussion and emotional support about issues and topics that were already part of the regular inpatient program. This group was not a no-treatment control group and was expected to have some treatment effects. In addition to one hour per week of group support and discussion, participants in the Spirituality and Cognitive groups also received spirituality or cognitive therapy readings and self-help exercises.	participants were in the 16 to 26 age range. Most of the participants were Caucasian (*n* =119; 97.5%). Female. 42 patients were diagnosed by an admitting psychologist or psychiatrist according to DSM-IV criteria with anorexia nervosa, 47 with bulimia nervosa, and 33 with eating disorder NOS.	effectiveness of the eating disorder inpatient program—somewhat more so than did the Cognitive and Emotional Support groups. The Spirituality group enhanced treatment outcomes overall somewhat more strongly than did the Cognitive group. The Spirituality group experienced somewhat larger reductions on the EAT compared to patients in the Cognitive group providing evidence that a spiritually oriented treatment approach is helpful	• The magnitudes of the treatment effects favouring the Spirituality group were small even though many of them were statistically significant. • Unable to generalize findings beyond this treatment setting, especially considering that there was a higher proportion of Latter-day Saints than in the general population among both the treatment staff and the patients. • Efforts to control for therapist effects and treatment fidelity were limited, study relied only on therapists' self-reports that treatment

		for reducing eating disorder specific symptoms, such as binging, purging, restricting, and attitudes about food and dieting. Patients in the Spirituality group experienced somewhat larger decreases in depressive and anxiety symptoms as measured by the OQ-45 symptom distress subscale. Patients in the Spirituality group tended to feel somewhat more positively about their relationship with God (religious well-being)	conditions were being implemented properly. • The reliability of the admitting psychologist and psychiatrist diagnoses for the patients in this study can be questioned given that we did not establish interrater reliability for the diagnoses.

				compared to patients in the other groups was of interest.	
Brytek-Matera & Schilz, 2013.	The aim of this research was to assess the relationship between coping mechanisms and eating disorders as well as to determine coping strategies as predictors of eating disorders pathology.	Coping strategies including substance misuse, religion, seeking emotional social support, positive self-instructions, and positive reframing.	52 females meeting the DSM-IV criteria for anorexia nervosa and bulimia nervosa and 55 female university students. The average age in the research group was 19.63 years (*SD* =2.56) and 20.19 years (*SD* =1.03) in the control group.	The regression analysis revealed that eating disorders were positively associated with coping strategies focused on substance use and religion, and negatively associated with using emotional support, positive self-instructions, and positive reframing.	• The limitations of our study are linked to its transversal approach. • The interaction of coping strategies and eating disorders over time could only be explored with the help of a longitudinal research design.
Tonkin, 2005.	Study compared a cognitive-behavioural therapy (CBT) intervention for the treatment of bulimia (BN) or binge eating disorder (BED) and obesity to a CBT intervention that	The spiritual aspect of this intervention used materials adopted from Mintle (2002), Homme (1999), and Gospel Lights (2001). All of the material approached eating disorders and weight loss from a Christian, non-	Female**.** Age (*M* = 45.72, *SD* = 12.37). Spirituality (*M* = 27.28, *SD* = 5.33).	Participants reported significantly greater eating/weight efficacy, less eating disordered behaviours, fewer binge eating behaviours, less body dissatisfaction, and increased physical	• The small sample consisted of only European American women. Therefore, it is unlikely that this sample is representative of other racial or ethnic groups.

	contained a spiritual component.	denominational perspective. The spiritual aspect of the program addressed many issues related to eating disorders and weight loss, including body image, social pressures, self-esteem, depression, the body as a temple, and family influences. The spiritual component consisted of 11 lessons that began during the third week of the program and were interspersed throughout the 16-week program.	Caucasian (*M* = 94.4, *SD* = 17), Hispanic (*M* = 5.6, *SD* = 1).	activity. Participants in the CBT plus spiritual intervention did not show significantly greater improvements than participants in the traditional CBT intervention on any outcome measures. In a qualitative assessment, participants reported that the spiritual component of the program was important to their success. Participants in the spiritual intervention endorsed that spiritual coping strategies were important to them.

				One hundred percent of participants reported learning what scripture says regarding food and using that to change thought patterns, 88% of participants reported prayer, 77% reported thinking about food as an idol, 55% reported bible study, and 11% reported that writing a letter to God regarding the eating disorder was helpful.	
Smith, Hardman, Richards & Fischer, 2003	This study investigated the relationship of religious orientation, religious affiliation, and spiritual well-being with treatment outcomes in an eating disorder inpatient treatment program.	Practice of religion.	88% patients were diagnosed with Anorexia Nervosa, 68 with Bulimia Nervosa, and 75 with Eating Disorder Not Otherwise Specified. The ages of the participants ranged from	Statistical analysis revealed that intrinsic religiousness was not significantly associated with reductions in eating disorder symptoms, concerns regarding body image, or	• The cross-sectional nature precluding generalization and strong causal inferences. • Majority Caucasian sample and therefore not generalisable to

			12 to 56 years (*M* = 21.85, *SD* = 7.47). Most participants were in the 15- to 24-year-old age category (*N* = 160). 90% of the participants were Caucasian (*n* = 226) and the remainder were from some other racial heritage (African American, Asian, Hispanic).	improvements in psychological health.	samples of different ethnic category
Angelova & Utermohlen, 2013	The purpose of this study was to examine the influence of local culture on body image and eating distress in a sample of urban Bulgarian women. Specifically, the study focused on two affiliated factors unique to the Bulgarian	Traditional fasting as the intervention related to faith.	Women ranging in age from 18 to 81 years with a median age of 26 and a mean age of 32.1 (*SD* = 16.3).	For women with higher EAT-40 scores, faith seemed to have harmful effects, perhaps by virtue of motivating or reinforcing asceticism and dietary restraint. For these women fasting was likely but one strategy for weight management	• The cross-sectional nature precluding generalization and strong causal inferences. • Consent to participation in surveys and interviews may have been based on the extent to which the study topics were of interest or

	context: faith and traditional fasting.			and the achievement of a desired thin figure consistent with the socio-cultural models. In contrast, among women with lower EAT-40 scores, faith seemed to have a protective effect against excessive dieting. These women were more likely to use fasting in the way intended by religious scripture, for faith-related reasons that have nothing to do with body image.	relevance to potential research participants. • Reliance on self-report and highly face-valid measures may have introduced self-presentational bias in the data.
Berrett, Hardman, O'Grady & Richards, 2007.	The study offers suggestions based on clinical experience for helping eating disorder patients who have suffered trauma to rediscover their faith and spirituality.	Clinicians supporting the patient's need for a relationship with God or a Higher Power by modelling an acceptance of a divine influence as part of treatment and recovery.	Female.	The study found that spiritual discussions and interventions can greatly help women with eating disorders that have experienced trauma reconnect with	• No standardised measures used. • Long term effect not reported.

	The study describes how spirituality can be used as a resource to assist women throughout treatment and in recovery.	Patients encouraged to turn to God for help and guidance to develop the wisdom to know what they do and do not have control over. Supporting patients develop a healthy, positive God image through writing letters to God, being sensitive to spiritual impressions, reading spiritual literature, engaging in meditation, and/or spiritual imagery, “telling God the truth,” and looking for evidence to support their faith in God’s love or a divine influence. Provide support and guidance for patients to get in touch with their spiritual identities by learning to listen to their hearts.	themselves, with others, and with their God in healing and life-changing ways.

Table 4.

Summary of quality assessment of six quantitative studies using the CASP quality assessment tool

	Studies											
	Richards, Berrett, Hardman & Eggett, 2006.		Brytek-Matera & Schilz, 2013.		Smith, Hardman, Richards & Fischer, 2003.		Angelova & Utermohlen, 2013.		Davis et al., 2014		Tonkin, 2005.	
Criteria	**R1**	**R2**	**R1**	**R2**	**R1**	**R2**	**R1**	**R2**	**R1**	**R2**	**R1**	**R2**
1	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2	No	No	No	No	No	No	No	No	Can't tell	No	No	No
3	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4	No	No	No	No	No	No	No	No	No	No	No	No
5	Can't tell	Can't tell	No	Can't tell	Can't tell	Can't tell	Yes	Yes	Can't tell	Can't tell	Yes	Yes
6	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8	No	No	Yes	Yes	No	No	No	No	No	No	Yes	Yes
9	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
10	No	No	No	No	No	No	No	No	No	No	Yes	Yes
11	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note. R1 = Rater 1; R2 = Rater 2

Table 5.

Summary of quality assessment of six qualitative studies using the CASP quality assessment tool (see Appendix G for criteria)

	Studies											
	Pivarunas, 2016		Hertz, Addad & Ronel, 2012.		Richard et al., 2018.		Spangler, 2010		Richards et al., 1998.		Berrett, Hardman, O'Grady, & Richards, 2007	
Criteria	**R1**	**R2**	**R1**	**R2**	**R1**	**R2**	**R1**	**R2**	**R1**	**R2**	**R1**	**R2**
1	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Some what	Yes	Can't tell	Can't tell
3	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell	No	No	No	No
4	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell
5	Yes	Yes	Yes	Yes	Yes	Yes	No	Can't tell	Can't tell	Can't tell	Can't tell	Can't tell
6	No	No	Yes	Yes	No	No	No	No	No	No	No	No
7	Yes	Yes	Yes	Yes	Yes	Yes	Can't tell	Can't tell	Some what	Can't tell	Some what	Can't tell
8	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No
9	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
10	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note. R1 = Rater 1; R2 = Rater 2

2.3.2 Study Characteristics

All twelve studies were conducted in high-income Western countries, majority of the studies originating from America (See Table 1). Six of the included studies were quantitative, five qualitative studies, and one case study (See Table 1.)

2.3.3 Sample and Intervention Characteristics

Majority of the study samples included female participants, there was one study that had a more balanced sample of participants with males and females.

The present review broadened the definition of religion to also include spirituality to accommodate studies that used either term. Six of the studies focused on Christianity or had a sample of majority Christian faith (Pivarunas, 2016; Smith, Hardman, Richards & Fischer, 2003; Richards, Berrett, Hardman & Eggett, 2006; Tonkin, 2005; Richards et al., 2018), some used spirituality as the term of reference to enable a broader application of their strategies with the rationale to not isolate anyone into one narrow path but meet the person at whatever stage they were on their journey of faith (Berrett, Hardman, O'Grady & Richards., 2007; Richards et al., 1998). One study involved all Jewish participants (Hertz, Addad & Ronel, 2012).

Typically, most of the studies offered group, family, and individual therapies for the treatment of an ED, however majority of the studies introduced the topic of religion and spirituality in a group setting (Pivarunas, 2016; Richards et al., 2018). One study did report that religiously informed therapeutic approaches that can be applicable in both group and individual settings (Berrett, Hardman, O'Grady & Richards., 2007; Richards et al., 1998).

2.3.4 Quality Appraisal

The quality of the studies included in the review was evaluated using the Critical Appraisal Skills Programme (CASP) tool for quality appraisal in qualitative and quantitative evidence synthesis (Long et al., 2020).

All studies included well-defined study objectives and aims related to the topic of religiously/spiritually informed treatment for eating disorders (ED) or disordered eating. A major strength across the studies was the use of appropriate measures and conclusions supported by results. All studies, apart from Spangler (2010), appropriately described their recruitment strategies in line with the aims of the research. Another strength of the present review was the range of methodologies employed, such as randomized pre/post-test control group studies, cross-sectional studies, case reports, qualitative thematic analyses, and peer-reviewed articles.

In terms of gender and ethnicity, studies that provided demographic information primarily included a majority of Caucasian female participants, aside from one study (Davis et al., 2014), which included 38.5% male participants and a predominantly African American sample population. One study did not report any demographic details of the sample beyond gender (Berrett, Hardman, O'Grady, & Richards, 2007). Moreover, one study used a randomized pre/post-test control group design to help control for confounding variables such as treatment length, age, and ED severity (Richards et al., 2006). Neither Spangler (2010) nor Richards et al. (1998) provided details on the validity and effectiveness of the proposed religiously informed interventions.

The final data set included a range of ED and disordered eating presentations. Most studies relied on either administering self-report measures or pre-existing diagnoses. Regarding religion, four of the included studies did not report participants' religious affiliations (Davis et al., 2014; Brytek-Matera & Schilz, 2013; Angelova & Utermohlen, 2013; Berrett, Hardman, O'Grady, & Richards, 2007). However, Berrett and colleagues (2007) justified this omission by aiming to include individuals not affiliated with a specific religious institution. Most

studies comprised participants affiliated with a Christian denomination, except for Hertz, Addad, & Ronel (2012), which included a sample of Jewish women.

With regards to ethical considerations, a significant weakness was that no studies discussed how the impact of the research was managed before or after the study given the sensitivity of the topics participants were asked to reflect on. None of the studies included in this review reported their epistemological or ontological assumptions, nor did they critically examine the role of the researcher-participant relationship. Interestingly, however, Spangler (2010) provided a detailed theoretical model to account for the observed influence of religion on ED.

All studies presented clear and explicit statements of their findings and linked these findings to the wider available literature. Both raters deemed all studies valuable for their contribution to the topic or their implications for religiously informed treatment for ED. Overall, most studies were considered of sufficient quality for inclusion in the thematic analysis. There was one disagreement between the raters regarding the inclusion of Berrett et al. (2007) due to insufficient information on the sample population and a lack of data to determine the efficacy of the proposed religiously informed strategies for EDs. Following discussions with the wider research team, a final decision was made to include the study, given its significant contribution to the topic, particularly regarding the role of spirituality in the treatment of EDs. Notably, weaknesses identified in the studies were often due to insufficient information provided by the authors rather than clear quality issues. These limitations should be considered when interpreting the review findings.

Given the lack of UK-based studies and the absence of a Muslim sample population, it is important to approach the findings of this review with caution. The final data set may not be applicable to a UK context or a Muslim population group, which is the focus of the subsequent empirical study.

2.4 Themes

The outcome of relevant data extracted, synthesised, and thematically analysed from the twelve studies that met the review inclusion criteria led to the emergence of the following themes. The main themes that occurred were the definition of religion, impact of an ED on faith, religion as effective in the treatment of an ED symptomology, and religiously informed coping strategies for an ED.

Table 6.

Overview of themes generated from thematic analysis

Theme	Subtheme
Definition of Religion	• Broad definition of spirituality and religion • Self-reported measures to define religiosity
Impact of an ED on Faith	• ED undermining faith • Insecure relationship with God
Religion as effective in the treatment of Eating Disorder Symptomology	• Religion effective for recovery from an ED • Religion as ineffective in the treatment of an ED
Religiously Informed Coping Strategies for an ED	• Recommended religious coping strategies • Integrating CBT with religiously informed ideas

2.4.1 Theme 1: Definition of Religion

It is important to acknowledge the broad definitions in the current research between religion and spirituality-based treatment for an ED and as mentioned before the distinctions

between both concepts are still contested. Consistent with our earlier hypothesis, the data set found a variation of how religion was conceptualised and investigated.

2.4.1.1 Subtheme: Broad definition of spirituality and religion

Four studies did not state the specific religion of their sample nor provide a conceptual framework (Davis et al., 2014; Brytek-Matera & Schilz, 2013; Angelova & Utermohlen, 2013; Berrett, Hardman, O'Grady, & Richards, 2007). Some studies did administer self-reported outcome measures to determine the level of religiosity within the sample, however these varied across each study (See Table 2). One study defined faith in measuring the depth of one's spiritual belief, categorising atheists, and agnostics as non-believes, passive believers as holding a belief in God or a higher power but not observant or considering themselves as religious, and active believers as both believing in God and observant of their religious practice (Angelova & Utermohlen, 2013). Due to the lack of clarity and heterogeneity within the data set, it can make it difficult to compare findings across studies in the nature and depth of religiosity within the included sample population.

2.4.1.2 Subtheme: Self-reported measures to define religiosity

There was a wide range of how religion and spirituality was defined and understood. Some studies recognised the complexities and methodological challenges in defining religiosity and therefore provided a broad definition as an effort to not exclude individuals. For instance, Berrett and colleagues opted for a broad definition of spirituality to offer patients the opportunity to figure out what spirituality means to them (Berrett, Hardman, O'Grady & Richards., 2007). Others used validated measures to assess spirituality and religiosity. The distinction and similarities between religion and spirituality have yet to reach a consensus in the literature. Many consider religion as more objective, specific to a divine power and in

relation to an organised religious affiliation, whereas spirituality more ambiguous and related to a collection of attitudes and practices along with the journey of discovery and connection to a Higher Power (Hernandez, 2011). However, it is also argued that the term of spirituality can fall under the umbrella of religion (Hernandez, 2011).

Nonetheless, many studies promoted the importance for assessment of religiously orientated patients with an ED to support clinicians in ascertaining the nature of relation the individual has with religion and how this may intersect with the ED (Spangler, 2010).

2.4.2 Theme 2: Impact of an ED on Faith

Many of the studies included in the present review found that ED commonly undermined their religiosity or spirituality (Richards et al., 2018). It is important to therefore recognise for many sufferers they may require time, reassurance, and non-judgemental opportunities to explore the impact ED has had on their faith.

2.4.2.1 Subtheme: ED undermining Faith

One qualitative study investigating a faith-based support group for women with disordered eating found that participants often characterised their ED as a form of imprisonment, however felt that this conflicted with religious ideas of gaining freedom through Christ (Pivarunas, 2016). The conflicting ideas left participants feeling as though the ED had become a distraction from a higher Godly purpose in their lives (Pivarunas, 2016). Similarly, Richard and colleagues noted important religious and spiritual issues that patients with EDs find difficulty with. For instance, negative images or perceptions of God, feelings of spiritual unworthiness and shame, fear of abandonment by God, guilt, or lack of acceptance of sexuality, reduced capacity of love, difficulty in surrendering or having faith (Richards et al., 1998). Consistently, another study revealed that participants reported similar themes around

negative feelings towards a Higher Power, feelings of shame, guilt and worthlessness connected to religious views intertwined with their ED (Richard et al., 2018).

One study found conflicting evidence within their findings where majority of the participants did believe spiritual intervention facilitated recovery from the ED, however a few participants expressed that spirituality was irrelevant to them in group sessions (Richards et al., 2018). These participants noting the importance of determining its relevance on a case-by-case basis for individuals in treatment for an ED and the consequence being that for those who were not spiritual or religious feeling left out in group (Richards et al., 2018).

2.4.2.2 Subtheme: Insecure Relationship with God

Moreover, another common theme during analysis showed the nature of how EDs impacted on the development of insecure attachments in relation to faith. The study refers to the term attachment in relation to the broader definition of relationships. The perspective of spiritual patients with an ED revealed an inner struggle, one participant stating,

"*My eating disorder has made me ashamed to confront my higher power for what I have done. It has made me feel not worthy and too depressed and hopeless to ask my higher power for help.*" (Berrett, Hardman, O'Grady & Richards., 2007).

For other participants there were feelings of blame towards their faith,

"*Because of what happened, I felt God was never there with me to protect me. I don't believe in Him anymore or in my spirituality*" (Berrett, Hardman, O'Grady & Richards., 2007).

One study participant characterised the experience of the ED as becoming a replacement to God,

"*My eating disorder became my God and was the focus of my spirituality. At the point when I entered the Center I had started to pray to my eating disorder. Promising to eat less, walk more, take more laxatives, and throw up more, praying that my eating disorder would*

give me strength to lose the weight that I need to so that I would be worth something" (Richards et al., 2019).

Another study illustrated the ED as a barrier to rebuilding a stronger relationship with God, viewing the relationship as a pathway to recovery,

"*I hope to be able to develop a stronger relationship with God. Through that relationship I hope to be able to find peace and healing from my eating disorder*" (Pivarunas, 2016).

Similarly, Richards and colleagues (2018) also found that for participants, religion offered a sense of hope, meaning and perspective. It is important here for clinicians to distinguish between whether the ED has harmed the relationship with faith, displaced faith in the individual's life, or is perceived as a source of hope in recovery and change.

2.4.3 Theme 3: Religion as effective in the treatment of Eating Disorder Symptomology

Most studies included in the present review agree that the approach to treating EDs should be multidimensional and integrative (Berrett, Hardman, O'Grady & Richards., 2007; Richards et al., 1998; Smith, Hardman, Richards & Fischer, 2003; Richards et al., 2018). However, the findings of the review found conflicting outcomes on the effectiveness of religion-based interventions for EDs. The included studies are not representative of all religious groups, some studies did not report on the affiliations of faith of participants, and therefore difficult to determine the generalisability of the findings for specific religious groups.

2.4.3.1 Subtheme: Religion Effective for Recovery from an ED

One study revealed that ED sufferers felt that their experience of a faith-based group deepened their relationship with God (Pivarunas, 2016). The participants reported the social support from the group setting and cultivated trust in Christ provided the possibility for healing from the ED (Pivarunas, 2016). Similar positive outcomes were reported by Smith and

colleagues (2003) who found that spiritual well-being was significantly correlated with improvement in eating attitudes as well as improvement in body image.

One qualitative study investigated the effectiveness of staff supporting the spiritual beliefs of patients during treatment (Richards et al., 2018). Participants reported that staff encouragement to engage with their spiritual beliefs and practices was useful, along with the positive value of staff providing a safe space to explore their spirituality and openly discuss this (Richards et al., 2018). Participants identified how the incorporation of spirituality in their treatment for an ED improved their relationship with others including a Higher Power, helped experience feelings of forgiveness, healing and offered a sense of hope with recovery from the ED (Richards et al., 2018).

One study promoted a spiritually informed intervention for the treatment of overeating as a culturally informed approach for a predominantly African American and Hispanic sample population group (Davis et al., 2014). The use of spirituality-related goals was associated with improved levels of engagement and motivation towards recovery (Davis et al., 2014). The study suggests that spiritually informed intervention can be a culturally effective method for meaningful change in the reduction of eating disordered symptoms in an African American and Hispanic sample (Davis et al., 2014).

2.4.3.2 Subtheme: Religion as ineffective in the treatment for ED

However, in contrast to the above findings, one study conducted a regression analysis which showed that EDs were positively associated with coping strategies that focused on religion (p = 0.001) (Brytek-Matera & Schiltz, 2013). The study stated that participants using coping strategies concerning religious activity such as prayer and meditation may be regarded as a form of suppression instead of confronting the ED problem (Brytek-Matera & Schiltz, 2013).

In another study, the spiritual intervention did not statistically result in better treatment outcomes compared to the non-spiritual intervention for obesity, bulimia and binge-eating disorder (Tonkin, 2005). However, the non-statistical difference in outcomes between intervention groups may be related to low statistical power. The study did show qualitative feedback from participants in the spiritual intervention reporting greater benefits such as 100% of participants finding learning what scriptures say regarding food and using that to change thought patterns was useful, along with 88% of participants reporting prayer, 77% about food as an idol, 55% reporting bible study, and 11% writing a letter to God regarding the ED as helpful (Tonkin, 2005).

Finally, Angelova & Utermohlen (2013) explored the role of faith-based fasting on eating distress. Faith-based fasting has been a long-associated tradition with religious doctrine and in the present study considered one type of religious intervention, though the literature on faith-based fasting as a risk factor for ED sufferers is conflicting. The study revealed the act of faith-based fasting as having a dual significance for individuals with elevated eating distress, the results suggesting that the stronger the faith along with higher levels of eating distress, the more dietary restraint participants reported (Angelova & Utermohlen, 2013). This suggests that faith-based fasting may exacerbate eating problems. The role of fasting appeared harmful in the motivation towards rigid, perfectionistic attitudes towards achieving thin ideals (Angelova & Utermohlen, 2013). The study contrastingly found women with lower eating distress seemed to draw on religion as a protective factor against excessive restrictive dieting and engaged in faith-based fasting in the way religious scripture intends it, for instance driven by faith related benefits rather than body image or thin ideals (Angelova & Utermohlen, 2013). This implies that there is a risk associated with the act of faith-based fasting for individuals with eating distress or an ED.

It is important to critically consider what aspects of religious practice has a positive impact on the relief of ED symptoms during treatment and what religious coping strategies may further exacerbate the ED. Whilst the outcome of review found conflicting evidence for

the impact of religion on EDs, majority of the studies did conclude religion as an effective treatment approach for EDs and a further suggestion that it may be an aspect to consider when developing culturally informed approaches.

2.4.4 Theme 4: Religiously Informed Coping Strategies for an ED

The data set provided detailed guidance on recommendations for clinicians on how to implement strategies into treatment for an ED. The following studies show a commonality in the use of a group setting to deliver religiously informed intervention for the treatment of ED (Hertz, Addad & Ronel, 2012).

2.4.4.1 Subtheme: Recommended Religious Coping Strategies

One study used a trauma informed perspective, using techniques that focus on cultivating self-compassion and divine love through the inner child imagery (Berrett, Hardman, O'Grady & Richards., 2007). The authors explored what God may consider about trauma and related this to the innocence of children, offering a possibility in a change in the perspective of what God may think of oneself (Berrett, Hardman, O'Grady & Richards., 2007). The study further hypothesised that patients tend to project their own negative images of the perpetrator of their abuser onto God and described inviting patients to disentangle this perception, and view God different to their abuser, but to also consider God in a more merciful manner (Berrett, Hardman, O'Grady & Richards., 2007). Another approach was the giving and receiving of love for ED patients, and a fundamental step was creating a supporting, loving relationship with God and with others. Patients were encouraged to tell God the truth ensuring not to leave anything out. Moreover, individuals encouraged to draw on the social support that faith brings, in that patients can offer to pray for others as an act of kindness and have others' well-being in mind (Berrett, Hardman, O'Grady & Richards., 2007). Other forms of encouragement can

be for patients to hand over things they feel powerless about to God and ask God for wisdom on what they do and do not have control over (Berrett, Hardman, O'Grady & Richards., 2007). Similarly, Richard and colleagues (1998) named some examples of spiritual interventions that can be applied during treatment. These ideas included encouraging prayer, spiritual imagery and meditation, promoting forgiveness, encouraging patients to seek spiritual direction from their religious leaders and supporting clients to be involved in their religious communities. Additionally, connectedness between individuals who share the same religious faith provided safety and a mutual understanding and the sharing of biblical passages provided hope in pathways to successful recovery from an ED (Pivarunas, 2016).

One study implemented a self-help workbook that used topics such as spiritual identity, grace, forgiveness, repentance, faith, prayer, and meditation (Richards, Berrett, Hardman & Eggett, 2006). This was offered alongside a 60-minute group where the facilitator highlighted important concepts from the workbook and encouraged patients to share their own learnings about their personal spirituality from the workbook (Richards, Berrett, Hardman & Eggett, 2006). Another study described an intervention from a Christian, non-denominational perspective which focused on body image, social pressures, self-esteem, depression, the body as a temple and family influences (Tonkin, 2005). The study did not however provide further details on the nature or content of the spiritual teachings that was used (Tonkin, 2005).

Another study explored the importance of shifting the perspectives of God as a vengeful, punishing God to believing in a loving compassionate one through constructing and modelling secure attachments within a group setting (Hertz, Addad & Ronel, 2012). The participants made comparisons between God and a parent figure, comparing Him to the parent figure who provides love, and this imagery used to support emotional recovering as well as spiritual recovery through the channelling of divine love (Hertz, Addad & Ronel, 2012).

2.4.4.2 Subtheme: Integrating CBT with Religiously Informed Ideas

A twelve-session spirituality-based intervention aimed at disordered overeating behaviours looked at three main areas, mastery of the mind, morality, and wisdom to facilitate the development of the spiritual self-schema (Davis et al., 2014). The intervention integrated cognitive-behavioural techniques and Buddhist psychology along with the individual's personal spirituality to increase motivation in treatment engagement (Davis et al., 2014). Similarly, another study suggested the integration of religion and cognitive behavioural therapy (Spangler, 2010). The author recommended value-based goal setting within treatment, proposing that patients with an ED may show a motivation towards engaging in religious behaviours such as attending church or reading scripture if in-line with their values (Spangler, 2010). Values can be an important pathway into unpacking the conflict between the thin-ideal the ED maintains, and the ED related cognitions that contradict with religious values such as living a God-centred life, humility and the trivial nature of a life centred around a pursuit of thinness (Spangler, 2010). The author states that this is not to create self-loathing, but to generate a dissonance between the current value system the patient is living by, which is likely driven by the ED, and what values the patient aspires to live by, motivating the patient towards recovery through their own moral code. In addition, clinicians may typically observe a conflicting attitude towards the body, and by opening the conversation of religion, the clinician may find dysfunctional cognitions supported by distorted religious beliefs, which could be an opportunity to update this belief with more accurate religiously orientated beliefs such as the value of the body as a gift from God (Spangler, 2010). Supporting the individual with visualising the body as a gift, with a compassion focused approach, in that the body was created from love, which may be a valuable coping strategy for ED sufferers.

2.5 Discussion

The present review explored current religious and spiritual-based interventions for the treatment of EDs. The key themes identified were the definition of religion, impact of an ED

on faith, religion as effective in the treatment of an ED symptomology, and religiously informed coping strategies. Sub-themes included the broad definition of spirituality and religion, self-reported measures to define religiosity, ED undermining faith, negative attachment style with God, religious coping strategies as effective for recovery from an ED, fasting for religious purposes as ineffective for ED treatment, religious coping strategies and integrating cognitive-behavioural therapy with religiously informed ideas. Finally, the significance of developing a positive, secure relationship between the religious individual and God, recognising how ED can impact insecure attachments with people and God.

The findings showed conflicting evidence, however majority of the studies concluded that religious based interventions can be effective in the treatment for an ED. Due to the small sample sizes and lack of longitudinal outcomes further research in this field is needed. Whilst religious teachings may be comforting and bring a sense of peace for many, it is also important to acknowledge religion can represent a significant inner struggle and stir up psychological distress for some, this depending on their lived experience, but also religion intersecting with the cultural, social and the political climate of the environment. Therefore, it must not be assumed that the integration of religious teachings into treatment can bring beneficial in treatment outcome for all but may be essential in recovery for some.

Previous studies have suggested religion to be a risk factor for the development of EDs (Abraham & Birmingham, 2008). Earlier studies have shown for instance that fasting for religious purposes may contribute towards the development of anorexia nervosa in some women and that the development of bulimia nervosa may be associated with the decline in religious devoutness (Berrett, Hardman & Richards, 2010). It is therefore important to understand the complexities of religious practice for effective integration into standardised evidence-base treatment for an ED. This is essential when working with patients who may hold misunderstandings or inaccurate cognitions in relation to their faith where the clinician is well equipped to sensitively identify how these misunderstandings may be reinforcing ED pathology (Masters, 2010).

The inconsistencies within the literature as to whether religion acts as a protective factor for those suffering with an ED, or contrastingly religion becoming a negative form of coping, may be related to the attachment styles the individual has with their God or a Higher Power. Studies have shown that a secure relationship with God has been associated with improved mental health (Cherniak, Milkulincer, Shaver & Granqvist, 2021), whereas in one study that investigated older adults in a nursing home found that depressive feelings predicted insecure attachment styles to God (Thauvoye, Granqvist, Golovchanova & Dezutter, 2018). Historically, in academic research, religion has been generally overly simplified to a conclusion of religiosity associated with positive mental health experiences, however this was not consistent with some of the findings in the present review. Further work needs to be done to better understand the way in which an individual orients themselves in relation to their religion and the consequences of this on their mental health.

Bowlby (1982) theorises that there is an innate system that motivates the seeking for protection and safety in times of needs. Attachment theory conceptualised differences in attachment styles between individuals depending on internal working models informed by their experiences of self and others. These interactions are mostly informed by caregivers, where responsive caregivers lead to a safety, security and stability reinforcing a positive internal working model. However, when attachment figures are not responsive or sensitive to the person's need this may subsequently develop an insecurity and negative internal working model (Ainsworth, Blehar, Waters & Wall, 1978). In relation to religion as an attachment model, this certainly offers a framework to understand how people may draw on God as a source of comfort and support (Cherniak, Milkulincer, Shaver & Granqvist, 2021). Positive internal working models may have representations of God as benevolent and merciful, whereas negative internal working models may foster negative representations of God as a punisher. Studies have shown young adults with secure attachments to parents and peers, were also more likely to have a secure attachment to their own religious beliefs (Cherniak, Milkulincer, Shaver & Granqvist, 2021). However, there are still unanswered aspects to this theory, much

of the study relies of self-report measures of God and mental health, and understanding how such an attachment to God followed by a loss still requires further work.

2.5.1 Clinical Implications

The present review identified the complexities of the role of religion and spirituality in the treatment of an ED. The review certainly emphasises the value of exploring religion for participants within the therapeutic context, providing suggestions for adaptations to current treatment approaches such as CBT. The review offers insight into the impact religion can have for an individual with an ED, such as EDs undermining of faith and exacerbating insecure relationship with God. Overall, the literature suggests the need to better understand religiously informed interventions for the treatment of an ED.

2.5.2 Limitations

The current review has shown the effectiveness religion can have on recovery from an ED. There is an apparent lack of academic research addressing the relationship between ED and religion in treatment. It is recommended that training of future and current practitioners, longitudinal research on the role of religion in therapy, outcome studies of religious and spiritual interventions in addition to adequate funding for the achievement of these goals must be considered (Masters, 2010).

The present study did not conduct a meta-analysis on the data due to the heterogeneity of the studies included in the final data set. In addition, it is also important to acknowledge the challenges in how religion is measured and defined within the remit of scientific research and therefore future research must consider developing a framework that can be applied to better understand the relationship between religiously informed treatment for EDs.

Approaches to the integration of religious and spiritual forms of treatment must be sensitive and culturally relevant to the population of interest. The studies included in the review offer no report on adverse events and results were conflicting. Finally, majority of the studies were conducted in high-income countries and therefore may not be applicable or generalisable to populations originating from or residing in low- and middle-income countries. The lack of a wide range in populations and small sample sizes also limits comparability and prevents better understanding the effectiveness of religiously informed treatment for an ED in migrant or asylum seeker populations.

2.5.3 Conclusion

It is unclear whether statutory healthcare services routinely consider the integration of religion into practice, and as mentioned earlier this may be related to the lack of empirical evidence on the effectiveness of religion-based intervention for EDs. Due to the sparsity in the available literature in this field, it was difficult to draw robust conclusions and guidance on what clinicians could consider. Nonetheless, religion has an impact on EDs, and it is essential treatment addresses the complexities that arise for this population.

2.6 Rationale for the Current Study

Following the findings of the systematic literature review there is an apparent gap in the literature on Islam in the treatment for an ED.

Muslim minorities have been shown to experience growing inequalities in healthcare. Despite longstanding documentation of the growing effects of Islamophobia and as a result a differential racialisation of this population, minority religious identity is rarely identified and discussed in relation to health disparities. The current NICE guidelines do not consider the cultural or religious adaptations to the treatment standards for an ED. In response to the gap

in treatment, the present study will aim to better understand the experiences of Muslim's with an ED who are receiving or received treatment to better understand this phenomenon and further inform suggestions towards future development of targeted, adapted care for this population.

Chapter 3

Methodology

3.1 Aims

3.1.1 The Primary Objectives of this Study

The study aims to investigate the experiences of Muslims receiving treatment for an eating disorder. The study hopes to draw on personal accounts to improve our understanding of the Islamic epistemic system in the context of an ED with the aim to use this knowledge to support with better informing clinicians when working with this patient population. The present study was informed by the systematic literature review which identified a gap in the research in religion-based interventions for Muslims with an ED.

The present study will explore how illness is constructed through the lens of Islam, better understand how Muslim patients understand these aspects in relation to themselves and how it shapes their experiences of receiving care.

1. The present study will ask what are the experiences of Muslims receiving treatment for an eating disorder?

3.1.2 The Secondary Objective of this Study

Having a framework to better understand a different epistemic system can allow for sensitive discussions when considering illness perception and contribute to future development of tailored treatment programs that draw on religious forms of knowledge and meaning making.

2. The present study will ask as a secondary question of what recommendations could be made to inform current treatment practices?

3.2 Study Design

3.2.1 Qualitative Research Design

A cross-sectional, qualitative study was conducted using semi-structured interviews. The study was interested in the personal accounts of Muslims who had experienced treatment for an ED in the UK, and for this reason a phenomenological approach was chosen (Smith et al., 2022).

3.2.1.1 Rationale for Interpretative Phenomenological Analysis

The qualitative method allows for flexibility and openness for researchers studying phenomena with limited prior knowledge. It is particularly appropriate when a quantitative method cannot adequately capture the sensitive variations in experience, perceptions, and meaning making. More specifically, IPA focuses on both the experience of a phenomenon and how individuals make sense of events that happen to them (Smith et al., 2022). IPA is a dynamic approach, allowing the researcher to take new interpretative directions depending on the data sample. This method accommodates unanticipated interpretations and outcomes as more information is acquired and a better understanding develops (Blumer, 1969 & 1980). Therefore, I find IPA to be the most appropriate method for this research question, as there is sparse literature available in this area of study to date.

IPA emphasizes the importance of analytic development and the value of flexibility in the process (Smith et al., 2022). Hermeneutics, a theory of interpretation, involves developing an understanding through analysing people's accounts and the meaning they derive from their

experiences (Smith et al., 2022). IPA incorporates hermeneutic processes, where the researcher attempts to make sense of the participant's account of the phenomenon of interest. Arguably, a 'double hermeneutic' process occurs, as the participant simultaneously seeks to make sense of their own experience (Smith & Osborn, 2003).

IPA is an idiographic approach, concerned with the nuance and detail of lived experience (Smith et al., 2022). In contrast, the nomothetic approach in psychology focuses on general principles and universal patterns that inform the laws of human behaviour. The idiographic perspective, however, is committed to capturing the intricacies and uniqueness of individual experiences. The IPA process encourages creativity, the formulation and reformulation of ideas, and a bidirectional relationship between reduction and expansion.

Other methodological options were considered, such as narrative analysis. Narrative analysis is a qualitative method that interprets participants' personal stories and examines how participants construct their narratives (Schegloff, 1997; Ntinda, 2019). One advantage of narrative analysis is its ability to capture the richness of how individuals make sense of their lives through storytelling (Ntinda, 2019). Additionally, it offers a temporal dimension, allowing the researcher to observe changes in participants' perceptions, identities, and understanding over time (Ntinda, 2019). However, narrative analysis has drawbacks, including its reliance on participants' storytelling abilities and willingness to share their stories, which can vary significantly between individuals (Ntinda, 2019). Moreover, the present study is interested in how Muslim participants experience treatment for an ED, rather than how they construct their narrative of the phenomenon.

One advantage of IPA is its flexibility in data collection, as it typically involves semi-structured interviews. This allows for the exploration of different aspects of the phenomenon as they arise.

Thematic analysis was also considered as a possible methodology. Thematic analysis involves identifying, analysing, and interpreting common patterns and themes in qualitative data (Clarke et al., 2015; Braun & Clarke, 2006). It is a flexible method that extends

beyond personal experiences, producing a broad descriptive analysis of all individual data sets, which are then combined into a single data set (Braun & Clarke, 2006). Thematic analysis is accessible and effective for highlighting commonalities and differences in participants' experiences (Finlay, 2021). However, this method was deemed less suitable for the present study, as it groups data sets together, whereas IPA focuses on the individual's personal account.

Thematic analysis has additional drawbacks. Categorizing data into themes risks oversimplifying complex phenomena and losing the nuances and uniqueness of individual experiences (Finlay, 2021). It also relies heavily on the researcher's judgment. Without the careful reflexivity emphasized in IPA, there is a risk of imposing the researcher's assumptions on the data (Finlay, 2021). Furthermore, group analysis may overlook differences in individual participants' experiences.

IPA, by contrast, is well-suited to small sample sizes and desirable for understudied topics. It aligns with the research question's aim of understanding in detail the experiences of Muslims receiving treatment for an ED. Additionally, a scoping review conducted during the initial stages of this study design revealed that a previous study also used IPA to explore the experiences of Christian women with EDs (Marsden, Karagianni & Morgan, 2007).

Finally, IPA was chosen for its commitment to capturing the nuances and intimate details of Muslims' experiences receiving treatment for an ED. IPA has been recognised as a method that facilitates the investigation of reports from underrepresented and understudied populations (Noon, 2018). There is a significant gap in the literature regarding sense-making in the treatment experiences of Muslims with EDs, further supporting IPA as an appropriate and effective methodological choice.

3.3 Researcher's Philosophical Position

3.3.1 Critical Realism

I will be taking a critical realist (CR) approach as it is congruent with the aim of the project which is to investigate the lived experiences of ED treatment received by Muslims. The critical realist approach reflects the held belief in Islam that there are fundamental truths and a material reality that we exist in but also considers how this context influences the subjective experience of participants and the sense-making of their lived experiences. Whilst there is an observable truth, it is important to draw on methods such as IPA that acknowledge the variations in perspectives, and subsequent interpretations of their relationship to the phenomenon of interest and construction of a truth depending on an individual's epistemic system and their context.

Using CR in conjunction with IPA allows researchers to acknowledge an objective reality (Fletcher, 2017), whilst also investigating individuals' subjective experiences, understanding, perception and views of a phenomenon (Brocki & Wearden, 2006). This allows the researcher to not only consider the nuances in individual lived experiences, but also the wider structures and social mechanisms that play an influential force on these experiences.

Both CR and IPA accept that our knowledge is limited and shaped by contextual factors, similarities are that CR acknowledges that knowledge is fallible, and IPA recognises that the researcher's interpretation is just one possible approach in sense making of the participant's experience (Fletcher, 2017; Brocki & Wearden, 2006). Whilst IPA is rooted in a constructivist epistemological stance (Brocki & Wearden, 2006), the present study must also consider the Islamic perspective, and therefore the researcher felt CR also captures the Islamic perspective in that Muslims believe in fundamental truths and realities but accept that there is also human perception and interpretation that informs lived realities (Al-Faruqi, 2012).

Moreover, participants' accounts will be shaped by their context and sense making however, they may not be aware of all the factors that influence their experiences (Fletcher,

2017). A participants' description of their lived experience may be a partial representation of reality rather than a reflection of 'direct' reality, as their experiences are communicated through a filter of interpretations. Therefore, the researcher has provided the political and social context Muslims currently navigate in the UK for the reader's own understanding but will also present intimate extracts from individual interviews that provide insight into the personal experiences of the participants.

There are challenges that the researcher must be aware of, for instance, as mentioned earlier, CR holds an ontological stance that there is a belief in an objective reality (Fletcher, 2017), whilst the focus in IPA is the subjective experience of individuals, therefore the researcher must be cautious in making sense of how 'direct' reality may influence subjective experiences.

3.4 Ethical Considerations

3.4.1 Ethical Approval

The study obtained ethical approval from NHS and University of Hertfordshire (protocol number: LMS/PGR/NHS/02302). The study was reviewed by London, Fulham ethics committee and approval was obtained.

3.4.2 Ethical Considerations for Current Study

Table 7.

Ethical considerations of the present study

Ethical Concern	Researcher's Consideration
Valid Consent	To ensure informed consent was obtained all participants were sent a participant information sheet (see Appendix C) via email upon expressing

	their interest in the project. The information sheet provided information about the research aims, the use and storage of personal data and the participants right to withdraw. All participants were invited to ask questions about the information sheet and what participation would involve either via video conference or telephone before the consent form was sent. Consent forms (see Appendix D) were sent electronically, and once signed and returned, one copy was retained by the participant and one copy was stored on a secure OneDrive with only members of the research team having access. Prior to commencing the interview, the consent form was revisited, and further verbal consent was obtained to audio record the interview.
Right to Withdraw	Participants were made aware of their right to withdraw from the study at any time without providing a reason prior to the completion of data analysis; in all cases this was at least one month after participating. Participants were reassured that any decision to withdraw would have no impact on any treatment or care that they are receiving or may receive. No participants chose to withdraw during or following the interview stage.
Confidentiality	Participants were informed that any identifiable information would be limited to the members of the research team only. As part of the reporting data, all identifiable information has been removed or changed in the current study and only pseudonyms have been used. All participants were informed that their data would remain confidential except for in the event of safety concerns as outlined in the participant information sheet and consent form.
Data Protection	Data was managed and stored in accordance with the Data Protection Act (2018), General Data Protection Regulations (GDPR), and the University of Hertfordshire data management policy. All participant data, including interview recordings and anonymised transcripts were encrypted and stored securely on the university's OneDrive where only members of the research team had access to. Participants were informed that some identifiable information such as name and telephone number would be stored securely as above, and this data will be destroyed by September 2024.
Minimising Harm	The ethics committee asked how distress would be managed in the present study. As a clinical psychologist in training, the primary researcher utilised their therapeutic skills to both monitor levels of distress and to offer support as needed during the interviewing process. Participants were reminded that

they could request a break at any point in the interview. No participants opted for a break.

Participants were also offered the opportunity to seek further advice from the principal investigator during the debrief at the end of the interview session if needed. Participants were also provided with a contact independent to the study and study research team which was included on the participant information sheet.

Another ethical consideration was the sensitivities in discussing personal topics such as the treatment for an ED and religion. It was important that the study recognise the unpredictability of what may be shared within the interviewing process and to ensure there are other different forms of support available to participants. Participants were reminded to share only what they felt comfortable with and that they could decline answering any of the questions. A mood check at the end of the interview was completed and opportunity to ask questions or share any concerns were provided. Participants were also electronically emailed the study debrief sheet with additional contacts should they experience any distress and wish to seek further support.

Moreover, as the present study had a focus on the experience of treatment in a mental health service, there is an expected and understandable sense of anxiety that comes with sharing the true experience of a service received, particularly if a negative one, and in some cases, we recognised the possibility that participants may still be under the care of the service. However, it can also be empowering in voicing and being listened to with regards to issues in relation to the quality of care received. The NHS ethics committee suggested the recommendation for participants to be provided with the NHS Patient advice and liaison service (PALS) who offer confidential advice, support, and information on health-related matters. PALS offers help with concerns or problems related to NHS services and can provide information on complaint procedures should participants wish to make a complaint following their experience. This service was included in the participant information sheet.

Remuneration

A final comment was the financial compensation for research participants where the ethics committee felt it was important to state explicitly on the participant information sheet the amount of financial reward and by what

means this will be offered to participating individuals (e.g., cash or via BACS payment).

One of the main ethical concerns in offering subjects financial reward for their participation is that this could be considered as coercion resulting in biased study enrolment, there are further concerns that participants may also overlook potential risks associated with participation (Wertheimer & Miller, 2008). Official recommendations state that research participants should be reasonably reimbursed for costs directly incurred during their participation in research activities (National Institute for Health and Care Research, 2022). The decision to offer a renumeration as a part of the study design was justified in line with the time commitment, token of appreciation for participant's involvement in the study and to promote recruitment of a marginalised group (Wertheimer & Miller, 2008). Indeed, a lack of financial reward or compensation for the time commitments may discourage individuals who are from disadvantaged backgrounds. Where financial reward was offered, additional care was taken to ensure participants were aware of the sensitivities in the topics that would be covered during the interview.

3.5 Coproduction with Experts by Experience

Coproduction refers to how service-users and service-providers work in collaboration to influence the way service and care is designed, commissioned, and delivered. Coproduction has become a popularised term in recent years and in many cases in the NHS become a fundamental part of the development of any project in healthcare. One of the key aims of coproduction is to facilitate the reduction of inequalities and support innovation. Coproduction comes with many strengths and benefits however, it is important for coproduction to not become another tick boxing exercise (NHS England).

Any coproduction of a study must be from the grassroots of conceptualisation upwards and led by values. To support the integrity of the Muslim and ED community, it felt essential to protect the voices and dignity of those from the very population of interest and therefore the qualitative method was opted for with the intention to allow for this. Nonetheless, we are working within a system that still holds rigid standards and expectations, and researchers must

consider the impact this has on research for understudied groups. For instance, the systematic literature review did not represent Muslim in the included data set and the general more widely available literature seems to solely focus on the anxieties during Ramadan for Muslims with an ED. This suggests a major gap in knowledge but also the possible subsequent impact in the lack of representation from minoritised groups has on healthcare research. Hence, the research team has made active attempts to ensure the study was driven by the values and processes of coproduction with an expert by experience. The study also consulted with service clinical leads of ED services and academics in the field of cultural research.

The role of the expert by experience was to consult on the study design and materials such as the information sheet, interview guide and support the systematic literature review and data analysis process. As mentioned earlier, I am myself Muslim and consider myself to be an Insider-researcher. My position and identity certainly played a role in the conceptualisation and development of the study design and influenced the lens at which I interpreted and made sense of the data set.

3.5.1 Further Involvement of Participants

All participants that took part gave consent to be contacted following their interview to arrange a further meeting to discuss findings of the study. The involved participants were invited to review the researcher's analysis of the data.

To support the validity of the qualitative research process, member checking was used. Member checking is when participants review and validate the data set and confirm or deny the researcher's interpretation of the data (Candela, 2019). This approach has been considered to offer an opportunity to equalise the power relations between the participant and researcher by allowing participants a space to pause, reflect and comment on how their experiences are being represented. Participants were informed that the involvement in member checking was voluntary, and they could withdraw at any time.

All participants engaged in an informal member checking session at the end of data collection where the researcher summarised the topics and key themes explored along with initial interpretation, participants confirmed or corrected the researcher for accuracy (Candela, 2019). One participant engaged in a formal individual member checking feedback session with the researcher following data analysis.

3.6 Participants

3.6.1 Eligibility Criteria

To ensure homogeneity in the study an eligibility criterion was developed. Eligibility was determined via an initial database search undertaken by the clinical lead in the recruiting services. Following this, potential participants who met the inclusion criteria were contacted to confirm their eligibility and whether they had an interest to participate in the study. In line with ethical research practice, individuals deemed to lack capacity to consent to participate were excluded.

For the purposes of the study, a brief screening tool was administered via telephone call prior to the interview which included demographic information on age, gender, ethnicity and diagnosis to support with the analysis and discussion. To ensure participants had relevant experience to address the research question, the study required participants to have received treatment for an ED within the last 24 months.

3.6.2 Participant Inclusion/ Exclusion Criteria

Table 8.

Inclusion and exclusion criteria

Inclusion criteria	Exclusion criteria

• To have a diagnosis of an eating disorder (anorexia nervosa, bulimia, binge eating disorder nervosa, Other Specified Feeding or eating disorder) • Identify as a Muslim • Participants will be required to be under the care of a GP and community eating disorders service in NHS and treatment if indicated as being accepted or received treatment within the past 24 months, • Participants over the age of 18 years old	• Does not have an ED disorder diagnosis, • Under the age of 18 years old • The service I will be recruiting from does not treat avoidance restrictive food intake disorder (ARFID) and therefore will not be considered in the present study.

The present study relies on the requirement of participants to have an ED diagnosis. The rationale that informed this decision was for the purposes of homogeneity which best suits the IPA method (Smith et al., 2022). I do recognise that there is a prescriptive medical definition for EDs, when and with many mental illness disorders, there is also the influence of shared cultural and social understands of what an ED entails and must also be named and explored in studies that rely on the requirement of a diagnosis for their inclusion criteria. So, it is essential that we understand through a critical lens the limitations and biases of the construction of mental health disorders and what other forms of knowledge shape our understanding of EDs. Whilst there is the usefulness to the shared understanding on the symptomology of the DSM-5's classification of EDs and particularly in research studies providing a shared consistency in the definition across studies, we must also recognise these categorisations may not capture the nuances of people's experiences or how this interacts with culture and other aspects of identity.

The ethics committee further asked how religion would be determined, and it was stated that during the screening process participants would be asked if they consider themselves as Muslims. One ethics committee member asked if the study would make

distinctions between converts or Muslims who were born into the faith, the response was that faith would not be measured and there would not be any prerequisites beyond self-identification. As this was a study exploring the lived experiences of Muslims it was important to not place boundaries that would restrict the sample to a particular sub-population within the Muslim community. Furthermore, the semi-structured interview does ask the nature of relationship the individual has with Islam and therefore will be closely examined. It also felt unethical and far from Islamic values to restrict who is and is not considered a Muslim. It is therefore important to not provide too much of narrow definition of what is required to claim the identity of being a Muslim as I do not seek this study to gatekeep Muslim identity. There are indeed fundamentals to every faith however, to what level an individual affiliates themselves with their faith can vary across a lifetime and will certainly not be quantitatively measured in the present study. Faith is considered a lifelong intimate journey between God and the individual which can entail many ups and downs, closeness and distance and is certainly not linier in nature for many.

3.6.3 Recruitment

Recruitment of participants took place in the Luton and East London area from an NHS adult community ED service. Purposive sampling was used in line with IPA methodology (Smith et al., 2022).

A key strength in the recruitment strategy was that potential participants were approached by members of the service care team who they were likely familiar with. Building rapport was an essential part of the recruitment process to ensure participants felt comfortable in sharing their experiencing in detail during data collection. The researcher was flexible with arranging initial meetings and interviews as well as rescheduling interviews at short notice when needed.

3.6.4 Recruitment Challenges

A major challenge for the project was recruitment from NHS adult mental health services. It is important to acknowledge the pressures NHS services are currently under and therefore there may have limitations in the time clinicians were able to commit to for recruitment. This reality perhaps reflects the lack of representation in the systematic literature review of studies in this area of research from the UK. Furthermore, as much as the present study has identified an under researched population and gap in the literature, it is important for researchers to not assume that this population is difficult to reach or hard to engage in research projects. There was a sense from interviewing participants a motivation to share their experiences and feedback on what services could do to better meet the needs of Muslims patients with an ED. Though this may have been more a reflection of participation biases, it may also be a projection of the urgency to speak of the reality that this population face when accessing mental healthcare services. Researchers must think more sensitively on how studies are coproduced and the process of approaching the population of interest.

Certainly, methodical issues such as recruitment challenges can be discouraging for future academics pursuing cultural research in populations that have typically been excluded or understudied. Often religion and science are considered two opposing entities which comes with its own complexities in academic research. Nonetheless, this is a valuable area of health research and essential for the quality assessment of services offered to marginalised groups.

3.6.5 Participant Information

Five female participants, aged between 18- and 55-years old. Demographic information along with their diagnosis can be found in Table 1.

Table 9. ***Participant Demographic Information***[1]

Pseudonym	Age range	Gender	Ethnicity	Diagnosis	Currently in Treatment (Y/N)
Maryam	18 to 25 years	Female	Moroccan and Spanish	Anorexia Nervosa	Y
Inaya	26 to 35 years	Female	Bangladeshi	Anorexia Nervosa and Bulimia	N
Fatima	46 to 55 years	Female	Bangladeshi	Anorexia Nervosa	Y
Aisha	26 to 35 years	Female	Pakistani	Anorexia Nervosa	N
Aaliyah	46 to 55 years	Female	Bangladeshi	Anorexia Nervosa	N

3.7 Data Collection

3.7.1 Semi-Structured Interviews

Individual semi-structured interviews were selected in line with IPA method as it allows for Muslim individuals to provide detailed accounts of their experiences of treatment for an ED (Smith et al., 2022). A strength in semi-structured interviews is that it facilitates the possibility of unpredictable trajectories as the conversation develops and offers opportunities for the participant and interviewer to focus on the hermeneutic processes. The semi-structured interview allows for the grounding into the topic of interest whilst also promotes a diversity in experiences to be expressed.

3.7.2 Devising the Interview Guide

[1] Pseudonyms have been used in replacement of participant names.

The interview guide was developed to cover various themes in relation to the experience of treatment for Muslims with an ED. The questions have been constructed so that they are open and expansive, with additional prompts to encourage the participant to speak at length (Smith et al., 2022). The open-ended questions provide the basis of not asserting too many assumptions into the individual's lived experience, however also ensured key topics were covered under broad themes (Smith et al., 2022).

The broad themes were divided into three main sections, with a fourth and final section asking participants if they had any concluding reflections or comments to add. The first section focused on identity, with sub-themes exploring what it means to be a Muslim in the UK, being a Muslim with an ED, and navigating the ED during Ramadan. The second section examined the experience as a service user and the influence of faith during treatment, while also exploring whether the service received could have been improved. The third section investigated service development and accessibility for Muslim patients, examining whether religiously informed care could be incorporated into mainstream treatment services and any recommendations the participants might have.

Earlier research in this field contributed to informing the methodology of the present study. For instance, Hoque's (2011) study on British South Asian women with an ED provided insights into the feasibility of applying IPA analysis. It also offered ideas on topics and themes to consider when developing the present study's semi-structured interview, such as the intersection of cultural issues and the impact of family on treatment and recovery (Hoque, 2011).

3.7.3 Data Collection Procedure

Participants were recruited between December 2023 and May 2024. Following the recruitment strategy, participants were electronically sent a consent form to sign and return prior to arranging a suitable time, date and location for the interview. The research interviews

were offered via Microsoft Teams Meeting or face to face to all participants. All participants opted to meet via Microsoft Teams.

The researcher at the start of the interview reminded participants of the aims of the study, confidentiality and the process in the event of safety concerns to ensure participants fully understand the procedures. Participants were provided with opportunity to take breaks, to ask further questions they may have prior or throughout the interview and that the interview will be recorded for the purposes of transcription. Verbal consent was obtained.

Interviews lasted between 50 to 80 minutes and at the end of the interview participants were given the opportunity to ask questions and share thoughts on anything that they felt was missed, which was followed by a verbal debrief. Finally, participants were transferred a sum of £15, all individuals opting to receive this via BACS payment as remuneration.

3.8 Data Analysis

The analysis as mentioned used IPA approach (Smith et al., 2022; Nizza, Farr & Smith, 2021). This approach is in line with the project's aim which is to be close to the lived experience of treatment for Muslim with an ED. The study used the transcription software on Microsoft Teams and then manually checked each interview transcript for quality and accuracy. NVivo software was used to analyse and code the qualitative data.

Table 10.

Step by step account of data analysis (Smith et al., 2022)

Step of Analysis	Summary of Analysis
Reading and Re-reading	All recordings were listened to by the primary researcher to immerse themselves in the original data set. Transcripts were read once with the

interview recording playing and once without the voice of the participant. This process was completed one transcript at a time. During this stage, first impressions, thoughts, connections, and emotional responses were documented, these notes were revisited at a later stage of analysis. The researcher considering their own dialogue with the participant, the varying contexts, and psychological knowledge.

This process was adopted to support the researcher in the familiarisation process by using a close, line by line analysis. The familiarising process contributes towards the identification of emergent themes, holding commonality and nuance in the first instance of single cases before broadening this to multiple cases (Smith et al., 2022).

Exploratory noting

The next stage was interpretation of the analysis and sense making. Within this there is the zoomed in look at small pieces of text in detail before drawing connections across larger samples where recurrent themes were identified, such as gender and culture in relation to how this shaped the participant's relationship to their identity as a Muslim with an ED, then moving onto applying this to their experience of treatment. It was important that when a theme is introduced evidence from the transcripts were provided to stay close to the lived experience and capture what invoked the interpretation (Smith et al., 2022).

This step included examining the use of language and semantic content on an exploratory level. Exploratory noting was completed in Microsoft Word (see Appendix K). Many comments had a phenomenological focus, staying as close to the participant's explicit meaning as possible. Annotations included descriptive comments on the content of what the participant was saying, linguistic comments such as repetition, language and metaphors used to describe the individual's experience was also noted. Another layer of notes included closer reading of transcripts, drawing out deeper interpretations around questioning what the participant may mean and potential underlying meanings (Nizzar, Far, Smith, 2021).

Extracts from the raw transcript is essential for transparency but also creates a sense of dialogue between the researcher and the participant (Smith et al., 2022). Moreover, there are different levels of interpretation, whilst there is the material reality communicated to the interviewer, there is also the theoretical underpinning of a constructed reality attached to

	their lived experience. The reader must be able to follow the narrative and development of interpretations but also may wish to disagree and therefore the explicitness is necessary for an informed debate. For this reason, it is important that what is claimed is evidenced within the context of the constant movement within the hermeneutic cycle (Smith et al., 2022).
Developing experiential statements	This step involved the researcher attempting to reduce the volume of data whilst also preserving but capturing the important features of the exploratory notes. This stage shifts from experiential statements (ES) being developed primarily from the exploratory notes rather than the transcript itself. From this, the development of structure and a framework, and relationship between the themes formed. Throughout this process the use of discussion with the expert by experience to support with audit and plausibility of interpretation was a valuable resource. In the final stages, a development of a narrative and reflection of my own perceptions and processes was important as the researcher must be mindful of the influence of their own interpretations and preconceptions during the process of analysis (Smith et al., 2022). As mentioned earlier, I acknowledge my position as a South Asian Muslim female, and curious about how my identity has impacted the lens in which I look through when interpreting the data set. A challenge in IPA is its reliance on interpretation of the data sets from the qualitative researcher where personal biases and assumptions may play an influencing force in the final written conclusions.
Searching for links across experiential themes	Experiential statements that were not relevant in answering the research question were removed from the analysis at this stage. Connections between ES were searched for, with each statement being treated as of equal importance. The researcher began searching for smaller discrete sub-groups which would later become sub-themes. Emergent themes were investigated in relation to their contextual and narrative elements throughout the analysis and across all transcripts (Smith et al., 2022). The transcripts were shaped by the participant's characterisation of their experience in the treatment for an ED as a Muslim, which was often of a narrative nature. Therefore, it seemed appropriate to highlight this, critical events were for instance, diagnosis and the different stages of their treatment in relation to their recovery such

as Ramadan, what participants named as being most unwell with their ED, whilst also contextualising their narrative by attending to their context of culture, gender, and the role religion played. The extraction of critical events and contextual themes were applied to each case before moving onto looking for patterns across cases. At this stage, it became a creative task of building connections and overlaps in similarities between narratives and experiences, whilst also holding space for participant's own unique idiosyncratic differences. During this process, the researcher also made decisions on removing statements. This was done based on the principles to ensure the integrity and depth was maintained. Preserving the participant's voice meant that ensuring the statements used as evidence did not distort or misrepresent the participant's lived experience, a part of this was including essential information for context. However, statements that did not contribute towards answering the research question or offer insight into the phenomenon being studied were removed, along with repetitive statements that did not add new information or insight. This was done with caution to ensure the emotional intensity of the experience was not lost, here the researcher took advice and guidance from the expert by experience. Information that would compromise the participant's anonymity or confidentiality was also removed. Notes were made in a document of why certain statements were removed to ensure transparency when discussing themes with the wider research team, this was to also allow for discussions if other members felt that the removal of statements may significantly impact the analysis. Moreover, the researcher regularly reflected on bias and assumptions whilst also engaging in ongoing reflectivity. These principles were followed to ensure the removal of statements in IPA was done ethically and methodically whilst also preserving the authenticity of the accounts.

Constructing personal experiential themes (PETs)

The selection of the quotes included in the final write-up of the analysis involved not offering repetitive extracts across transcripts since these extracts would all state the same thing but instead making a note reporting when the theme numerically applied to a number of cases (Smith et al., 2022). Extended raw extracts felt essential to protect the narrative element of the individuality of participant's experience and ensure the voice of each participant's account comes through into the analysis, whilst also providing a whole picture for the reader to gain a good sense of the patterns and connections between themes.

	The clusters of ES formed in the previous stage were named during this stage to become that participant's personal experiential themes (PETs), followed by their sub-themes.
Continuing the individual analysis of the other transcripts	Steps one to five were repeated for each case. Each case was treated as a single body of data keeping with the idiographic commitment of IPA. Inevitably, the researcher was influenced by what they would have read previously, but great care was taken to minimise the influence of previous data, by the researcher regularly reflecting on if individual exploratory notes or if outside influence was creeping into this process with the use of a reflective diary to support this. Tables were created for each participant, these tables included brief interpretative commentary for each theme linked to supporting quotes from the transcript to exemplify each theme to ensure coding process remained grounded in the participant's own words. By treating each case individually, the researcher maintained the idiographic focus of IPA. The process involved creating a thematic map to support with visualising the relationships between patterns, hierarchies and connections between themes. The researcher engaged in an immersive experience of printing transcripts cutting out extracts to support with visualising the map of themes with quotes and drawing associations during the organisation stage. The researchers exploratory noting was matched up with extracts as a guide for the later stage of developing individual tables. The mapping facilitated the researcher to be able to eyeball what is present and not present for each participant. The visual mapping further supported not relying on a fixed structure during the initial stages of analysis, but to have the freedom to move parts of the thematic map around before settling on a coherent structure that was transferred on to NVivo. Transferring to NVivo supported the stages of developing the GETs and the software allows to move between transcripts and observe patterns across multiple data sets with ease and better visual clarity. The analysis process in IPA is iterative and therefore involves moving back and fourth between the data and interpretation, developing tables of themes for each participant, the research ensured a structured and organised approach was employed, whilst still allowing for the depth and richness IPA promotes. This process allowed for a comprehensive understanding of each participant's nuanced lived experience but to make connections across study participants and broader patterns.

Development of group experiential themes (GETs)	The final stage of the analysis involved looking for patterns of similarity and difference across the PETs to reorganize the data into a set of group experiential themes (GETs) which represent the group of participants. Asking 'what connections are there across contributing cases?' which allowed the researcher to form initial ideas regarding potential GETs. Handwritten notes were made to capture these ideas (see Appendix J). These initial ideas, which included groups of PETs and sub-themes informed a process of organising data in. GETs were developed not only at the level of the PETs and sub-themes, but at the level of ES. The developed GETs were put into a table of GETs, with each GET being the highest level of organisation, followed by sub-themes and the ES that make them up. Each ES is accompanied by a phrase or sentence from the transcript, and this sometimes involved revisiting the transcript to check the context of the quote attached to the original ES and ensuring that the meaning making of the researcher remained as close as possible to the meaning making of the participant. A master table of GETs was developed that represented all cases which was analysed against the transcripts by the expert by experience consultant and chief investigator. Any differences were discussed before finalising on a list of master themes and sub-themes.

3.8.1 Quality, Validity and Self-Reflexivity

3.8.1.1 Assessing Quality

The quality of this study was assessed using the CASP tool for quality appraisal in qualitative evidence synthesis. This tool has eleven questions that each focus on different aspects of qualitative research, including: conceptual coherence, methodological rigour, ethical considerations, and value.

3.8.1.2 Quality Appraisal of the Present Study

A comprehensive quality appraisal of the current study is presented in Table 1. This is followed by a summary of the study's strengths and limitations.

Table 11.

Quality Appraisal of Current Study Using the CASP Qualitative Checklist Tool (Long et al., 2020)

	Quality Criteria	Appraisal
1.	Was there a clear statement of the aims of the research?	The current study has a clear set of aims which includes exploring Muslim's experience of receiving treatment for an eating disorder (ED). The study fills a gap in the current available literature on religious individuals receiving treatment for an ED. The study provides an opportunity for a marginalised group to share their personal accounts and improve services.
2.	Is a qualitative methodology appropriate?	The current study aimed to interpret the lived experience of participants. The IPA methodology is considered appropriate in its nature to reveal intimate detail and a nuanced account of Muslims receiving treatment for an ED. The quality indicator such as the construction of a compelling narrative, vigorous experiential accounts and close analytic reading of participants words, and the idiographic depth and systematic comparation between participants (Nizza, Farr & Smith, 2021). The study offers quoted materials that illustrate both patterns of similarities across accounts, whilst also considering the individual differences.
3.	Was the research design appropriate to address the aims of the research?	The study was interested in the personal accounts of Muslims receiving treatment for an ED. A qualitative research design was selected due to the limited preexisting knowledge on this topic, and therefore its focus on meaning and understanding of a phenomenon of interest from the perspectives of individuals with lived experience was appropriate. I reflected on my position as an Inside Researcher and the risk of taking on an 'expert'

	stance, ensuring that I was positioned as a co-learner, working alongside the project supervisors and frequently drawing on consultation with an expert by experience to ensure the research design was appropriate for the topic of interest.
4. Are the study's theoretical underpinnings clear, consistent, and conceptually coherent?	The philosophical position of the researcher as taking a critical realist approach is described in detail and theoretical underpinnings of the study also addressed. For instance, the study acknowledges the lived experience of participants in the results section whilst also detailing other contextual factors in the discussion such as social and political context. The hermeneutic cycle (Smith et al., 2022) is also acknowledged by the researcher.
5. Was the recruitment strategy appropriate to the aims of the research?	Purposive sampling was selected for the purpose of recruiting a homogenous sample in line with the aims of the research question and favoured by the IPA method. Recruitment challenges were also discussed in the methodology. The challenges in recruitment detailed in the methodology certainly shaped the timeline of events for the study as this took a considerable amount of time. However, it was important to the researcher to reflect on being sensitive to the systemic challenges that many staff teams face within an NHS setting and how a research project can provide further pressures on these services. Additional time was given to allow for the recruitment process to be successful and ensure pressure was not placed on staff teams. Furthermore, participants who were approached during the recruitment process, the researcher felt it was important that they were respected throughout the process and necessary steps were taken to address any potential ethical concerns. The researcher's considerations and the steps taken to address these are detailed in Table 7.

6. Was the data collected in a way that addresses the research issue?	IPA requires detailed qualitative data so that the meaning making of participants can be explored and interpreted in great depth. The interview guide was discussed with an expert by experience, research team and academics in cultural research. The questions were developed to elicit detailed accounts of the phenomenon of interest and guided by the wider literature in the field of interest (Smith et al., 2022).
7. Has the relationship between researcher and participants been adequately considered?	The researcher engaged in reflective exercises through the current study which has been detailed in the methodology. A reflective journal was used to aid in decision making and support with exploring personal assumptions and biases. The researcher is explicit in being an Insider-researcher and engaged in self-reflective process on how this may have impacted interviewing, interpretations of the data analysis and motivations with decisions made.
8. Have ethical issues been taken into consideration.	Ethical issues were considered including confidentiality, data protection, right to withdraw, informed consent and risk of harm. The researcher addressed and implemented appropriate adjustments in response to the feedback provided by the ethics committee.
9. Was the data analysis sufficiently rigorous?	An in-depth analysis process was undertaken which was detailed in the methodology. Data was presented in the form of direct quotes from interview transcripts. Member checking and bracketing was employed throughout the data analysis process for each data set.
10. Is there a clear statement of findings?	A clear statement for the study rationale is presented. The findings are clearly presented and related back to the original research questions outlined in the methodology. Throughout the results, participants interview extracts support the findings of the study.

11. How valuable is the research?	The lack of drawing on religious forms of knowledge in treatment for an ED certainly informed the decision to conduct such a study. To the author's knowledge, the present study is the first to explore the experience of Muslims receiving treatment for an ED. The study highlights the nuanced experiences Muslims face when accessing services for an ED and offer valuable insight into the implications of service delivery as well as recommendations for quality improvement and future areas of research.

3.8.1.3 Validity and Reliability

Measures were taken to ensure the validity and reliability of the present study. Content validity was considered and discussed with the project supervisors to ensure the questions used during the interview stage is in line with the purpose of the project aim.

Triangulation was adopted to help minimise personal biases of the primary researcher and to ensure interpretations are rooted within the personal accounts of the participants (Flick, 2004). The primary researcher consulted with the research team throughout the analysis stage which allowed for conversations about blind-spots, assumptions and ensuring the researcher remains close to the sense-making of the participants. Member checking was implemented as mentioned earlier (see Appendix L), where the researcher and participant review the data and interpretations for consistency and accuracy. Addressing or minimising participants risk to validity and reliability such as building trusting rapport with participants to be able to openly and comfortably share their experience of the phenomenon of interest.

3.8.1.4 Self-Reflexivity

Reflexivity has been defined as the act of examining our own assumptions, belief and judgement systems in qualitative research. A reflective diary was used to support the process and reflexive discussions with the research team and expert by experience consultant.

The reflective diary was used to consider my own background and motives that led to conducting this research and how personal experiences may impact my own understanding of participants accounts of the phenomenon under study. For instance, during the interviewing process, I noticed I was able to relate to many points the participants shared which may have been an influencing force behind some of the direction of curiosity and comments. The reflective diary also helped during times where I realised how emotionally taxing the research had become, ensuring to reflect on this and make note on what actions I would take to take care of myself during the process so that the integrity of the research was not impacted.

Pre-research reflexivity involved identifying personal biases in a reflexive journal. It was important to acknowledge the experiences that may be harder to fully grasps and challenges that the participants experience that I may not be familiar with, and therefore being aware of blind spots and gaps in my own understandings was an important area to reflect on.

The researcher during interviewing employed active listening to minimise influence of assumptions and ensure the depths of experiences was captured. During data analysis, it was important to revisit transcripts to ensure themes were not overlooked. For instance, the researcher noticed themes of struggle to connect with the identity of being a Muslim with an ED prior and during treatment, often associating this with the stereotype of middle-class white women as typically have an ED. The researcher revisited transcripts to check other themes were not filtered out such as moments of relief or validation when receiving a diagnosis or accessing the service for help. This process ensured that space was made to ensure opinions that may have been different to the researcher's own could be identified and not overlooked.

Certainly, the requirement of a final fixed element in the write-up has been overwhelming and challenging at times.

3.8.1.5 Bracketing

For qualitative researchers, bracketing is setting aside one's own beliefs systems and assumptions about a phenomenon throughout the investigation to ensure the participants own perception, meaning making, and experience is not misrepresented (Chan, Fung & Chien 2013). The use of the supervisory team, expert by experience and member checking supported bracketing. Furthermore, bracketing requires the researcher to make a purposeful and conscious effort to set aside knowledge, beliefs and experiences to accurately describe the lived experiences of participants. Despite these efforts, it certainty does not mean assumptions and biases were eliminated from the hermeneutic phenomenological approach, but to instead acknowledge that these may play an influential force in the interpretations and conclusions made.

In practice, before conducting interviews or data analysis the researcher engaged in self-reflection. One major focus of this was potential, personal biases and assumptions that may exist as an Insider-Researcher. These reflections were journalled and discussed with the expert by experience consultant. During data collection, open ended questions were employed in interviews to ensure participants were able to communicate their experiences in their own terms and minimise the researcher's influence on the perspective. In the interviewing stage, the researcher ensured to listen without interrupting and strived to stay focused on the participants own account. As mentioned earlier, reflective journalling was a key tool throughout the analysis process which supported in ensuring interpretations remained grounded in the data, whilst also understanding how my own personal context may influence perceptions of the phenomenon and consciously bracket these. The researcher interpreting the participants interpretation of their experiences (the double hermeneutic) requires an awareness of interpretation and striving to ensure the researcher acknowledges their own interpretative role played.

For example, during data analysis phase, the researcher noticed consistently interpreting participants' reluctance to disclose during psychology therapy sessions as a sign of mistrust in services, however upon re-examining the transcripts during coding, the researcher asked themselves, "Am I letting my assumption of mistrust towards institutions surface through my interpretation of the reluctance to disclose during treatment, and is this overshadowing other possible reasons for this behaviour?". This then led the researcher to consider alternative explanations, such as a desire for self-reliance and differences in social contexts between patient and clinician. Other examples involved bracketing emotional responses, such as noticing a strong emotional response of anger. Recognising this, the researcher reflected on feeling a deep sense of anger towards systems, acknowledging this but ensuring to not let it shape interpretations of the participants' experience. Reminders such as focusing on the nuances of their experiences rather than my emotional reaction was key in the practice of bracketing during analysis and coding.

3.9 Dissemination

Throughout this project consideration has been given to how the findings of this study will be disseminated. This is particularly important given the current gap in the literature identified by the systematic literature review. The study was presented at the fifth international culture and mental health symposium on the 26th of March 2024 hosted by Nottingham Trent University, speakers included academics involved in cultural research. The organisers have invited the researcher to present the study findings next year.

I also plan to share the outcomes and recommendations with the organisations that offered recruitment channels to this project.

Chapter 4

Results

4.1 Overview

The purpose of this chapter is to present a narrative account using Interpretative Phenomenological Analysis (IPA) on the experiences of eating disorder (ED) treatment for five Muslims residing in the United Kingdom (UK). The researcher has drawn on the double hermeneutic cycle of IPA (Smith & Osborn, 2003), naming key themes to illustrate a story towards recovery entailing migrational histories, cultural, social and religious identities and experiences of marginalisation from statutory mental health services.

4.2 Summary of Findings

The five interviews resulted in the development of five group experiential themes (GETs). The five main themes presented capture specific parts of the participants personal account of their identity as a Muslim with an ED and their experiences of treatment, followed by suggestions for change for services to consider when offering care to Muslims with an ED.

For many, being Muslim in the UK comes with an intersection of identities. Themes around ethnicity, being female and social-cultural norms were narrated to provide the context to being Muslim with an ED, before moving onto exploring how this then informed their experience of treatment and recovery in services.

Table 12.

Group Experiential Theme (GET) and Personal Experiential Theme (PET)

Group Experiential Themes (GETs)	Subthemes
The labyrinth of Culture, ED, and Islam	• Navigating through cultural and social norms • The realities of the Migrant Family Systems • Living with the stigma of mental health
Navigating life as a Muslim woman	• The Value of thinness • Tolerating the Expectations on Women • What having an ED looks like
Living with an ED as a Muslim	• Coping with an ED during Ramadan • The Role of Islamic clothing for women with an ED • The relational changes with God • Making sense of a religious explanatory model for EDs
The experience of Treatment and on the road to recovery	• The value of rapport and therapeutic alliance • To disclose or not to disclose: mentioning Islam during treatment • The challenges in cultural familiarity between clinician and patient • The inaccessibility of ED services: neglecting our needs
The hope for future change in treatment services	• Drawing on Peer-support for Recovery • Empowering Staff Teams • What positive change could look like for ED treatment services

4.3 The labyrinth of Culture, Eating Disorder, and Islam

4.3.1 Overview of GET

This GET captures participants' experience of the intersection between culture, religious identity and having an ED. Participants often associated religion as being entangled with culture and at times difficult to make distinctions between both entities.

4.3.1.1 Subtheme: Navigating through Cultural and Social Norms

An important feature of participants' descriptions of their experiences as a Muslim was the unspoken but known cultural and social standards of being. Participants narrating how these norms informed their sense of self as an individual with an ED.

"We don't talk about it at home… I think if you have an eating disorder, and you're Muslim, people usually just say pray or is not a psychological thing." (Aisha)

Where culture intersects with religion, religion seems to have been used as a tool to minimise, invalidate, and dismiss the mental illness. Whilst praying is valuable in attending to distress, Muslims are also advised to seek professional help for illness. Cultural oppression of distress may be the reason why many opt to stay silent and avoid seeking help in the early stages of their ED.

Similarly, Inaya describes how family members would question her on some occasions as to why she would not eat, however beyond these 'one or two occasions' there seemed to be a perceived silence and avoidance of the topic,

"It was a subject that was just avoided altogether, and I think there's maybe one or two occasions that my grandparents would make comments and be like, why aren't you eating? Why aren't you doing this? Why aren't you doing that? But it, that was just, you know, they, they just had no understanding of eating disorders at all. Umm, but aside from that, it was very much a topic that was just completely ignored and kind of brushed under the carpet really." (Inaya)

Another common theme that arose from individual participant's account was how food was often associated with culture and religious celebration.

"For example, in Morocco, and I feel like in many Muslim cultures and societies, food plays a huge role. So, when it comes to celebrating when it comes to even visiting your grandma like, that's a huge thing in our religion. Well, in my culture in Morocco, it's always,

food is the, is the main thing or like my, my grandma would always, she would always try to over feed me." (Maryam)

There seems to be a stir of anxieties for individuals with an ED and their family systems which may subsequently alienate them from family gatherings or key cultural events. Maryam illustrates the social isolation that may be experienced from having an ED.

4.3.1.2 Subtheme: The Realities of the Migrant Family Systems

The importance of generational differences was mentioned in a number of participants accounts. Managing family dynamics also surfaced as a key theme when navigating between the ED, cultural and religious differences between generations within the family network.

"Because there is, there is that cultural split. So, there's the British identity part of, of cultural identity but also the, the ethnic and Asian side. Which so yeah, it's trying to balance both right and then build awareness of between both identities and… And then on top of that, there's being Muslim and having just migrational history as well, parents, or parents and many layers… I used to think I was part of a lost generation because my parents used to try and force it down our throats about how we're Bengali and Bengali food, Bengali clothes". (Aaliyah)

One participant explained that the cultural transition from Bangladesh to the UK came with many challenges. The participants identified the impact from acculturation and acculturative stressors for migrant minority groups.

"So older adult moving from Bangladesh, everything is different. I say all the time food is different, weather is different. We have a different lifestyle, and the space is different. You arrive here and you cannot even interact with anyone because nobody is speaking your language… I think the lifestyle that we have in Bangladesh is different. Yeah, you may be anxious because your kids are growing up, you know, they may become independent. You can be worried because you have a baby born and you know you don't know how to cope, but

you have always the support from all the extended family that is living with you back home". (Fatima)

Fatima highlighted difference as a theme in her experience of migration. Fatima also discussed the social isolation that comes with migrating, describing some of the challenges in adjusting to a different cultural lifestyle. She shared how this can stir up feelings of uncertainty and anxiety.

The lived experience of participants who are younger and born in the UK compared to those older who migrated to the UK may differ. For instance, the cultural differences may seem more prominent for those who migrate in older age and therefore may find it more difficult to adjust, they may feel less familiar to the Western cultural context and lifestyle compared to those who were born and raised in the UK.

4.3.1.3 Subtheme: Living with the stigma of Mental Health

A number of participants reported the stigma existing within their communities towards mental illness and feeling unsupported by these cultural systems. Stigma towards mental illness certainly exists across all cultural and social groups. However, the implications of this for some may be the reluctance to then disclose if in distress or suffering from an ED.

"I may say, oh, I am feeling pain my leg, in my knee, you know, I don't think I would share anything related to mental health to friends or anyone… because some people are really ignorant". (Fatima)

Another participant similarly explained the sense that others within her home country may not understand or invalided her ED.

"They see how disrespectful you're being. You know, you haven't got any, like, proper illness. Like it's just a made-up disorder in your head. So, I think that's like one really awkward thing. Like, I just absolutely hate. No one gets it in Morocco… You use the right word there.

Like, minimising that is literally how it feels with an, with an eating disorder and being Muslim. It's just a very minimising experience for me." (Maryam)

Maryam describes how others were not able to grasp the ED as being a legitimate illness. The need to be understood but subsequent fear of being misunderstood felt strong for Maryam where she described feeling 'minimised' as a Muslim with an ED. There are certainly experiences of anticipating negative consequences to speaking out where there is a lack of awareness and perceived ignorance on EDs.

4.4. Navigating life as a Muslim woman

4.4.1 Overview of GET

This theme captures the experience of participants through a gendered lens. The study sample consisted of all females who shared their experience as being a female within a patriarchal system. Participants narrated the impact idealised standards of beauty impacted their sense of self and exacerbated their ED symptoms.

4.4.1.1 Subtheme: The Value of Thinness

This theme illustrates the Western standards of valuing thinness and the consequential impact of this on women's health.

"I just had my child, and I was starving myself and I lost most of the weight and I was praised for it… pregnancy weight was seen as someone not doing well, like that's, that's what I understood". (Aaliyah)

Aaliyah recounted the pressures that come from others by their explicit nature to value thinness. Thinness becoming a symbol of health as Aaliyah associates the 'pregnancy weight' as a cultural indicator for a mother 'not doing well'. The value for postpartum thinness

seemingly superseded the mental wellbeing of the mother, Aaliyah naming that she was restricting food at the time.

During the month of Ramadan Aisha described her family ritual before and after a fast,

"With my family. It's a bit weird. They used to like weighing themselves before and after. Let's see if they've lost weight." (Aisha)

Another participant went onto associate the value of thinness to Western standards of beauty.

"Well, when I went to like France, for example, or like Spain, I was, I was complimented a lot, which was very triggering like I was always complimented. Wow. Like, how do you do it? We love the gym. They're always trying to lose weight. They're always trying. Like, I don't know, medications for weight loss, you know, active lifestyles very much promoted there and very like, slim bodies. But it always just seems unrealistic. Like little did they know that I was, you know, I didn't wanna be like that. I'm literally suffering like I'm not. I'm not. I'm not, I'm not healthy at all. But they all think I'm healthy and I, when I go to Morocco, they will see that I'm very unhealthy and they need me to, to fatten me up and they find it very unattractive. Yeah, and like and it's always in a in a male's point of view." (Maryam)

Maryam communicates her experiences of the different cultural expectations in what is considered as physically desirable. Both Aisha and Maryam's contexts illustrate the reality of body shaming attitudes and as Maryam describes can create unrealistic expectations on an individual.

4.4.1.2 Subtheme: Tolerating the Expectations on Women

This theme captures the cultural and social pressures and expectations that come with gender roles and the impact this has on the religious identity of participants.

There were apparent themes of patriarchal family structures that surfaced in the participants account of their family systems. One participant illustrates what seemed to be a gendered hierarchy where her father held power and freedom of choice over her mother.

"*He can do whatever he wants, and mum really can't… Yeah, like it's just it's not the, the religion says the right thing. It's just the culture stirs it around in the wrong way, which, you know, people use it as an excuse to do whatever they want. Well, men especially. I find. So that's one huge problem, but yeah*." (Maryam)

In addition, the value and expectation of having a nuclear family was more associated with culture over religion.

"It's literally just cultural. Not even nothing to do with Islam. It's just culture. Their expectations and stuff like that. You feel a lot of disappointment if you don't do certain things… marriage is the biggest one… you should get married, so it's still pressure on us in a different, it's like in a blackmail pressure type of thing". (Aisha)

Aisha associated the pressures of marriage to the idea of 'blackmail', perhaps illustrating how these expectations may feel coercive in nature.

4.4.1.3 Subtheme: What Having an ED Looks Like

This theme illustrates a constructed idea of what type of person is typically diagnosed with an ED from the perspective of the participants.

A key theme was the intrinsic idea of a constructed identity typically associated with an ED.

"I could never identify with any eating disorder because I wasn't a white middle class girl." (Aaliyah)

"Like, I've always just seen white people come in. I have never seen black people come into the clinic. I've never seen brown people. It's just always white girls coming in who have an eating disorder, you know, even online like TikTok-ers or like recovery pages. It's all like,

just white girls who are, like, I don't know, maybe they come from, like, middle income families or something, but I've sometimes, I always feel so like, damn, I must be like, really bad 'cause. I'm a Muslim with an eating disorder and I have all these other mental health diagnosis, and I just feel very, I feel very weak sometimes in my religion like as a Muslim because there's, I don't know anyone else who's who's you know brown or Muslim who has like the same experience as me." (Maryam)

The stereotypical idea of those who have an ED as typically a white middle class female can have harmful effects on individuals who do not fit this social mould. Maryam explained how this had a subsequent impact on her internalisation of a negative sense of self as a Muslim with an ED. Maryam began describing whether this meant she was 'really bad' and 'weak' in her religion.

Moreover, not only is the "white middle class" stereotype asserted, but also an ageist bias held within this constructed preconception.

"Because sometimes eating disorder they seem like there's a problem only for woman. There's a problem only for young younger generation, it is not, to be honest, is can affect anyone… It can affect many people, they can affect ethnic minority groups, it's not just young teenager. You know, anyone, it can be an older person". (Fatima)

As noted by Fatima, often it is adolescent or younger women assumed to develop an ED rather than older adults. Despite growing evidence in the greater risk of mortality and morbidity in the elderly compared to the younger population of ED sufferers, the information available on the treatment of an ED in older adults makes it difficult to provide treatment guidelines for this population (Mulchandani et al., 2021).

4.5 Living with an ED as a Muslim

4.5.1 Overview of GET

This theme examines the intersection between EDs and religion. The participants narrated the complexities in their own sense of self in relation to their God, but also the undercurrent of ED related anxiety triggered by common religious and cultural practices and how they navigated these events.

4.5.1.1 Subtheme: Coping with an ED during Ramadan

The participants recounted Ramadan and Eid as difficult when suffering from an ED. For some of the participants it was a sensitive, anxiety triggering period and for others it was a relief from the pressures to disguise the ED.

"*I used to restrict basically even in Ramadan, but in some ways it's easier because you couldn't eat in the day, so I didn't have that. I didn't have that worry of what am I going to eat? Anything to do with food, I didn't have that".* (Aisha)

"It's incredibly hard. Like for me, even now actually to eat when other people are around me aren't eating I struggle with that because I felt like, OK, I, if other people aren't eating, I don't need to eat… It was really, really hard and, and it was just incredibly triggering for me and I think now that I've, you know, completed my first Ramadan actually fasting since I've been in recovery umm it still was triggering… I actually went into Ramadan with the mindset that ohh I might be able to lose a little bit of weight." (Inaya)

Interestingly, Inaya went onto further explain how Ramadan became a period where she noticed the competitiveness of the ED surface.

"I know I can fast longer than that, but I've not done it without liquids, so it'll, I was always trying to see how long I can go without liquids now, even though I'm not supposed to be fasting. And it was just kind of this whole thing of like I did, and I wanted to be the best. I wanted to be the best at not eating." (Inaya)

For individual's receiving treatment in an outpatient setting who are likely be surrounded by family members who are fasting may risk reinforcing the ED cognitions and

behaviours. This is also consistent with the literature, where the act of religious based fasting can interact with internalised cultural values of thin ideals. Certainly, those with a higher disposition to the development of an ED will likely use fasting as a strategy to reinforce social-cultural models of body image rather than solely motivated by faith related reasons (Angelova & Utermohlen, 2013).

"*See, I just don't really express anything to do with Islam until it has, until it's Ramadan really. So, I came out during Ramadan, that's when I joined outpatient, and they were really good at helping me navigate my feelings. I dunno whether maybe I felt insecure that my sister was fasting, you know, and I, I had. Maybe some days I had an urge to fast, and my mum was like making me eat loads."* (Maryam)

"Think you know, especially during the period of time where I wasn't allowed to fast because of my eating disorder and everyone around me was fasting like my family. They were all fasting, and I really struggled with that and I ended up becoming even more disconnected from my faith and from my family as well, and even with Eid like, I was never excited for Eid because it was just food. It was just so much food and I just wanted to avoid it and run away from it, and it was just it was just a day filled with, like, anxiety." (Inaya)

Participants further narrated their experiences of the cultural shaming from others but also from themselves when impacted by their reduced ability to practice faith whilst trying to recover from the ED.

"*Oh, that's, that's, that's Haram. You can't waste food like that. You know, it's disgraceful, especially when it comes to like again, I know Ramadan is mentioned mainly. But like when I wasn't, when I tried to fast Ramadan or when I wasn't fasting, my dad would be very disappointed in me*." (Maryam)

"I would rather die than not be forgiven if that makes sense, like fasting is like an important pillar and that I, I would never again, forgive myself if I had not fasted." (Aisha)

There was an interesting variability in the significance of Ramadan across the sample, illustrating the uniqueness of the lived experiences for Muslims with an ED. One difference

was living in an environment where others were restricting food and this for some participants becoming a trigger to the ED however, alternatively for some this provided them with a sense of relief. For example, Inaya described Ramadan triggering the competitiveness of the ED, whereas Aisha shared that it meant that she no longer had to make excuses for her ED tendencies, however for Maryam there was a felt sense of insecurity in that her sister was fasting but not her.

Maryam also shared that due to her ED which meant she was unable to fast during the month of Ramadan she noticed her father feeling disappointed in her. The cultural shaming that may occur for some can understandably be difficult for ED suffers. As described by Maryam and Aisha, these critical attitudes towards not being able to attend to religious duties may trigger feelings of guilt or shame from others or from the self.

4.5.1.2 Subtheme: The Role of Islamic Clothing for Women with an ED

This theme describes the role of Islamic clothing for women and how this impacts the participants identity as a Muslim growing up in the UK. There was a variation in the study sample of participants who wear the *hijab* and participants who did not, however one common understanding across all accounts was the implications of the visibility of being a Muslim that comes with wearing the *hijab*.

"*Hijab. So, I'd be like, no way. Like, I can't do that. I can't wear that at school. I can't. I can't wear that outside. You know, I can't be associated with it. Yet. When I go to Morocco, I, I, you know, I love embracing Muslim culture. But the moment I arrive back in England. That's it. Like, I need to switch that off*." (Maryam)

Maryam shares the internal conflict she experiences in wearing the *hijab*, describing how some of this is driven by the worry of judgement from others. Perhaps these similar anxieties and fear of judgement may also be experienced within a treatment setting.

"When I started the, the initial assessment, I was wearing hijab… it was hard to do. Yeah, to just, to do that like no one in my family wears it. No one in my extended family, so like already felt like the old one out… I'm just gonna take it off… If you wanna take it off just don't judge, people are gonna come in and out… My dad was happy. My mom wasn't happy, so yeah. It's this just trying to make sense of this huge thing. And, and sometimes not realizing how mentally and emotionally it's actually affecting us." (Aisha)

As described by Aisha, the wearing of the hijab is complicated and certainly not a linear process for many Muslim women. From Aisha's lived experience, it seems that attitudes towards Islamic clothing may vary within family systems.

"There is a lot of Islamophobia I'm aware of that, but I think especially because I'm not at the moment with where I'm at and where I've, I've never been at a point where I've covered my hair, where I've worn hijab or been outwardly like obviously Muslim if that makes sense… I don't think people look at me and immediately know that I'm Muslim." (Inaya)

Inaya makes a key distinction between the visibility of being a Muslim in the UK in relation to wearing the hijab. The participant describes how those who do not wear the hijab in some ways are protected from the immediate visual cues of being identified as Muslim and therefore less likely to experience discrimination.

4.5.1.3 Subtheme: The relational changes with God

The relationship between the participant and God was often recounted during participants narration of their experience as a Muslim with an ED. The theme of attachment was a key component in the meaning-making and understanding of the nature of the relationship each participant had with themselves in accordance with their faith and the ED.

"*I was raised Muslim and when I first became unwell with my mental health, that's when I kind of started straying from Islam and I started questioning things because I ended up with the mentality that how can God put me through this and how do, how, how can a God that*

loves me like kind of put me through these sorts of challenges and that sort of stuff… I wasn't praying at all. I wasn't reading Qur'an. I wasn't trying to educate myself and any situations where religion was involved, I would get incredibly uncomfortable, and I wouldn't want to attend or like I had avoided those situations". (Inaya)

"Like I just feel like it's my fault. Like, you know. Why am I doing this to myself? You know God's gonna punish me now. God has given me so much food and life and I'm, all I'm doing is destroying my body." (Maryam)

Inaya reflected on her religious journey sharing that she is in a different place in her relationship with God following her recovery from the ED.

"The challenges that we go through are a way of drawing us closer to God or a way of erasing our sins and the way to kind of teach us in this life how to get through things, and not a single person in this world goes through life without some kind of challenge." (Inaya)

4.5.1.4 Subtheme: Making sense of a Religious Explanatory Model for EDs

This theme captures an important component in the present study which is to understand possible alternative cultural or religious explanatory models for the Muslim participants with an ED.

One participant communicated how her ED symptoms were explained by her family through the lens of religious ideology.

"So, in Morocco, as you know, black magic is a huge thing there. So, my dad's mom, she also has, she has schizophrenia and BPD... So, we don't really visit her much. So, whenever like that stuff comes up, my dad, like she, she very much, she also believes in like demons a lot and Jinns and stuff like that. And she tells it so whenever my dad tells her about, I don't know, maybe I've self-harmed or something, or I'm not eating. She'll. She'll be like, oh, your daughter's possessed. You know, you need to clean her. And then my mum might think that too. Sometimes she tries to not to show, but then she does get scared. And she might, I

don't know. But one time she brought rose water from Morocco. And like, my grandma brought rose water from Hajj or something like that. And then she'll try to spray on me at nighttime when I'm sleeping." (Maryam)

Maryam describes within her own family system how the influence of religious models of understanding is shared through generations and how this informs her own lived experience of an ED. Her father's mother's own explanatory model not only offers an assertion on what could explain Maryam's symptoms but also the meaning of this being, "you need to clean her" suggesting that Maryam is impure. Maryam goes onto naming the emotion of fear affiliated with this religious explanation.

Maryam describes how it felt for her ED to be associated with the religious opinion of possible *Jinn* possession.

"So sometimes when I do have my anorexia moments or like I might have a BPD rage, my dad would say, oh, you're possessed by Jinn and it's just like, OK, like they, always my mum or my mum will come, and she'll try to rock me to sleep, and she'll start praying for me… On top of my head like, I meant, like I'm possessed and that has been a really huge thing that has like it's impacted me so much like over the past years 'cause I always just feel like, oh, OK, I'm just possessed. Like I'm just a possessed person and I haven't really told my friends that 'cause. I just think it's so, it's so I don't know, it feels embarrassing. It feels it's very niche to my religion. Yeah, my sister has tried every now and then. If my mum comes and tries to pray, she'll be like mum. She's not possessed." (Maryam)

Maryam's account narrates an experience of how religious explanatory models can at times alienate the person who has an ED through the associated shame attached to being considered as 'possessed'.

Another participant detailed her experience of visiting a religious leader who also determined that she was possessed by associating the participant's tendency to purge with *jinn* possession. Again, through the lens of Islamic theology, the religious leader interpreted

her ED symptoms to be a sign of possession encouraging the family to ensure the participant take tablespoons of black seed oil as treatment. For Inaya, she details how the treatment was forced on her but did not feel this was conducive for her recovery.

"Someone religious within the community, they told me that I was possessed because I was purging and, and that was like ohh damn like that was a scary time… then I was told that I'm possessed and I was incredibly unwell at the time being told that, just heightens your anxiety, but also it just brought so much fear into my family because in my family thinking Oh my gosh, she's possessed. Like, do something and being told that you gotta do all these different things. And one of the things being I had to have black seed oil and bearing in mind I have anorexia. I don't think force feeding someone with anorexia tablespoons of oil is the best thing." (Inaya)

Like Maryam, Inaya also shares the fear associated with religious models of understanding. However, religious explanatory models can also offer a sense of understanding. One participant did share how her faith supported her journey towards recovery.

"At times when I felt like none of it makes sense and that this is something that will eventually kill me like I really had huge paranoia around kind of my health when I deteriorated quite a bit a couple of years ago. And that's when I started practicing my religion and I started understanding and applying the core context of it to my life. And it's very important for my eating disorder because I feel like it's been a very strong hold in terms of my recovery and still is." (Aaliyah)

4.6 The experience of Treatment and on the road to Recovery from an ED

4.6.1 Overview of GET

This theme takes into consideration the earlier narration of participants accounts of their social, cultural context and through these lens', understanding how this has influenced their experience of treatment for an ED.

4.6.1.1 Subtheme: The Value of Rapport and Therapeutic Alliance

Building a trusting therapeutic alliance is a key aspect for effective healthcare treatment. This theme narrates how the participants examined and made sense of their experience of interactions with clinicians from ED services.

For marginalised populations, their experience of mental health services often consists of assumptions driven by unconscious biases and blind spots due to missing information leading to delayed diagnosis and treatment.

"My family and all my friends that I knew said, Ohh I'm losing a lot of weight because I'm depressed. That's what it was put down to. And so, when I interacted with service I say yes, I'm depressed. But there was, there was never, like, no one ever asked. It was. I only said that because that's what everyone else told me, so I was never actually asked what's going on, and I felt like everything was just so staged for me." (Aaliyah)

A major part of treatment is the meal planning and management of eating behaviours. One participant recalled working collaboratively with the nurse to develop suitable meal plans as a valuable contributor towards her commitment and engagement to treatment for her ED.

*"I would just say, look, I, I can't eat that food or, you know, I'm scared or, you know, in things like. And she never dictated to me what to eat. That was that was another thing that was really different about it. She never said no… eating things that I knew I could manage, rather than having these ideological meal plans, I never would bother with." (*Aaliyah*)*

Aisha shared that she received an overall number of seventeen psychology treatment sessions during her time with the community adult ED service but explained how over time she became more at ease to speak on personal topics.

"I literally just used to cry the whole time and not even about anything. But then slowly you get a bit more. Umm. Comfortable with like speaking and stuff." (Aisha)

"I never realized until it got to that point that I actually was getting therapy from a Muslim woman, that that was actually very important to me… she really really helped me because not only did she understand like my identity, my faith, etcetera, but she was very soothing in terms of, you know, you're not a bad Muslim if you don't fast and that your health you know is the main thing. But if it's something you want to do, then you know you have to go on the recovery journey and you know, she obviously gave me lots of advice and tips and strategies to do that. I just felt like, I felt really comforted and at the same time I felt like my treatment was resonating with who I am and not just being treated as someone with, you know, the diagnosis of AN and all of those, all of that stuff that I've had for years, I felt like I was being seen for me." (Aaliyah)

Religious commonality between therapist and patient can be valuable in promoting a safe, nurturing therapeutic bond. This type of alliance can further support conversations around exploring the types of difficulties Aaliyah was experiencing in relation to her poor sense of self as a Muslim with an ED.

4.6.1.2 Subtheme: To disclose or not to disclose: Mentioning Islam during Treatment

This subtheme considers the impact a perceived lack of understanding of Islam or lack of cultural awareness from services can have during treatment for Muslim's with an ED.

Participants narrated that the perceived lack of understanding seemed to be projected through an avoidance in clinicians around asking questions that explore this part of the participants identity.

"They don't ask about the family and the family has a major impact, you know, are you religious? You know, are you religious now or were you religious at any point in your life, where you brought up religious?... Do you want to be religious? You know, it's just I think it was just so bare minimum. Like, are you religious? Are you practicing right now?... if you don't have

these conversations, you're ignoring the fact that actually someone's faith in religion has an impact on their recovery, on their mental health, on the way that they view things, their perception of things, umm the way that their family interact with them and view the diagnosis as well." (Inaya)

There was also a felt sense of burden to educate the care team placed upon participants when there was a lack of understanding within the service.

"That person doesn't have any understanding of, like, your faith or your race or your ethnicity or your upbringing or your culture. That can be a barrier, because then I find myself like I find myself kind of focusing like on trying to explain, for example, why I can't have these conversations with my mom. Because that's not what we do in our culture… it would be nice if we could match up the clinician with the service-user and have some kind of mutuality in terms of other race or faith, or, or something". (Inaya)

Another participant similarly shared

"There are rules and regulations in place because of religion… people don't understand why they're there and then they just could take it wrong and I'm not the best person to educate. So, I'd rather just not speak on it." (Aisha)

The lack of knowledge and understanding can have a substantial impact on the quality of care received. Participants explained that if clinicians were to bring religion into the conversation it may have influenced the motivation to disclose more in relation to this part of their identity during treatment.

Aisha described her experience in receiving treatment from a white Christian therapist and how with the support of her therapist, she was able to make sense of the impact her religious identity had on her ED.

"She was Christian, but she was, she used to use herself as an example like because, but it's different when in a Muslim household, you've got a lot of pressures because she didn't really understand. She didn't really understand how I could still be living at home at this age and it's not like, it's a different pressure." (Aisha)

Whilst there was a lack of understanding in the nuances of culture, Aisha found her therapist to be supportive in bringing up topics of religion and related this to her therapist's own lived experience and social interactions.

"She said she grew up with like a large South Asian community. She said she knew, she had friends and stuff like that. She knew what, how South Asian families and community's work. So, she had a lot of experience about that… I wouldn't have probably even opened up about religious side because a lot of people just don't understand. It will. Umm. Somehow it worked because she had that knowledge. It was a lot easier for us to, like, talk about that. Yeah, that helped a lot." (Aisha)

It is key to note the value of therapists using their position to bring the topic of religion into the therapeutic space. Participants show a reluctance to bring this part of their identity into treatment, however, despite this recognised its relevance to making sense of their own lived experience of an ED.

"I mean, I would, I think it would be amazing if someone would speak to me a bit more about Islam in, in the therapy I'm receiving right now." (Maryam)

"I feel like, I needed my faith at that time, but no one guided me back towards it, but also in the same breath, that's not mental health services like role to do so, but I think I would have benefited massively if that discussion was had and if someone had the ability to kind of question, OK, well, your family is, you know, religious, quite practicing. You were brought up Muslim. Why did you like kind of go away from it? Like, you know, not necessarily to kind of push me either way, but maybe just to get a better understanding as to why I stopped practicing." (Inaya)

During Inaya's treatment, she describes a sense of disconnection from her family and her faith. Perhaps due to Islam and cultural being deeply conflated within her family system and therefore difficult for her to disentangle. Consequently, Inaya may have felt entirely alienated by both parts of her identity.

Despite Inaya saying that she felt she needed her faith during treatment, she ultimately makes the conclusion that it was perhaps not the role of the service to help her to reconnect with Islam. Subsequently, her identity as a Muslim and relationship with God was not mentioned or explored at all during treatment but she reflected during the interview on possible areas that may have been valuable for her to have explored, such as the reasons why she stopped practicing Islam and what this meant in the context of her wider family system who were still closely practicing Islam.

4.6.1.3 Subtheme: The challenges in Cultural Familiarity between Clinicians and Patients

This theme captures the challenges ethnic and racial identity has in a healthcare setting and how this can influence participants' experience of treatment.

Participants recounted the lack of ethnic and racial representation with healthcare staff teams.

"I went to my GP and my GP was a white middle-aged man and I said I need some help. I think I have it. It was so uncomfortable, but I said I think I have an eating disorder and he looked at me and he put me on the scales. That's the first thing he did. It was such like to this day I have PTSD from then." (Aaliyah)

"*The, the, the services for eating disorders are predominantly white, and all the therapists I've had are all white males. I've had some females, but they're all white and there's no one ever coming from a Muslim background. I've, even in CAMHS, I've never seen anyone in CAMHS coming from a Muslim background*." (Maryam)

"*So, look, my dad said, my dad would prefer, like, if there wasn't, like, anyone who was Muslim helping me because he doesn't want the embarrassment to come with it from his side*." (Maryam)

Within this extract, there was the naming of the emotion 'embarrassment' as a key marker for how the participant made sense of her father's attitudes towards help-seeking, specifically receiving help from within the Muslim community. Certainly, stigma within communities can stir up uncomfortable emotions of shame and embarrassment.

4.6.1.4 Subtheme: The Inaccessibility of ED Services: Neglecting our Needs

This subtheme provides a narration of the participants' account of their experience of services. The participants reported services mostly being inaccessible and neglectful of their cultural needs.

"*The fact that you are South Asian you are just flagged with so many biases and further named one assumption is that healthcare professionals assume because they're Asian, that this lifestyle they won't change*". (Fatima)

"You know, having to say the right things, having to turn up and, you know, be who they want you to be. And that was just draining… It was never me in, in the whole treatment plan. It was just what everyone else was saying. What everyone else thinks, and we just going along." (Aaliyah)

Identity felt important to the participants. Another participant added the value of choice when she moved from CAMHS to an adult outpatient service.

"*I, I absolutely hated being an inpatient. So yeah, like outpatient, it's been really like. Nothing's been too pushy, so when I used to be in CAMHS, it was a bit more, obviously, it was a bit more strict, so I would have like meetings every week. Oh God, it was just. It was just hard. Like I, I, I personally, I just didn't like my CAMHS experience.*" (Maryam)

Inaya's recalled her experience of treatment to be heavily focused on weight management and there being an absence of focusing on addressing the anxieties that come with dietary plans, mealtimes and culturally specific challenges in eating particular types of

food. Her opinion being that they neglected to treat the ED by overly focusing on one aspect: feeding.

"They didn't actually treat the eating disorder, they just fed me up and discharged me. […] Treatment focuses so much on dietary plans and this and that without acknowledging how much anxiety there is around like Bangladeshi food for example." (Inaya)

Furthermore, Fatima shared her experience of using the translating services and was asked whether this helped with improving access to an ED service.

"*100% it was not accessible, to be honest, even you know you can use that language line for translation. Yes, despite translating, they are not health care professional themself. So, the way they translate is approximate… If you cannot have a fluent conversation with a health care professional or even a basic conversation at this point with a healthcare professional everything, every sort of care that we receive is being in approximate care*." (Fatima)

Fatima names a key limitation to the use of translation services in healthcare settings, in that she illustrates the nature of the support offered to be 'approximate care'. The use of 'approximate' to describe her experience conjures up a sense of estimation and the care therefore seeming subpar in nature. This is an important distinction in the quality of care provided for English speakers compared to non-English speakers. As Fatima goes onto explain, certainly if there is the absence of 'fluent conversation' there is a risk of losing meaning within the communication and an increased risk for misunderstandings to occur, and assumptions and biases to play out during treatment.

A final point was the failing to not attend to the different parts of an individual's identity impacting access for minoritised groups.

"I do think that a lot of Muslims feel alienated even at the point of accessing the service themselves…if we're not having these conversations, we are almost like icing them out from seeking help." (Aaliyah)

4.7 The Hope for Future Change in Treatment Services

4.7.1 Overview of GET

This theme captures participants' own account of their reflections on what services could change for quality improvement from their own experiences of treatment and recovery. Much of the recommendations were drawn from participants own experiences of what they felt could have been beneficial to them at the time of treatment.

4.7.1.1 Subtheme: Drawing on Peer-Support for recovery

Earlier themes examined the impact of lacking awareness and the lack of cultural, religious representation in services had on participants during treatment. This sub-theme speaks to addressing this gap but suggesting the value of offering peer-support to Muslims with an ED as an option.

"*A Muslim support group that would have been good… just hear different religious views… how people navigate religion in the UK, basically that would have been good… it will be, they'll be nice to like, see, to talk to other people." (*Aisha*)*

"*I guess, like it would be a bit more easier to, to talk about it. Like when you're all within the same community."* (Maryam)

To further add to the idea of peer-support, one participant also noted the value of improving awareness within the Muslim community by encouraging more open conversations, this perhaps could help to destigmatise mental illness.

"*It just should, like I don't know, even like within, Muslim communities, it should be talked about, perhaps like a lot more. There are some Muslim communities like, or charities, that try to combat depression, for example. You know, general mental illnesses like that, but like, not really. It's never. It's never eating disorders."* (Maryam)

Maryam emphasises the importance of building a sense of community for those living with an ED. This may be related to factors mentioned earlier, such as the experience of being

a Muslim with an ED as feeling shameful, the felt sense of social isolation and minimisation, therefore peer support as a means of providing safety and comfort through shared, mutual experiences. This may contribute towards the process of validating an ED as not just a 'made-up' illness and challenging cultural tendencies to 'brush it under the carpet'.

4.7.1.2 Subtheme: Empowering Staff Teams

This theme captures the participants emphasis on the importance of staff teams being skilled to work with minoritised cultural and religious groups.

"They just need some sort of little bit of education about the different religions." (Aisha)

"*To have some understanding cultural awareness, explore identities. If they're uncomfortable about speaking about religion and things like that, maybe try and give them that training to help them understand how they could speak about it… If they're going to do training awareness, they must, absolutely must do it with a cohort of people that have been in treatment to understand, not something that they're gonna learn from a textbook."* (Aaliyah)

4.7.1.3 Subtheme: What Positive Change could look like for ED Treatment Services

This theme accounts the recommendations from the perspectives of the participants for services to consider. The quality of care must be carefully thought out for ED patients of a Muslim faith background.

"When they do the letters, the clinic letters, they send a copy to your GP and then you get a copy. So, I can't remember the whole cause so many years ago, but I clearly remember this because again to this point I never made me so self-conscious. But she said patient arrived in clinic today, looked well, blah blah, blah, wearing very thick black eyeliner… I never, ever wore eyeliner to the, to her appointments again, and I don't know what that was about, but it made me so self-conscious.… I've got quite big eyes and I feel like when I lose weight

you my eyes get really hollow and sunken and it's really noticeable… So that it was kind of masking, you learn, you know you learn, how you could appear bigger or distort, you know, that kind of thing… maybe that's the lesson for services to learn as well about how they were writing their letters and to be sensitive." (Aaliyah)

In recent years the appropriateness and accuracy of using the Body Mass Index (BMI) as a measure of a person's health calculated using height and weight has come under question. Many ED services rely on the BMI measure to determine the physical health status of a person with an ED.

"*We want to scrub this out because BMI it doesn't really say the truth about yourself*." (Fatima)

Moreover, self-reported measures are routinely administered across all mental healthcare services and a form of assessing the status of a person's mental or physical health. However, perhaps greater care could be taken when requesting patients to complete these questionnaires as mentioned by one participant.

"Sometimes some questions are not appropriate. Or, you know, you need to take things like. So, let's say more like baby steps… You just need to be in uh, with a clinician answering the question maybe, and ask you that is because it seems to be a tick box. You know, all the background information for some people to open up, for example, I never share these kinds of things." (Fatima)

Finally, one participant recommended better promotion of health-related knowledge and a possible helpline.

"Like at least even posters like, there's no posters in, in the clinics I go to for like, you know, I don't know, from, even like I know be an uploaded article about Ramadan, but that was it. Like, there's just nothing else to do with it. Like there should be a helpline, perhaps specifically for Muslim people perhaps and eating disorders or mental health illnesses in general. But there's no help lines. I think that would be great." (Maryam)

Chapter 5

Discussion

5.1 Chapter Overview

In this chapter, the findings of the current study will be discussed in relation to the research aims, the existing literature and relevant previous studies and psychological theories. Clinical implications and future recommendations will also be discussed.

5.2 Overview of Findings

The participants described how their context such as gender, ethnicity and faith impacted their experiences of accessing eating disorder (ED) services for treatment. Their accounts certainly highlight the different aspects of their lived experiences of an ED that were left unexplored during their time in treatment and the significance of this for recovery. For instance, participants shared the cultural and religious explanatory models of understanding mental illness and EDs and how this influenced their interactions with family members, in that this subsequently created a dissonance between themselves and loved ones. Participants shared in detail the pressures from the value of thinness, and the impact the ED had on their perception and relationship with God and their practice of Islam, such as the challenges faced in the month of Ramadan during treatment.

Moreover, participants spoke of the differences in being non-visibly and visibly Muslim due to their choice to wear the hijab and what this means for them as a Muslim in the UK. Participants linked their identity and social context to their choice to disclose these experiences to their therapist during treatment, some opting to stay silent, sharing that they feared being misunderstood. Those who did discuss their Muslim identity in treatment reveal

experiencing a positive shift towards making sense of how Islam and culture may have informed their perception towards themselves in relation to their ED.

In the context of wearing the hijab, key themes surfaced, one being female and Muslim and this relating to issues of gender and power. The participants communicated overcoming the pressures of expectations placed on them as women and navigating cultural and migrant family systems whilst in treatment. Participants also shared one barrier to their recovery during treatment being the fear that God would not forgive them if they did not fast during Ramadan. Finally, participants drew from their own lived experiences of services and offered gifts in the form of what future change in services could be. The women spoke on the value of offering Muslim peer support groups, and empowering staff teams by upskilling them in the field of religious and cultural knowledge to help improve service accessibility and build trusting therapeutic alliances with Muslim patients accessing treatment for an ED.

5.2.1 Individual Findings

There were a number of similarities across the accounts which were identified within the GETs. However, it is important to acknowledge that each participant bought individual, nuanced elements of difference and perspective to the topic of interest (See Appendix M).

Maryam spoke much about her experience of the differences in the cultural perceptions towards her ED when she was in Morocco compared to when she is in the UK. She shared the value of thinness in a Western context, which contrasted with the shaming she experienced in Morocco towards her visibly thinner stature. Maryam was the only participant to name the role of social media and shared that she would only ever see white women with the disorder on social media platforms which triggered her to think that she was a ‘bad Muslim’. At the time of the interview Maryam was in treatment with an adult community ED service and shared that she hoped someone would explore her identity as a Muslim with her during treatment.

Inaya explored her experience of having a therapist who she perceived as someone that may not understand her experience of being a Muslim with an ED. Inaya named the perceived lack of cultural familiarity between herself and her therapist as a barrier for her recovery during treatment. She described how she would often opt out of disclosing elements of her context during treatment from her worry of being misunderstood. Inaya further explained how she made sense of this, stating that it is already emotionally demanding to talk through what had led to her developing an ED and that there is an additional burden in then having to explain to a therapist the significance of faith and culture within this. Most significantly, Inaya shared that she felt had her culture and faith in relation to her ED been explored during her time in treatment, she may have recovered sooner.

Fatima provided an account of what is it like to be a first-generation older adult migrant, and a non-English speaker receiving treatment for an ED in the UK. Fatima shared the difficulties in navigating the cultural and social differences, and the challenges in communicating her needs which were often neglected by clinicians. For instance, gender sensitivities were not always respected, assumptions in her inability to adhere to treatment such as meal plans were made, and issues of confidentiality violated where personal, sensitive health related information would be shared by clinicians to her in the presence of family members who were able to understand English. Fatima also shared how exclusionary stereotypes for individuals with an ED are, in that older adults were not typically considered to suffer from an ED which she felt was unhelpful in making treatment feel inaccessible to her and that these attitudes needed to change.

Aisha emphasised the cultural and interpersonal challenges she faced in having an ED and being Muslim during her journey towards recovery. Aisha spoke of how her therapist aider her recovery in supporting her to make sense of her relationship with her faith and ED. For example, she recalled her therapist identifying that she was not forgiving herself, Aisha adding that she made sense of her inability to forgive herself being related to her fear that God would not forgive her. Aisha also spoke on how including her family in therapy was not helpful.

She shared that her family better understood and accepted her experience through the lens of culture and Islam. However, as Aisha moved closer towards her recovery, she described her journey towards better understanding her relationship with God and her illness, which was where she came to her own realisation that her family were perhaps misled in their understanding of her ED, sharing that their perceptions was more informed by cultural beliefs rather than Islam. Aisha detailing how some of these cultural beliefs towards mental health can be stigmatising and shaming.

Aliyah reflected on her identity as a mother with an ED. She spoke about her experience of being praised in losing weight so quickly after the birth of her daughter and perceived this to be problematic by recognising that her weight loss was a result of having an ED. Aliyah made sense of this by explaining how thinness is often associated as a signifier to good health and wellness which she added was far from her reality at the time. Aliyah shared the guilt she carried in her identity as a mother who was severely unwell, and that eventually it was her identity as a mother that gave her the strength to engage in help and work towards recovery. Aliyah also spoke highly about the significance of having a Muslim therapist who supported her in disentangling the misconceptions she held towards her faith and culture which helped her towards recovery.

5.3 Relevance of Findings

In this section, the findings from the current study will be discussed in relation to the systematic literature review, the wider literature and the socio-political context of Muslims in the UK.

5.3.1 Islam and Eating Disorders

One key perspective that informed the research was attachment theory (Ainsworth et al., 1978). The present study findings were consistent with the wider literature on EDs in

relation to attachment styles, and religion (Latzer, Hochdorf, Bachar, & Canetti, 2002). Participants reported anxious, avoidant attachment styles with God during their time in treatment, for instance describing a fear that God would not forgive them if they did not fast during the month of Ramadan due to their ED. Attachment theory provided the researcher a framework to make sense of the changes in relational pattern's participants experienced during and after treatment. Most of the participants reported a secure attachment with God when in recovery, consistent with the wider literature in this area of research (Latzer, Hochdorf, Bachar, & Canetti, 2002). Attachment theory provides a contextual perspective on adult functioning and a backdrop to better understanding the patterns across time for an individual's relationship to caregivers and God, God perhaps taking the position of a parental-like figure.

Furthermore, the present study also portrayed the theme of the pressures that arose from the cultural values of thinness in Western societies and how this intersects with an ED and Islam. Previous studies have indicated the substantial role body image plays in the development and maintenance of an ED (Wilhelm et al., 2018). However, in the context of religious women and specifically in relation to the wearing of the veil, the significance of religious body covering and ED symptomology such as body checking and negative body-image cognitions can be important to consider in treatment (Wilhelm et al., 2018). One participant in the present study acknowledged that body checking became an issue during Ramadan where her family would check their weight before and after a religious fast, which may be understood as reinforcing the social value placed on the restriction of food in relation to achieving thinness, but also that this idea relates to the behavioural compulsion to check. Body checking in EDs can be defined by the behavioural component of checking the physical appearance of the body or body parts, the comparison of one's body to another person's, weighing oneself or pinching body parts as a common form of checking (Mountford, Hasse & Waller, 2007). These strategies of checking are usually related to the individual assessing their weight, shape or size and are often compelled by or reinforce negative body-image cognitions (Mountford, Hasse & Waller, 2007).

In the context of Muslims, one study revealed that unveiled Muslim women reported more body checking than veiled Muslim women (Wilhelm et al., 2018). In Islam, the wearing of the *hijab* (veil) symbolises religious duty, and for some includes gaining respect and sense of identity, but also the concealment of body parts as a method of averting sexualised gaze (Wilhelm et al., 2018). Swami and colleagues (2014) found that when controlling for religiosity, British Muslim women who wore the *hijab* had more positive body image and placed less importance on appearance than women who did not wear the *hijab*. The difference between veiled and unveiled women in Islam is important, as many Muslim women cover their bodies, but this varies in degree of body concealment (Swami et al., 2014). Much of the current body of work not only relies on small sample sizes, but also the use of the *hijab* not measured consistently, making cross-study comparisons challenging (Swami et al., 2014).

Moreover, attitudes towards veil and unveiled women within the Muslim community may vary. For instance, one participant in the present study disclosed the pressures of unveiling, explaining that she was not supported entirely by her family in wearing the *hijab* and during treatment she decided to stop wearing the *hijab* entirely. Perhaps her family system may have reinforced internalised Western standards of beauty, that being unveiled is the social norm in a Western context for women where there is an over emphasis and value placed on female physical beauty (Mahmud & Swami, 2010). One study investigated the attitudes towards physical attractiveness and veiled compared to unveiled women, revealing that men perceived unveiled women as more attractive than veiled women (Mahmud & Swami, 2010). However, the relationship between ED, self-image and the veiled versus unveiled Muslim is complex in nature. The visible component of being veiled presents many challenges for Muslim women when navigating islamophobia and desirability. In a social context, it could be argued that Muslim women may assume other people perceive them to be more attractive when unveiled compared to being veiled as this represents assimilation and acculturation into Western society.

In the presence of an ED, from interpretation of the participants accounts the researcher suggests that the veil and body covering may have a dual role. The veil holds religious meaning and significance but can also be used to disguise the physical effects of the presence of an ED. Participants disclosed that it was easier to conceal the ED due to the cultural norms of body covering in the Muslim community. Nonetheless, it remains unclear whether the veil is a protective factor for Muslim women or to be considered a nuanced issue. Ultimately, the self-objectification present in ED pathology must be better understood in relation to the differences of a *hijab* wearing Muslim compared to a non-*hijab* wearing Muslim. Better understanding these differences can inform clinicians on how to support emotions or cognitions related to body covering, body checking and body dissatisfaction during treatment for Muslims.

5.3.2 Feminism, Islam, and Eating Disorders

The present study sample consisted of entirely female identifying participants. Maryam described the power differences she experiences as a woman, stating that men are free to do as they wish. All participants spoke about navigating the pressures and expectations they face as women within their own community stemming from marriage to religious clothing. Participants stating these factors impacting their sense of self and journey towards recovery.

These power differences within the religious and cultural field may reflect what some Western feminist scholars have historically argued is that religion as an institution inherently embodies the patriarchal world (Pope, 2012). The debate of religious institutions as playing a key role in upholding patriarchal values often considers religion to be a powerful social and political tool in the building of the obedient, domesticated female ideal which has long oppressed and controlled the autonomy of women (Pope, 2012). Secular societies often consider religion as holding outdated views with regards to the traditional role of men and women, where women are oppressed and belittled (Pope, 2012). The idea of religion

upholding patriarchal values may risk excluding religious women from modern feminist dialogue. This theoretical perspective perhaps offers insight into why the participants found themselves working on disentangling cultural and faith-based understanding of gender roles during treatment.

Islamic feminists have pushed back in arguing that culture and the socially constructed model of patriarchy has often influenced the interpretations of key religious texts (Barlas, 2002; Pope, 2012). In the context of Islam, scholars have argued that the Qur'an does support gender equality, and that Islamic law is more fluid and flexible than what most secular societies may assume (Barlas, 2002).

There has been a growing interest in gender and Islam, where scholars have questioned the issue of Muslim female agency in society and the differences of interpretations that can be drawn from key verses in the Qur'an (Barlas, 2002). Islamic feminists argue that Hadiths have long been authored by men and consequently, patriarchy read into the religious teachings and subsequently distorting these teachings (Barlas, 2002). Moreover, academia also plays an important role in the construction of the oppressed Muslim woman and thus re-enacting the colonial tendency to assume that Muslim women are dependent on Western societies for their liberation and freedom, further assuming Islam as a religious institution requires reformation and modernisation (Pope, 2012). The researcher argues that this position conveniently abandons the role modern societies have played in their own systemic oppression of women, failing to acknowledge the values placed on idealised standards of female physical beauty. For instance, one participant makes the distinction between the cultural differences in beauty standards between Europeans and Arabs, where she was praised for her thinness in a Western cultural context.

5.3.3 Socio and Political Context for Muslims with an Eating Disorder

The theory of intersectionality is a powerful critique that arose from exclusionary mainstream feminism (Crenshaw, 2005). The term intersectionality derived from the discipline of critical race studies in the 1980s and refers to the interaction between multiple layers of oppressive systems such as race, gender, and class (Crenshaw, 2005). During this time, the prominent example used to demonstrate the complexity of race in America was the idea of law holding a position of neutrality. This accepted illusion of colourblind policies was challenged through critical race theory as law often had unequal outcomes for marginalised racial communities and identified the racial inequalities persisting in the United States post-civil rights (Crenshaw, 2005). When we consider intersectionality, it creates the space to recognise the complexities in people's lived experiences.

Islamophobia as an ideological phenomenon has increasingly come under investigation (Qureshi, 2020). Post 9/11 there have been undeniable displays of overt islamophobia rooted in racist ideology (Qureshi, 2020). Moreover, Layton conceptualises the theory of Islamophobic normative unconsciousness, where these processes can be enacted within clinical spaces where both the patient and therapist unconsciously collude with upholding norms that may be contributing towards the psychological pain (Sheehi, 2019). This theory may provide one perspective in making sense of the possible underlying forces at play for participants' during treatment.

One participant noting that she found herself conforming to playing the good patient role when faced with a therapist who did not acknowledge her cultural or religious context, reporting that this experience only led to her continuing to be trapped in the vicious cycle of her illness. The participant stating that it was only until she was freed from the felt sense of judgements and her identity as a Muslim was acknowledge by another Muslim woman, that she was able to fully engage with treatment. Perhaps there is a necessary sense for safety and trust required to build a trusting therapeutic alliance, and if efforts are not taken to ensure this secure grounding exists then this may show through poorer treatment outcomes. When we consider the intersectional factors that impact the experience of Muslims receiving

treatment for an ED, there is the presence of performing the 'good patient' alongside the 'good Muslim', and the 'good woman', whilst also masking the presence of an ED to seem in 'good health'. If the clinician is to meet the clinical needs of the patient, then these layers require acknowledging and unpacking.

Whilst recounting the lived experienced for each participant, there is a reality of oppression that exists in the undercurrent to their narrative that impacts their experience of receiving treatment for an ED. For example, the researcher drew from the theory of gender performativity to make sense of the participants' accounts (Butler, 2004). Butler originally states that the gendered body is already and always constructed by gendered discourse and individuals perform through the repetition of acts to uphold the illusion of gender roles (Butler, 2004). This concept of performativity can be applied to other social constructs, such as racial performativity, where religious or cultural minorities are expected to continuously self-craft in-line with Western cultural norms in order to assimilate (Chadderton, 2018). This arguably becoming a never-ending process of self-regulation, a self-regulation that perhaps plays out during treatment and may delay the progression towards recovery in the context of mental illness if the power difference is left unaddressed. One participant stating that when she travels back from Morocco to the UK, she must 'switch off' her religiosity to assimilate into the British context. It may be a part of the participants reality that if there is a perceived sense of judgement from the clinician or lack of understanding, this may consequently increase the individual's attention and preoccupation to the differences in identities, causing the individual to adjust themselves as best as they can to satisfy the social status quo that these norms and standards represent.

For Muslims this adjustment to fit the standards of Whiteness is not always possible, as one participant named that wearing a *hijab* comes with its own preconceived ideas and judgments that are inescapable. As mentioned before, in a post 9/11 climate, Muslims have been systematically racialised into bodies who present as a threat and dissent from Western values and ideologies (Qureshi, 2020). In the same way gender is a construct originating from

patriarchal gendered discourses and repetition of acts (Butler, 2004), racial identities similarly do not simply exist as a biological fact, but rather function though performativity of repetitive acts and social discourse (Chadderton, 2018). Specifically, for minoritized racial bodies, to have any sense of agency and movement within Western society, they must tend to the standards of Whiteness (Chadderton, 2018). Therefore, in healthcare settings, clinicians who represent those norms of Whiteness may unconsciously bring this into the therapeutic space and those who fail to actively dismantle these socially constructed borders, further reinforce the oppressive function it serves for the racially marginalised body and risk alienating the patient during treatment (Sheehi, 2019).

5.3.4 Culture, Religion and Eating Disorders

A key theme in the sense making of the participants' experience of receiving treatment for an ED was the reported intersection of culture and religion. The participants described experiences where religion was often diluted with cultural misconceptions and these misrepresentations at times harming them as a result. Participants acknowledged the role Islam had in their recovery, but also recognising the influence culture and faith had in the development and maintenance of their illness.

Many clinicians of the dominant culture do adjust for the cultural and religious needs of the individual in treatment as evidenced by participants in the present study. For instance, one participant stated that her therapist disclosed to her that she has friends who are of a South Asian, Muslim background which meant that she understood some of the contextual factors the patient was bringing into the therapeutic space. This knowledge allowed the therapist to be able to gradually unravel the intertwined layers of religion and culture to then treat her ED. The patient recognising that she would not herself have brought her religion into the therapeutic discussion had the therapist not done this herself, the participant further relating this to an assumption that people outside the boundaries of her religious and cultural

context would not understand. The researcher interprets this as the cost of being misunderstood may feel far too high for some minority individuals. The fear of harm being done from judgement and misrepresentations of Islamic culture can be observed through the level of disclosure a clinician receives from their Muslim patient.

One area of disclosure that was withheld from treating clinicians was the explanatory model of the ED as indicative of spirit possession for some participants. The idea of spirit possession comes with a long historical legacy and certainly not unique to Islam, where similar beliefs in spirit possession and its attribution to mental illness are held in Hinduism, Buddhism and Judaism (Dein & Illaiee, 2013). The Quran refers to *jinns* (spirits) as having the ability to shapeshift and teleport and some religious scholars accepting the possibility that *jinns* can possess people (Dein & Illaiee, 2013). A Muslim's misfortune or illnesses can often be attributed to *jinns* and it is believed to have potentially disastrous effects on human health and behaviour (Dein & Illaiee, 2013). Some of the common signs and symptoms associated with *jinn* possession may be impairment of consciousness, auditory hallucination, difficulty in controlling impulses in words, deeds, and movements (Guthrie, Abraham & Nwaz, 2016; Dein & Illaiee, 2013). Individuals can protect themselves from *jinn* by prayer, fasting and forbidding wrong (Guthrie, Abraham & Nwaz, 2016; Dein & Illaiee, 2013). However, for some, if there is a possible sense of *jinn* possession, they make seek help from traditional healers to provide a confirmation of the presence of a *jinn* and then subsequent religiously informed advice and intervention (Dein & Illaiee, 2013).

Much of the available research focuses on *jinn* possession associated with psychotic related disorders, however the present study suggests clinicians must not assume the belief of *jinn* possession as exclusive to dissociative disorders. Moreover, there is a culture associated within Muslim communities where Islamic theology and teachings on *jinn* possession and its affinity with mental health are received differently between generations (Guthrie, Abraham & Nwaz, 2016; Dein & Illaiee, 2013). Participants reportedly felt that their families did not understand the ED and in one case the family finding it easier to accept *jinn*

possession as more plausible over the mental illness. There is a sensitive difference between culturally sanctioned beliefs and psychiatric symptoms, and as shown the in the present study the generational differences in the acceptance of religious explanatory models of mental illness. The participant's treatment did not address the experiences of the family's perception of EDs and consequently failed to acknowledge or explore the experience of receiving faith-based advice and intervention.

Another aspect that surfaced from the participants' accounts was the interaction between culture and religion, and the cultural shame that occurs when mental illness effects an individual's ability to attend to their religious duties. Participants reported an 'ignorance' and stigma towards EDs and therefore receiving minimal support from family member or carers. The involvement of carers in the treatment of an ED for an adult population is understandably complicated and often reliant on individual needs and preferences. Carer involvement and support is typically encouraged within treatment guidance, however in a minority context, clinicians may need to be sensitive to the potential barriers (Wales, Brewin, Raghavan & Arcelus, 2017). One study conducted in the UK reported older South Asian members, particularly those not born in the UK were more likely to not recognise or less aware of EDs, compared to younger generations or generations who grew up in the UK (Wales, Brewin, Raghavan & Arcelus, 2017). Further studies revealed that South Asian females in the UK from traditional homes who are least integrated into British society reported a higher prevalence compared to their White counterparts of bulimia and disordered eating attitudes in adulthood (Anand & Cochrane, 2005; Dolan, Lacey & Evans, 1990; McCourt & Waller, 1996). The study also revealed the positive view of thinness held, lack of knowledge on the seriousness of EDs and concerns related to confidentiality being barriers for help-seeking for an ED in a South Asian population sample (Wales, Brewin, Raghavan & Arcelus, 2017), this consistent to the themes reported by participants in the present study. It is important for services to consider the barriers that migrant and religious minority populations may experience in the UK when help seeking.

Similarly, Hoque (2011) found that culture and the role of the family belief system intersected with ED presentation and help-seeking behaviours. Both the present study and Hoque's (2011) study found the "value of thinness" to be a common theme reported by participants. In Hoque's (2011) study, this was associated with ideas held within British South Asian society, whereas in the present study, it was associated with both minority culture and Western values of thinness. In addition, there were similarities in the findings, as participants in both studies reported that family systems often valued more culturally familiar interventions, which were typically spiritual and religious-based approaches to the treatment of EDs, over mainstream mental health services. Moreover, both studies reported family dynamics as a factor impacting participants' experiences of receiving treatment for an ED.

Participants in Hoque's (2011) study described family therapy as appearing counterproductive to recovery from an ED. Similarly, in the present study, participants reported that the involvement of family members during therapy had a negative impact on the recovery process. Hoque's (2011) study provided valuable insight and context into factors that may influence help-seeking behaviours and delays in accessing treatment for an ED. One such factor identified was the family's response to the ED, which included a lack of acknowledgment, denial, or refusal to accept the presence of the disorder. This response may reinforce the function of the ED, such as serving as a form of regaining control and coping with difficult family dynamics (Hoque, 2011). However, novel to the present study is its focus on the experience of receiving treatment for an ED through the lens of religion. Despite the significance of Islam as a marker of minoritised difference in their lived experience, participants reported that their identity as Muslims was often overlooked by clinicians during treatment, and they detailed the impact this had on their recovery. Furthermore, the present study provides insight into the challenges of receiving treatment for an ED as a non-English speaker, emphasising the importance of better meeting the needs of individuals who require a translator.

5.4 Clinical Implications and Treatment Recommendations

5.4.1 Cultural Competence of Services

One approach to address the treatment gap is offering staff training and regular networking to increase clinicians understanding and awareness on topics such as religion. Over the years the NHS has been criticised for its lack of cultural appropriateness, impacting help-seeking and responsiveness to treatment interventions (Cowan, 2009). In response, cultural competence has become a buzzword in healthcare practice in recent years. Cultural competence is a term that is typically associated with institutions seeking to address the challenges that arise from increasing cultural diversity (Cowan, 2009). Within mental healthcare settings, many acknowledge that current systems in the UK do not meet the needs of culturally minoritized individuals and the ongoing culturally blind treatment practices have contributed towards longstanding health disparities (Cowan, 2009; Kirmayer, 2012).

In the present study a link between religion and culture was made by participants, the question on how to achieve culturally informed care still requires thought. Cultural competence within services is a term used to describe the aim to make health care systems more accessible and provide better quality of care to individuals who bring a diverse set of beliefs, behaviours, and values (Cowan, 2009). To reach cultural competence services are expected to offer tailored treatment to meet patients' social, cultural, and linguistic needs (Kirmayer, 2012). For instance, one participant shared a positive experience of a clinician who was non-Muslim however was familiar with the cultural and religious expectations placed of female Muslims which helped to build a trusting rapport during treatment but also created a curiosity around how this may have impacted the participants own sense of self in relation to their ED. Whilst there are positives in considering cultural competence in practice,, there are limitations. For instance, it seems that holding cultural knowledge as an 'outsider' and applying this clinically is a complex skill that perhaps requires training and practice in a clinical setting. The risk could be that patients feel singled out, stereotyped or scrutinised if met with a cultural

'outsider' attempting to role model cultural competence (Kirmayer, 2012). Patients may also wish for psychological distance from their own community or prefer privacy (Kirmayer, 2012). Cultural competence in some cases may be superficial if causes of the causes are not being acknowledged or there is a lack of effort to address them, such as systemic oppression or institutional racism as the contributing factors in health disparities (Douglas, 2016).

Furthermore, on an individual and services level, movement towards working in partnership with Muslim community leaders, families, and peers to support with quality improvement of treatment delivery and the offer of culturally competent care could encourage positive change. This approach may also provide opportunities to gain insight into the contextual needs of the community.

Another theme from the present study was the suggestion of culture matching of clinicians and patients in mental healthcare treatment. An earlier meta-analysis revealed that cultural matching of therapists with patients does not influence treatment outcomes (Cabral & Smith, 2011). Generally, the researcher believes that all therapists must become comfortable with discussing ethnicity, race, and religious differences/similarities to promote positive experiences in treatment. Addressing these issues can help equalise power differences and build a trusting therapeutic alliance. In addition, it is important to acknowledge the wider context beyond individual factors such as cultural differences in the therapy room during treatment. For instance, as mentioned earlier, developing strong links within the wider community can foster positive, trusting relations. If services consider working in partnership with Muslim religious leaders and making links with local mosques, these efforts may help in overcoming barriers such as preconceived fears of services upholding Islamophobic ideology, and begin to dismantle ideas such as the stereotypical image of who would typically have an ED.

Healthcare services must do better to foster an environment that is safe for minority groups to access. It is an impossible task for any clinician to understand all the nuances that come with the differences in the makeup of our social graces (Burnham, 2018). Certainly, the

knowledge we hold is vulnerable to inaccuracies and mistake, and so there must be space held for humility when it comes to addressing topics such as culture and religion. Hence the researcher also suggests the practice of reflexivity for clinicians offering treatment to Muslims for an ED as this may feel more of a sustainable approach in treatment.

5.4.2 Cultural and Religious Adaptations of Treatment for an Eating Disorder

There is growing research on adapting evidence-based treatment for EDs (Reyes-Rodriguez & Franko, 2020). Cultural and religious adaptations require systematic modification with the intention to appropriately attend to and integrate the target populations values, beliefs, and attitudes in the therapeutic process (Reyes-Rodriguez & Franko, 2020). Within the method of adapting treatment, coproduction and feedback from the target population is essential. The systematic literature review provided examples of religiously informed interventions for EDs however a major gap was the absence of literature on Muslim population in a UK context.

There is a lack of understanding of Islam as reported by the participants of the present empirical study and moreover, Eurocentric frameworks of mental illness have become the dominant influence on treatment protocols in mainstream services. One distinction within Islamic epistemology is the process of secularisation present in Western European healthcare systems that is absent in the Islamic traditional views on health (Keshavarzi & Ali, 2019). Indeed, there has been a more recent movement towards holistic approaches in the formulation and treatment of mental illness, however this has long been a defining characteristic of Islamic ontology and epistemology where it is recognised that the physical, spiritual, and mental health of an individual are all interconnected (Keshavarzi & Ali, 2019).

From an Islamic theological perspective, human beings are created to follow a path that will ultimately lead to their salvation in the hereafter, and it is in this lifetime, health is associated with the ability to acquire God's pleasure and remain on the path of worship

(Keshavarzi & Ali, 2019). For Muslims, whilst in this lifetime and on this path, any obstacles that may impact functioning, for instance, psychological pain or suffering, regardless of whether this meets a clinical threshold or has enough symptoms to be named as a problem, merits attending to (Keshavarzi & Ali, 2019). This is since psychological pain may cause an individual to stray from the path or impede their ability to worship, therefore intervention is encouraged. For many statutory services there is a process of gatekeeping, and those who do not meet significant impairment in either social, occupation or familial functioning will be subsequently denied access to mental or physical healthcare (Keshavarzi & Ali, 2019). In ED services, it could be argued the body, mass index measure serves as a function for gatekeeping access.

Furthermore, Islamic law requires Muslims to refine their inner character and eliminate negative character traits such as malice, envy, and arrogance (Keshavarzi & Ali, 2019). Psychiatric and psychological practices show marginal attention to underlying character traits, whereas in Islam there is an emphasis on good character traits such as patience, compassion, gratitude and to strive to fulfil civic duties for the benefit of others (Keshavarzi & Ali, 2019). This is one distinction to Eurocentric frameworks. For instance, overly occupied with one's body image may be considered as a pathological character flaw in Islamic spirituality. Arguably, some may view the focus on a person's character as controversial and problematic, where it may be preconceived as placing blame or locating the problem within the person. Nonetheless, spiritual approaches to mental health open the opportunity to exploring the make-up of an individual's character, perhaps reveal how this may feed into their conduct in life, their psychological distress, or relational troubles.

Moreover, cultural beliefs are often bound up with and distort religious teachings as mentioned in the present empirical study and systematic literature review. Therefore, time spent unpacking this in treatment with the individual may be beneficial to their recovery. For example, recognising the compassion and love within Islam may support techniques such as cognitive restructuring. Cognitive restructuring informed with religious scripture as supported

by the systematic literature review can be a useful strategy in treatment for individuals reporting anxious or avoidant attachment styles towards God. There are many versus in the Qur'an that provide safety during hardship, such as Surah Ad-Duha which is the 93rd chapter of the Qur'an and in English means "The Morning Brightness" (Quba & Al Qatawna, 2024). The significance of Surah Ad-Duha in a mental health context is that it was revealed to the Prophet (peace be upon him) to relieve him of negative feelings and uncertainty (Quba & Al Qatawna, 2024). This Surah reminds believers that God is aware of our struggles, and He has not abandoned us or is not displeased with us as we might come to believe when feeling low or depressed (Quba & Al Qatawna, 2024). This very powerful verse teaches us that there is strength in hardship and when in a depressed state of mind. When we feel hopeless this Surah can serve as a reminder that better times are ahead, that our current difficulties are temporary and will pass (Quba & Al Qatawna, 2024).

5.4.3 Ramadan and Eating Disorders

Ramadan and Eid are sensitive periods for Muslims who are suffering with an ED. Participants reported that there is sparse guidance on how best to manage symptoms during this time. Indeed, there are some valuable teachings from Islam that can provide insight into guidance for clinicians on how best to manage treatment during the month of Ramadan. For instance, knowing that illness is a valid, permissible reason for not fasting during Ramadan, particularly if there is a fear that fasting will cause damage to the body or delay recovery from the illness (Abolaban & Moujahed, 2017). Many Islamic scholars state that it is an obligation to break the fast if fasting will cause a debilitating weakness for the person and this knowledge may be used to offer some reassurance whilst the person is in treatment (Abolaban & Moujahed, 2017). The participants shared that fasting often forms a significant part to Muslim identity and when the individual is no longer able to attend to that religious duty it can be a major turning point in either a motivation towards recovery or reinforcing a further downwards

spiral. Ramadan was also named as a time where masking an ED becomes much easier and therefore involving carers where appropriate could be valuable in some cases.

5.4.4 Interpretation Services

A key point was the experience of interpreter patient in an ED setting. It has been long documented the barriers non-English speakers face when accessing healthcare services and clinical research (Chang et al., 2021). The quality of care significantly is impacted when a translator is required, one participant noting that often it is difficult to fully relay their experience when speaking through an interpreter (Chang et al., 2021). Meaning and cultural nuances may be lost in translation. Furthermore, the option between sharing sensitive health related information with an interpreter or reliance on family members often becomes the reality for many non-English speakers as shared by one participant in the present study. Equal access to mental health services is a fundamental value in the NHS and efforts must be taken to ensure equity of service provision.

Guidelines have been provided to mental health services on how to provide sensitive treatment that better serve diverse communities with interpretating language needs (Tribe & Thompson, 2022). These guidelines recommend services to conduct a language needs analysis of the local population, and to employ in-house interpreters where possible or if external interpretating agencies are used, to ensure quality checks are completed (Tribe & Thompson, 2022). Translation services can at times be viewed as an additional pressure on already stretched resources as appointments tend to be longer and information gathering becomes more complicated when translating through an individual who is not trained within the field of mental health. The challenges in the practicalities of requiring an interpreter can have an impact on reducing opportunities to explore other aspects of identity such as religion where this may fall to the bottom of the priority list.

5.5 Working with Difference

The participants in the present study reported that naming differences during treatment for an ED was valuable in building a trusting therapeutic alliance and contributed to improved experiences. As mentioned earlier, there are many approaches documented within the existing literature that provide methods for working with differences in therapy. For instance, tailored interventions informed by religious and cultural values can support the engagement of minority individuals (Reyes-Rodriguez & Franko, 2020). More specifically, participants reported that holding space for open dialogue in therapy regarding issues such as the influence of cultural ideas of thinness on internalized belief systems, and the impact of this on ED cognitions and restrictive eating behaviours, can make therapeutic processes more inclusive. Moreover, services that provide training to staff to promote cultural competence can foster an improved shared understanding of religious-specific factors that may impact ED presentations, such as fasting (Reyes-Rodriguez & Franko, 2020).

Furthermore, the findings from the present study revealed that the lack of cultural similarities between participants and treating clinicians became a deterrent for individuals to disclose their cultural and religious roots in therapy, due to fear of judgment. Relational cultural theory emphasizes the value of relationships as essential to human development and psychological well-being (Jordan, 2017). This theory provides a framework suggesting that chronic interpersonal disconnections can result in a sense of isolation and disempowerment (Jordan, 2017). It also promotes social justice as a key factor influencing interpersonal relationships, offering a guide to therapeutic practice where acknowledgment and respect for an individual's religious and cultural values are key to developing clarity when differences arise (Jordan, 2017).

Finally, acknowledging and addressing differences during treatment can support the redistribution of power when working with individuals from a minority religious group. Power imbalances may arise when a clinician fails to acknowledge or identify how cultural and religious contexts influence a patient's experience of mental health difficulties (Cowan, 2009;

Kirmayer, 2012). Critical race theory can provide a valuable framework by examining how racism and cultural dominance impact individuals. Adopting cultural humility and a reflective stance can help address differences and power dynamics during treatment for an ED (Crenshaw, 2005). Cultural humility involves actively listening and validating the patient's unique perspective, rather than making assumptions based on dominant cultural norms (Cowan, 2009; Kirmayer, 2012).

As mentioned earlier, attachment theory highlights the value of a secure and trusting relationship for emotional regulation and recovery (Ainsworth et al., 1978; Akrawi et al., 2015). The relevance of this theory, when discussing differences in relation to power dynamics in clinical practice, is that for minority individuals, the experience of marginalisation may have influenced their attachment patterns. This could contribute to their mistrust of institutions and authority figures, including therapists (Kirmayer, 2012). Therefore, it is important for therapists working with religious minorities during the treatment of an ED to mitigate power imbalances by adopting a culturally sensitive approach (Kirmayer, 2012). This can be achieved by understanding the individual's cultural attachment frameworks and cultural or religious explanatory models, and by prioritizing the building of rapport during treatment (Jordan, 2017; Kirmayer, 2012).

5.6 Strengths and Limitations

The current study is the first to explore the experiences of Muslims receiving treatment for an ED in the UK from an IPA perspective. The research has made significant contributions by providing personal accounts that highlight the barriers Muslims with an ED face when accessing mental health services.

A strength of the study is the participants' feedback on how they felt the interview gave them an opportunity to examine and explore meaning in relation to an aspect of their identity that often goes unspoken.

The final sample size was five participants. Qualitative research has recently come under criticism for a lack of justification regarding sample size. However, there is sparse literature on the management or a definitive answer as to what a sample size should be (Boddy, 2016). To facilitate in-depth analysis, too large a sample may obscure the results, particularly when qualitative research concerns itself with developing a deeper understanding of a particular topic or phenomenon (Boddy, 2016; Sandelowski, 1995). A balance must be achieved between the number of participants and the breadth and depth of the analysis. Therefore, the issue of sample size in qualitative research is not always straightforward. Nonetheless, it is important to keep this in mind when drawing wider conclusions. Consultation with supervisors, experts by experience, and academic researchers is a valuable resource for managing potential bias.

A methodological strength of this research is the great care taken to ensure reliability and validity by implementing measures such as triangulation of data, member checking, reflective journaling, and reflective exercises. The quality assurance strategies adopted were effective in supporting the integrity of the study. These strategies were employed to help mitigate any major influence from assumptions or biases stemming from factors such as the researcher's own relationship to the topic and position as an insider researcher. The researcher continuously reflected and documented these processes during data generation and data analysis. Nonetheless, there are limitations to these strategies, and the expert by experience provided valuable insight and perspective on how best to further protect the integrity of the research.

The use of NVivo during data analysis was another strength of the present study, as the software provided increased flexibility in managing large amounts of qualitative data and improved auditability by allowing the researcher to organize and share large datasets with research team members.

One limitation of the methods used in the present study was the small sample size. While a smaller sample size is suitable for IPA, as it allows for richness and depth in the

personal accounts of participants (Smith et al., 2022), the final sample could still be considered a limitation. Recruitment in the National Health Service (NHS) came with many barriers, and it is important to reflect on how these pressures impact research in understudied populations. Men in ED research studies are particularly underrepresented, and the present study lacked representation of male participants in the final sample. Furthermore, while the present study did not exclude non-English speakers, it is important to consider the ongoing challenges these individuals may face navigating exclusionary obstacles in healthcare systems and clinical research.

These limitations may impact the generalizability of the present study findings. Nonetheless, this study is the first of its kind and provides valuable insight into an understudied topic. If a similar study were to be conducted in the future, efforts to overcome the underrepresentation of men in ED research would be essential. Efforts could include additional recruitment sites to increase the pool of potential participants.

The researcher demonstrates an awareness of the socio-cultural contexts of Muslims in the UK. This understanding and grounding in the research help acknowledge the underlying issues that Muslim minorities with an ED may experience when accessing treatment services and explicitly identify systemic factors that may influence qualitative research (Yardley, 2000).

The present study provides the reader with a theoretical perspective, a socio-cultural setting, and individual accounts from participants detailing their lived experiences on the topic of interest (Yardley, 2000). The study also addresses potential ethical issues and shows a commitment to upholding an in-depth, rigorous engagement with the topic of interest and methodology. The researcher offers detailed rationale for the choice of methods and the factors that informed data analysis, drawing on reflexivity to support the transparency of the methodological processes (Yardley, 2000).

Finally, the present study will enrich and contribute to current available research on this topic, offering guidance on how the findings can be used to shape clinical practice and future studies (Yardley, 2000).

5.7 Future Research Recommendations

Further research in the field of investigating the experiences of receiving treatment for an ED in the Muslim population group in necessary. The participants in this study communicated the complexities of Muslim identity when receiving care in a Western healthcare setting. What surfaced within the present findings was the intersection between culture and faith which seemed to play a significant role in understanding the individual lived experiences of having an ED. Moreover, the systematic literature further emphasises the current gap for this field of research.

Future researchers should focus on working collaboratively with Muslim communities in mental health awareness programmes as suggested by participants in the present study. Due to the time limits of the present study, the project was unable to go beyond the remints of statutory mental healthcare services and did not consider participants who did not have a pre-existing diagnosis of an ED. It may therefore be beneficial to consider individuals who do not have an ED diagnosis but may fall under the category of disordered eating. As identified by the present study, Muslim population may be underdiagnosed due to presence of social-political barriers and therefore, consequently less likely to access to mainstream services.

Moreover, the experiences of participants conjured up female gender related themes and drawing on the strengths and limitations of the study, one limitation is the absence of men in the final sample. Future research could certainly benefit from understanding the lived experiences of Muslim men receiving treatment for an ED.

Finally, the present empirical study was Quality Appraised using the CASP tool which states that the researcher opted for a qualitative method, the reason being that the topic of interest as revealed by the systematic literature review is novel and therefore where there is limited prior studies in this field, a qualitative research method offers an openness and flexibility that felt important to the research team. Opting for a qualitative method provided the opportunity to capture any unexpected nuances.

5.8 Final Reflections and Conclusions

As an insider researcher, carrying out this study has been a deeply moving experience, though at times I may have underestimated how emotionally taxing it would be. It was a heavy responsibility—overwhelming yet empowering at the same time. One unexpected finding was the recurring similarities in the accounts of alienation experienced by Muslim women within the context of a Western healthcare setting. For instance, many participants described feeling that they did not fit the mould of someone typically associated with having an ED. While this highlights broader issues around societal constructs of illness, the inner strength displayed by each individual in pursuing recovery despite these social and cultural barriers provides a powerful narrative of hope and resilience. Participants spoke of both hardship and personal growth, offering valuable insights into how their journeys could inform improvements in service provision.

I also want to acknowledge that this study has attempted to offer both macro- and micro-level understandings of the topic. On one hand, I have explored the political and social contexts that Muslims must navigate in the UK; on the other hand, I have examined the individual lived experiences of receiving treatment for an ED. Providing this context felt essential for helping readers understand the systemic elements that form the backdrop for Muslim individuals. My aim was to ensure that readers hold in mind the influential forces shaping individual treatment experiences and service delivery, as participants spoke to both systemic and individual factors. For instance, some participants specifically named Islamophobia in their accounts and described how it affected their experiences of receiving treatment. I felt it was important to acknowledge this broader reality—not only to validate their accounts but also to recognize the larger issues influencing their experiences.

One of the challenges in conducting this research was maintaining a balance between systemic and individual factors, as I occasionally found myself overly focused on one or the other. At times, my emphasis on individual factors may have been a reflection of the

novel and unexpected nature of participants' contributions. However, one perspective does not negate the importance of the other. This duality was a key theme communicated in participants' accounts.

In conclusion, this study has contributed to a better understanding of the experiences of Muslims receiving treatment for EDs in the UK. The novel findings not only highlight a gap in the current literature but also offer suggestions for quality improvement and broader considerations regarding the social and political climate faced by Muslims in UK society.

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Appendix

Appendix A.

HRA Ethical Approval letter

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

Dr Keith Sullivan
University of Hertfordshire
Hatfield
Hertfordshire
AL10 9EUN/A

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

24 October 2023

Dear Dr Sullivan

HRA and Health and Care Research Wales (HCRW) Approval Letter

Study title:	**An investigation of the experience of ED treatment received by Muslims: An Interpretative Phenomenological Analysis**
IRAS project ID:	**327772**
Protocol number:	**N/A**
REC reference:	**23/LO/0803**
Sponsor	**University of Hertfordshire**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards the end of this letter.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) have been sent to the coordinating centre of each participating nation. The relevant national coordinating function/s will contact you as appropriate.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?

The standard conditions document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:

- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **327772**. Please quote this on all correspondence.

Yours sincerely,

Mathew Barnes
Approvals Specialist

Email: approvals@hra.nhs.uk

Copy to: *Ms Leire Caselles Vallejo*

List of Documents

The final document set assessed and approved by HRA and HCRW Approval is listed below.

Document	*Version*	*Date*
Copies of materials calling attention of potential participants to the research [Materials calling attention of potential participants]	V4	28 September 2023
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Evidence of sponsor insurance]		
Interview schedules or topic guides for participants [Screening and interview schedule]	V3	17 August 2023
IRAS Application Form [IRAS_Form_05092023]		05 September 2023
Letter from sponsor [Letter from sponsor]		
Organisation Information Document [Organisation Information Document]	V2	01 September 2023
Participant consent form [Participant consent form]	V4	22 September 2023
Participant information sheet (PIS) [Participant information sheet]	V5	24 October 2023
Participant information sheet (PIS) [Participant information sheet]	V4	22 September 2023
Research protocol or project proposal [Protocol]	V4	29 September 2023
Schedule of Events or SoECAT [Schedule of events]	V1	01 September 2023
Summary CV for Chief Investigator (CI) [Summary CV for CI]	v1	27 July 2023
Summary CV for student [Summary CV for student]		

IRAS project ID	327772

Information to support study set up

The below provides all parties with information to support the arranging and confirming of capacity and capability with participating NHS organisations in England and Wales. This is intended to be an accurate reflection of the study at the time of issue of this letter.

Types of participating NHS organisation	Expectations related to confirmation of capacity and capability	Agreement to be used	Funding arrangements	Oversight expectations	HR Good Practice Resource Pack expectations
This is a multiple research site study where all research activities will take place in the same way at each site. There is, therefore, only one research site type.	Research activities should not commence at participating NHS organisations in England or Wales prior to their formal confirmation of capacity and capability to deliver the study in accordance with the contracting expectations detailed.	An Organisation Information Document has been submitted and the sponsor is not requesting and does not expect any other agreement to be used with participating NHS organisations of this type.	No application for external funding has been made.	A Local Collaborator should be appointed at participating NHS organisations.	Where an external individual will be conducting any of the research activities that will be undertaken at this site type then they would be expected to hold a Letter of Access. This should be issued be on the basis of a Research Passport (if university employed) or an NHS to NHS confirmation of pre-engagement checks letter (if NHS employed). These should confirm Occupational Health Clearance. These should confirm standard DBS checks.

Other information to aid study set-up and delivery

This details any other information that may be helpful to sponsors and participating NHS organisations in England and Wales in study set-up.
The applicant has indicated that they do not intend to apply for inclusion on the NIHR CRN Portfolio.

Appendix B.

Declaration of the End of Study

NHS
Health Research Authority

Declaration of the end of a study

(For all studies except Clinical Trials of Investigational Medicinal Products)

To be completed in typescript by the Chief Investigator or sponsor representative and submitted to the Research Ethics Committee (REC) that gave a favourable opinion of the research within 90 days of the conclusion of the study or within 15 days of early termination

For questions with Yes/No options please indicate answer in bold type.

1. Details of Chief Investigator

Name:	Dr Keith Sullivan
Address:	University of Hertfordshire, Hatfield Hertfordshire AL10 9EU
Telephone:	[redacted]
E-mail:	[redacted]

2. Details of study

Full title of study:	An investigation of the experience of eating disorders treatment received by Muslims: An Interpretative Phenomenological Analysis.
IRAS ID:	327772

Name of REC:	London – Fulham Research Ethics Committee
REC reference number:	23/LO/0803
Date of favourable ethical opinion:	24.10.2023
Sponsor:	University of Hertfordshire

3. Study duration

Date study commenced:	01/02/2023
Date study ended	06/05/2024
Did this study terminate prematurely?	**Yes**. If yes, please complete sections 4, 5 & 6. If no, please complete section 4 and then go directly to section 7.

4. Recruitment

Number of participants recruited	5 participants
Proposed number of participants to be recruited at the start of the study	6-10 participants
If different, please state the reason or this	A sufficient level of data saturation to respond to the study question was achieved.

5. Circumstances of early termination

What is the justification for this early termination?	The final report will detail the recruitment challenges the project faced in an NHS setting. Since a sufficient level of data saturation to answer the study question was achieved, following discussions with the wider research team, service clinical leads and the University module lead, it was agreed that the project could end recruitment and submit for a viva examination on the basis that recruitment had stalled for a number of weeks. A sufficient sample of data was achieved for the purpose of an IPA analysis. In the final report the researcher was able to provide an informative narrative detailing the nuanced experience of Muslims receiving treatment for an eating disorder with clear justifications, evidence from the data sample to support the conclusions made, and report on clinical implications and recommendations for future clinical practice.

Declaration of end of study (non-CTIMP), version 1.6, May 2022

6. Potential implications for research participants

Are there any potential implications for research participants as a result of terminating the study prematurely? Please describe the steps taken to address them.	No potential implications for research participants as a result of terminating the study prematurely. Recruitment sites have been notified to end recruitment, sites have confirmed no further prospective participants will be approached in relation to the project.

7. Final report on the research

Have you submitted a Final Report?	**No** If no, please submit a Final Report within 12 months of the end of the study (or for paediatric CTIMPs, within 6 months). More information is available on the HRA website

8. Declaration

*Signature or Electronic Authorisation of Chief Investigator/sponsor representative: *Please print below or insert electronic signature	Maisha Murshed
Print name:	Maisha Murshed
Date of submission:	07/06/2024

Appendix C.

Participant Information Sheet

PARTICIPANT INFORMATION SHEET

1 Title of study

An investigation of the experiences of eating disorder treatment received by Muslims: An Interpretative Phenomenological Analysis

2 Introduction

You are being invited to take part in a study. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask us anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part. The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link:

https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs

(after accessing this website, scroll down to Letter S where you will find the regulation).

The study sponsor and data controller is the University of Hertfordshire.

Thank you for reading this.

3 What is the purpose of this study?

My name is Maisha Murshed, and I am a second-year trainee Clinical Psychologist at the University of Hertfordshire. I am exploring the experiences of Muslims who are currently receiving treatment for an eating disorder (ED) using interpretative phenomenological analysis (IPA). IPA is a method of analysis used to draw out focal points in the data, the main aim of IPA is to help us make sense of an individual's own lived experience in a given context and how that individual makes sense of this. There is currently limited research in the area of Islam and ED. In addition, there is little option for adapted treatment that acknowledges or addresses Islamic perspectives on the management of EDs.

I hope this study will offer us a better understanding on the experiences of Muslims receiving treatment for an eating disorder. The study will aim to recruit from NHS services East London, Bedfordshire, and Luton Adult Community Eating Disorder services. The study findings will be shared with the teams to help inform whether services can do more to support this populations needs, no personal identifying data will be shared.

4 Do I have to take part?

It is completely up to you whether you decide to take part in this study. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you must complete it. You are free to withdraw without giving a reason up until the start of data analysis which will be in three months' time.

A decision to withdraw until the start of data analysis, or a decision not to take part at all will not affect any treatment/care that you may receive (should this be relevant).

5 Are there any age or other restrictions that may prevent me from participating?

You must be 18 or over to participate in this study. You will not be able to participate in the study if you do not have an ED diagnosis and/or under the age of 18 years old. The service I will be recruiting from does not treat avoidance restrictive food intake disorder (ARFID) and therefore will not be considered in the present study.

6 How long will my part in the study take?

If you decide to take part in this study, you will be invited to attend a semi-structured interview. The interview will involve pre-determined questions with some prompts, these prompts will provide an opportunity for us to explore your responses with you further too. The interview will ask about your experiences of ED treatment as a Muslim, and you will be asked open-ended questions to support with getting an understanding of your own personal lived experience on this topic.

7 What will happen to me if I take part?

The first thing to happen will be if you decide to take part, you will be given this information sheet to keep, and you will also be asked to sign a consent form. You will then be invited to take part in an interview, the interview will last around 90 minutes and will be voice recorded. You will be asked to provide your name, contact details (email and telephone/ mobile number). If you change your mind about taking part in the study, you can stop participating in the study up until the start of data analysis which will commence January 2024. In addition, if you decide to stop after you have completed individual interview you can withdraw by contacting the lead researcher (see contact details below), following this your data will be securely destroyed by a member within the project's research team.

8 What are the possible disadvantages, risks, or side effects of taking part?

The main cost to you will be the time needed to take part in the individual interview, you will be compensated £15 for your time. This can be paid to you by cash or BACS payment, and you will be asked to sign a receipt confirming that you have been compensated for your time.

I do ask that you only share what you are comfortable to share during the individual interview, and that you do not have to respond to all the questions asked if you do not wish to. If you do find the discussion difficult, you can withdraw yourself from the interview while it is ongoing, you will not be asked why you have withdrawn and there will be debriefing. This will be an opportunity to discuss anything you may have found difficult about the discussions held, the content of the debrief discussions will not be recorded or included in the project findings.

Due to these measures, we feel the risk of any serious distress is low. If you experience serious distress and feel you require ongoing support, you will be signposted to the appropriate support or service.

9 What are the possible benefits of taking part?

We hope that you will find the research activities interesting and an opportunity to contribute and shape the Islamic psychology knowledge base in current research and practice in the field of eating disorders. We also hope you will take satisfaction from helping to co-develop knowledge of this important topic and influence future practice.

10 How will my taking part in this study be kept confidential?

If you chose to be interviewed for this study all information you provide will be kept confidential from your treatment team. In the event of an adverse event or should there be any concern related to risk to yourself or others then data may need to be shared with your treatment team, care coordinator or GP. If you share concerns or raise a complaint about the treatment you received from the eating disorder service, this information will be passed on to your current or if most recent care-coordinator, and if either is not applicable your GP. You can also contact the Patient Advice and Liaison Service (PALS) if you wish to make a complaint independent from the study team. You can contact the PALS office on freephone 0800 783 4839 or via email PALS@elft.nhs.net.

Data will be collected and stored in line with the Data Protection Act 2018 and the General Data Protection Regulation (GDPR) 2016. The recording of your interview will be given a code (i.e., Interview A) and stored on a secure in a secure file on the University of Hertfordshire's One drive. A transcription service will be used to transcribe the interview, which involves typing up the interview verbatim. No identifiable information will be shared with the transcription service, although it is possible you could make yourself identifiable during the interview the responses you provide will be pseudo anonymised.

A signed confidentiality agreement from the service will be obtained before any recordings are provided. All names and personally identifiable information will be removed from the transcripts by the researcher. Personal information will be kept securely and separately from the transcripts. Demographic information questionnaires will also be stored securely and separately from your name and contact details. The researcher's supervising team will also be kept blind to the identity of participants when reviewing transcripts.

The audio recording and transcripts will be handled only by the research team's designated members, in line with data protection principles and our approved research protocol. Hard copies of any research notes and consent forms are kept in locked filing cabinets, and electronic files are kept on password protected devices which are not accessible to any other university staff. Once the write up has been completed the audio recordings will be deleted.

The data will be kept for the length of the study and destroyed after this time which we intend to be completed by September 2024.

11 Audio-visual material

The semi-structured interview will be transcribed onto a written password protected word document. At the end of the study, all anonymised transcripts will be destroyed. Any information that identifies you, or that gives any clues to your identity, will be removed. We are confident that these precautions will ensure that no-one will be able to trace your transcript back to you.

You will not be named or otherwise identified in any publication arising from this project. Excerpts of things you have said during the interview discussion may be published as they form an important part of the project findings. If there is anything you have said that includes identifiable information (for example, where you work, where you live, or your name) we will

omit or change these details to protect your identity becoming known. I will exercise all possible care to ensure that you cannot be identified by writing up our findings.

12 What will happen to the data collected within this study?

I will analyse all the data and use this as a basis for writing up a thesis on the topic. The data collected will be stored electronically, in a password-protected document until September 2024, after which time it will be destroyed under secure conditions. Participants will have rights to request their data, participants will not however be able to access, change or delete their research data themselves as this would compromise the security of the University shared drive and confidentiality of the other participants data involved in this project. Should you wish to change or delete your research data, you can request a research member to do this on your behalf.

The results of the research will be presented in a thesis for the purpose of gaining a qualification in Clinical Psychology. The thesis will be held at the University of Hertfordshire Learning Resource Centre and will be accessible to all interested parties. A summary of the main research findings may be published in written work or articles that project myself or my supervisors write, as well as for the purposes of teaching and conferences.

Information originating from the study will only be made public in an unattributable format.

13 Will the data be required for use in further studies?

The data will not be used in any further studies.

14 Who has reviewed this study?

This study has been reviewed by:

The study has been reviewed by the London- Fulham Research Ethics Committee.
The study has also been reviewed by the University of Hertfordshire Social Sciences, Arts and Humanities Ethics Committee with Delegated Authority. The UH protocol number is LMS/PGR/NHS/02302.

15 Factors that might put others at risk

Please note that if, during the study, any medical conditions, or non-medical circumstances such as unlawful activity become apparent that might or had put others at risk, the University may refer the matter to the appropriate authorities and, under such circumstances, you will be withdrawn from the study.

16 Who can I contact if I have any questions?

If you would like further information or would like to discuss any details personally, please get in touch with me, in writing, by email: maisha.murshed@herts.ac.uk, (mobile contact: 07447090112). Supervisor Dr Keith Sullivan k.sullivan3@herts.ac.uk (Telephone contact: 01707 284000)

Doctorate in Clinical Psychology
Wight Building
College Lane Campus

Hatfield
AL10 9AB
You can also contact the Research Governance and information office for data protection related concerns via email: research-sponsorship@herts.ac.uk.

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:

Secretary and Registrar
University of Hertfordshire
College Lane
Hatfield
Herts
AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix D.

Participant Consent Form

Participant Consent Form

Study title: An investigation of the experience of treatment receiving Muslims with an eating disorder: An Interpretative Phenomenological Analysis

CONSENT FORM

I, the undersigned *[please give your name here*, *in BLOCK CAPITALS]*

……..…

of *[please give contact details here, sufficient to enable the investigator to get in touch with you, such as a postal or email address]*

…..……

hereby freely agree to take part in the study entitled *[insert name of stu*dy *here]*

……..

(UH Protocol number ……)

	Initials
1 I confirm that I have been given a Participant Information Sheet (a copy of which is attached to this form) giving particulars of the study, including its aim(s), methods and design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my personal information on this form will be stored and for how long. I have been given details of my involvement in the study. I have been told that in the event of any significant change to the aim(s) or design of the study I will be informed, and asked to renew my consent to participate in it.	
2 I have been assured that I may withdraw from the study at any time without disadvantage or having to give a reason.	
3 In giving my consent to participate in this study, I understand that voice recording will take place and I have been informed of how/whether this recording will be transmitted/displayed	
4 I have been given information about the risks of my suffering harm or adverse effects. I have been told about the aftercare and support that will be offered to me in the event of this happening, and I have been assured that all such aftercare or support would be provided at no cost to myself. In signing this consent form I accept that medical attention might be sought for me, should circumstances require this.	

5 I have been told how information relating to me (data obtained in the course of the study, and data provided by me about myself) will be handled: how it will be kept secure, who will have access to it, and how it will or may be used, including the possibility of anonymised data being deposited in a repository with open access (freely available).	
6 I understand that my participation in this study may reveal findings that could indicate that I may require medical advice. In that event, I will be informed and advised to consult my GP and I acknowledge that, following discussion, I may be required by the University to withdraw from the study. If, during the study, evidence comes to light that I may have a pre-existing medical condition that may put others at risk, I understand that the University will refer me to the appropriate authorities and that I will not be allowed to take any further part in the study.	
7 I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.	

Signature of participant……...…Date……

Signature of (principal)
Investigator……Date……

Name of (principal) investigator *[in BLOCK CAPITALS please]*

……

One copy will be provided as a record for the study research team and one copy to the participant.

Appendix E.

Pre-screening tool and Interview Schedule

Pre-interview Screening tool

Title:
An investigation of the experiences of eating disorder treatment received by Muslims: An Interpretative Phenomenological Analysis

Interview date:

Individual pseudo-ID:

Participant demographic info:

Age:	☐ 18-25	☐ 26-35	☐ 36-45	☐ 46-55	☐ 56-65	☐ 66-75
Gender:	☐ Male	☐ Female	☐ Non-Binary	☐Prefer not to say		
	☐ Other					
Do you identify as Muslim:			☐ YES	☐ NO		
Diagnosis:						
Are you currently receiving treatment for an eating disorder?			☐ YES	☐ NO		
Ethnicity:						

a. Semi-structured interview

Interview schedule

SECTION (A): EXPERIENCES AS A MUSLIM WITH AN EATING DISORDER

Question 1. What is your relationship with Islam as a religion and how has this informed your identity in the United Kingdom (UK)?

Question 2. What role has your faith played in your experience of having an eating disorder?

Prompt (I) Do you feel your experience as a Muslim with an eating disorder differs in some ways to other people who are not Muslim?

Question 3. What has your experience with an eating disorder been like during the holy month of Ramadan?

SECTION (B): EXPERIENCE AS A SERVICE USER IN AN EATING DISORDER NHS SERVICE

Question 2. What has your experience of receiving treatment for an eating disorder at the service been like?

Has this been influenced at all by your religious identity as a Muslim?

Question Do you think your religious identity has been acknowledged during treatment, if so, in what way? And if not, why do you think this has not been acknowledged?

Question 3. What could be improved with the service to better meet your religious needs?

SECTION (C): SERVICE DEVELOPMENT

Question 5. Are there any religious ideas and practices that could be essential to consider when offering treatment for an eating disorder for Muslims?

Question 6. Based on your experience, do you feel access to religiously appropriate services or support could be improved for Muslims? If so, in what way?

Prompt (i) What are some important aspects of caring for Muslim patients with an eating disorder service should consider?

SECTION (D): FINAL COMMENTS

Question 7. Are there any other thoughts you would like to share in this conversation that has not been discussed related to the topic?

Many thanks for your participation!

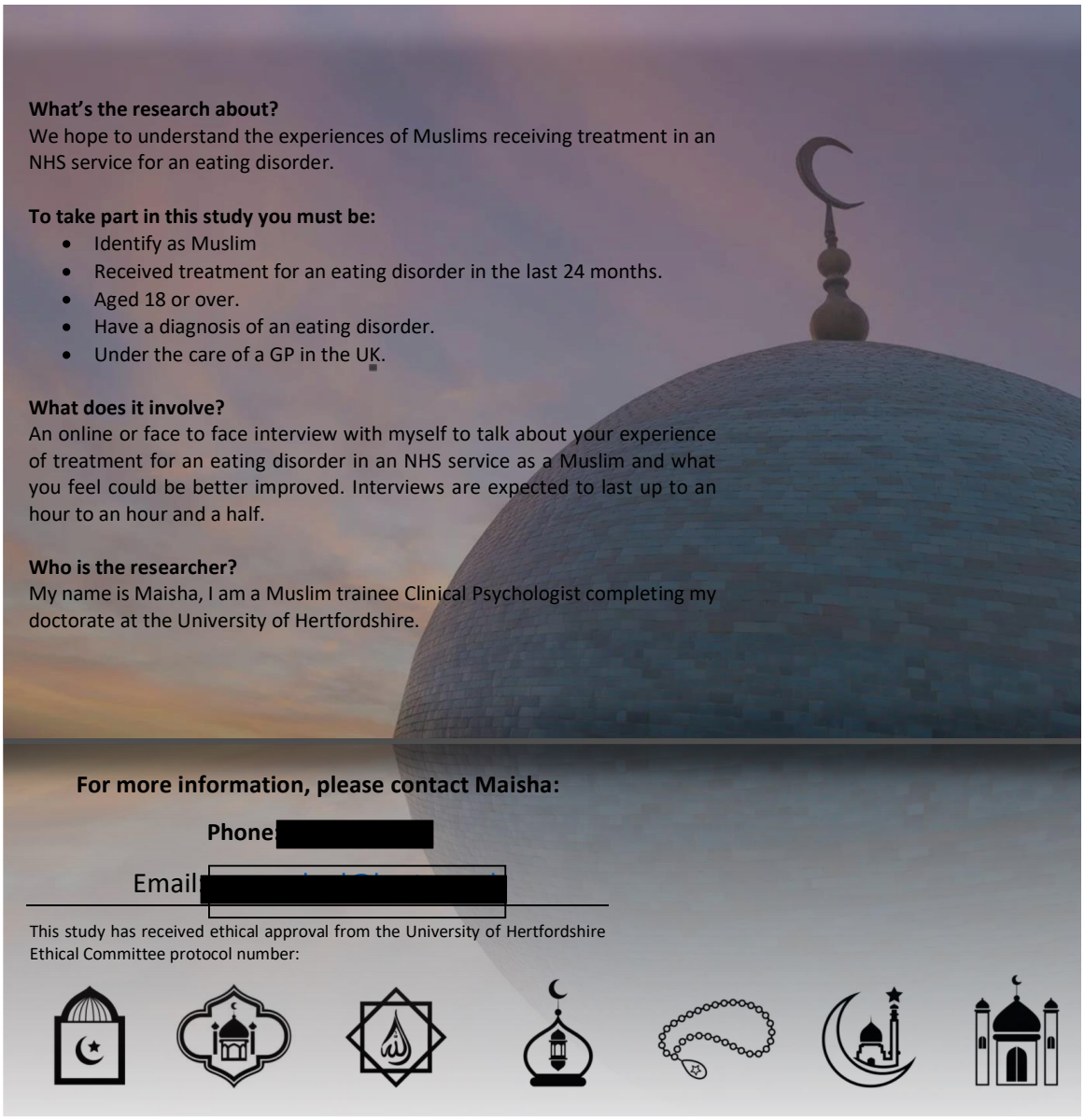
Appendix F.

Recruitment Advertisement Poster

Version 4_ 28/09/2023
IRAS ID: 327772

University of Hertfordshire UH

I am looking for Muslims to participate in research about your experience of receiving treatment for an eating disorder.



Appendix G.

Modified CASP Qualitative Checklist Tool (Long et al., 2020, p. 35)

Box 2. The questions in our modified CASP qualitative checklist tool

1. Was there a clear statement of the aims of the research?
   - What was the goal of the research
   - Why it was thought important
   - Its relevance
2. Is a qualitative methodology appropriate?
   - If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants
   - Is qualitative research the right methodology for addressing the research goal
3. Was the research design appropriate to address the aims of the research?
   - If the researcher has justified the research design (e.g. have they discussed how they decided which method to use)
4. Are the study's theoretical underpinnings (e.g. ontological and epistemological assumptions; guiding theoretical framework(s)) clear, consistent and conceptually coherent?
   - To what extent is the paradigm that guides the research project congruent with the methods and methodology, and the way these have been described?
   - To what extent is there evidence of problematic assumptions about the chosen method of data analysis? e.g. assuming techniques or concepts from other method (e.g. use of data saturation, originating in grounded theory) apply to chosen method (e.g. Braun and Clarke's reflexive thematic analysis[39,40]) without discussion or justification.
   - To what extent is there evidence of conceptual clashes or confusion in the paper? e.g. claiming a constructionist approach but then treating participants' accounts as a transparent reporting of their experience and behaviour.
5. Was the recruitment strategy appropriate to the aims of the research?
   - If the researcher has explained how the participants were selected
   - If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study
   - If there are any discussions around recruitment (e.g. why some people chose not to take part)
6. Was the data collected in a way that addressed the research issue?
   - If the setting for the data collection was justified
   - If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)
   - If the researcher has justified the methods chosen
   - If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)
   - If methods were modified during the study. If so, has the researcher explained how and why
   - If the form of data is clear (e.g. tape recordings, video material, notes etc.)
   - If the researcher has discussed saturation of data
7. Has the relationship between researcher and participants been adequately considered?
   - If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location
   - How the researcher responded to events during the study and whether they considered the implications of any changes in the research design
8. Have ethical issues been taken into consideration?
   - If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained
   - If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)
   - If approval has been sought from the ethics committee
9. Was the data analysis sufficiently rigorous?
   - If there is an in-depth description of the analysis process
   - If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data
   - Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process
   - If sufficient data are presented to support the findings
   - To what extent contradictory data are taken into account
   - Whether the researcher critically examined their own role, potential bias and influence during data analysis and selection of data for presentation
10. Is there a clear statement of findings?
    - If the findings are explicit
    - If there is adequate discussion of the evidence both for and against the researcher's arguments
    - If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)
    - If the findings are discussed in relation to the original research question
11. How valuable is the research?
    - If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research-based literature)
    - If they identify new areas where research is necessary
    - If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

Appendix H.

List of Examples of Reflexive Questions Used by the Researcher

Reflexivity in research

Reflexivity as introspection

Reasons for being drawn to the topic

Investment in the research

Experiences, thoughts, feelings

Opinions, values, assumptions

fears and desires

locations in relation to class, culture, sexuality, gender, education, etc.

Reflexivity as consideration of power and as social critique

How are you similar to your research participants?

How are you different from your research participants?

What might your allegiances represents for your participants?

What relationships (actual or implied) do you have with the gatekeepers in your research (e.g., those helping you to recruit, the services you are recruiting through)?

What are the strengths and limitations of the researcher-gatekeeper relationships in your research?

Who might you be in the eyes of those you hope to disseminate to?

How might your research be used? By whom?

Are there actions you can take to address power in your research relationships?

Reflexivity as discursive deconstruction

Which dominant discourses surround the field of your research?

What are the areas of contention surrounding your research?

What differences of opinion play out within the literature within the field of your research?

How are your participants socially constructed and positioned within your profession, within the literature, within society?

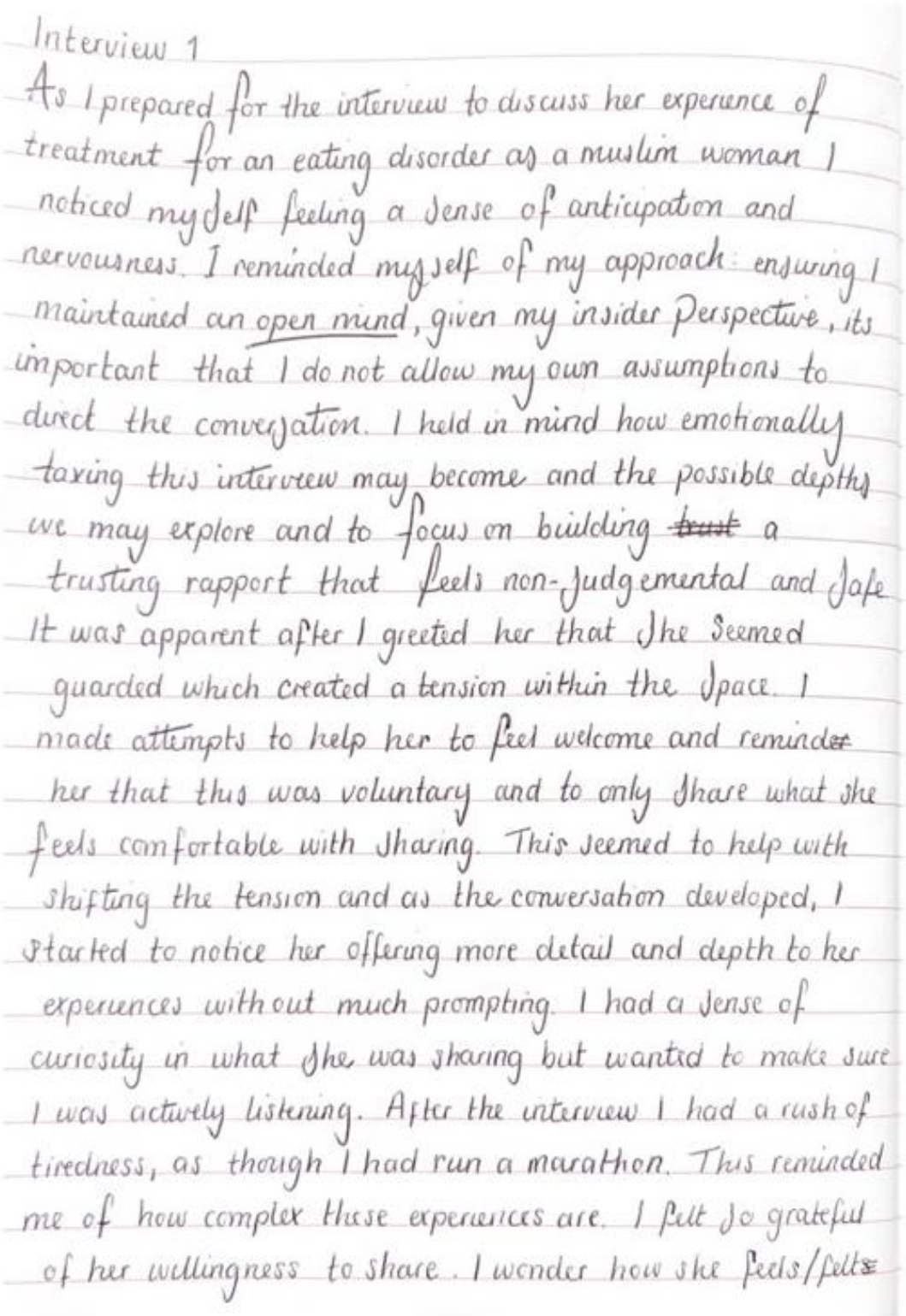
Which positions, discourses, opinions and constructions do you find yourself most/least aligned with? How does this speak to the purposes you see for your research? How might it help / hinder the research?

How might the above impact on your research?

How do you hope to / how are you relating to these potential impacts?

Appendix I.

Extracts from reflective diary

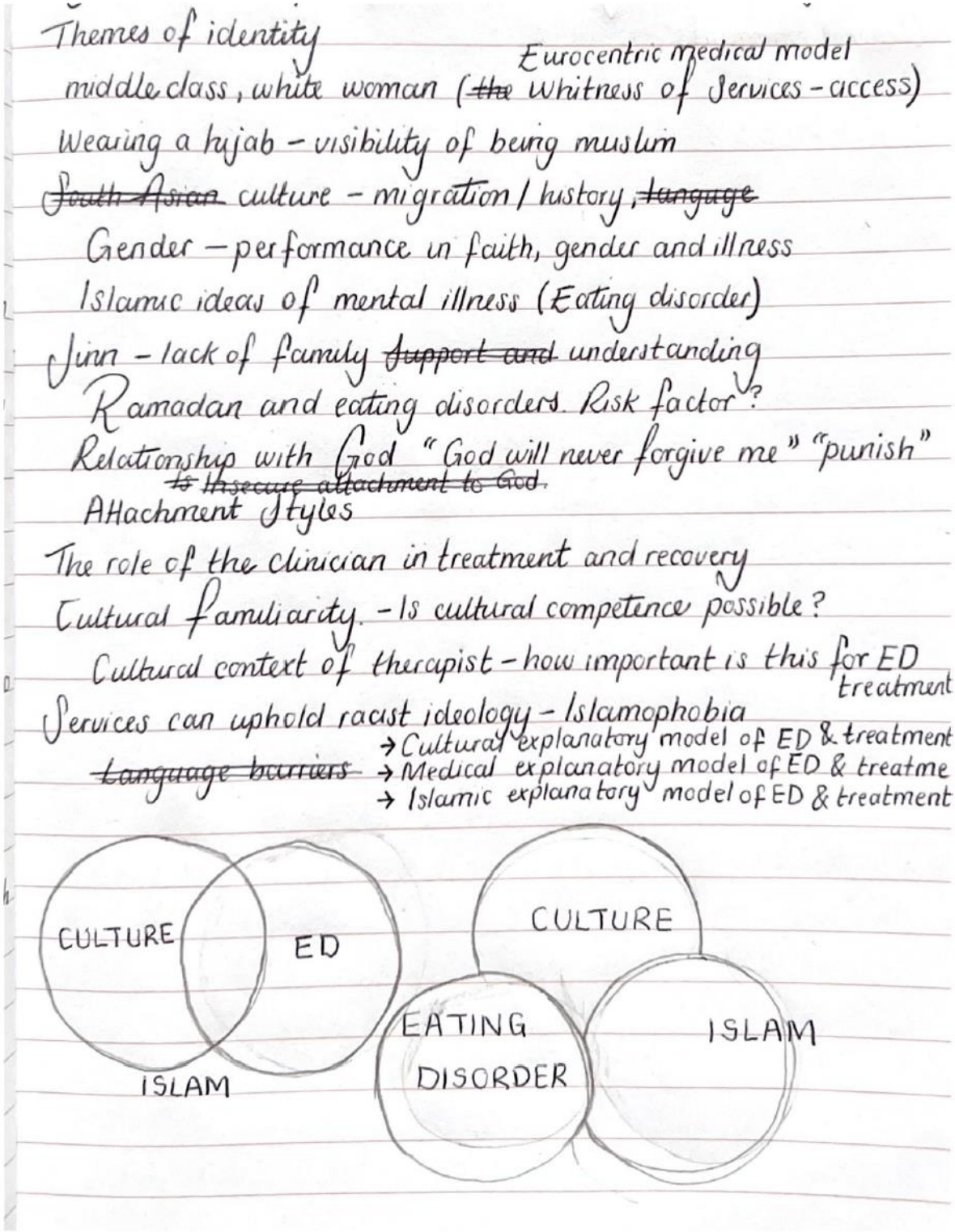


Interview 1

As I prepared for the interview to discuss her experience of treatment for an eating disorder as a muslim woman I noticed myself feeling a sense of anticipation and nervousness. I reminded myself of my approach ensuring I maintained an open mind, given my insider perspective, its important that I do not allow my own assumptions to direct the conversation. I held in mind how emotionally taxing this interview may become and the possible depths we may explore and to focus on building ~~trust~~ a trusting rapport that feels non-judgemental and safe. It was apparent after I greeted her that she seemed guarded which created a tension within the space. I made attempts to help her to feel welcome and reminder her that this was voluntary and to only share what she feels comfortable with sharing. This seemed to help with shifting the tension and as the conversation developed, I started to notice her offering more detail and depth to her experiences without much prompting. I had a sense of curiosity in what she was sharing but wanted to make sure I was actively listening. After the interview I had a rush of tiredness, as though I had run a marathon. This reminded me of how complex these experiences are. I felt so grateful of her willingness to share. I wonder how she feels/felt~~

Appendix J.

Construction of GETs



Appendix K.

Example of a typical participant interview transcript

Experiential Statements	**Participant Interview Transcript Extracts**	**Exploratory Notes**	**Reasons for Including Extracts**
	Aliyah Participant: And then in terms of when it was acknowledged, so two years ago, I was very fortunate enough to be paired up with a therapist that has Muslim identity and that's when she she, I mean, the first thing she acknowledged was obviously I looked different, I wear a headscarf. You know those visual things you know, cause eating disorders are visual, right? They took. They talk about the most invasive thing. Interviewer: Yeah. Participant: They weigh you, they tell you you're BMI. I, you know, it's quite obvious like to acknowledge and recognize, you know that the headscarf and the religion and things like that. But anyway, so she did. And and you know from the very beginning, she she, she asked me questions like how I coped with Ramadan and things like that, and she just got to the crux of it. Interviewer: Yeah. And I guess do you think that it was because she was Muslim? Participant: Yeah, because she, she already had an understanding and knowledge of things that could kind, kind of affect the eating disorder. So, I don't know like how therapists do training, but obviously they, they have that kind of expertise to understand what Christmas means for a lot of people because it's food, is celebration, etcetera. But it's the same if you're Muslim and then Ramadan and Eid. Interviewer: Umm. Participant: But I don't know why not many people are aware and so in answer to your question, she	The visibility of being Muslim e.g., wearing hijab Parallels between the physicality of an eating disorder and being Muslim. Being under surveillance and observation. Lack of acknowledge of the sensitivities around 'modesty' for women in Islam. 'Being seen' by a Muslim therapist The value of having an awareness of cultural and religious needs for building a trusting therapeutic	This extract was chosen as Aliyah provided an intimate account of her positive experience with a Muslim therapist and the meaningfulness of treatment when a level of understanding is shared between therapist and patient. Aliyah also shared religion beyond just the practice but as a cultural identity.
Gender sensitivities for Muslim women in Islam Religious and cultural familiarity between patient and clinician			

Eid and Ramadan as trigger points for the Eating Disorder	obviously had an awareness of it. So, she was able to talk about those things. Interviewer: Um and do you think it might have been, uh, I don't know, but might have been more comfortable for her to bring religion up. What do you think? Participant: I think um that question is very interesting because I think kind of a lot of people like, ohh, you know, religion is one of those areas that you don't know etcetera. But the thing is, it's when you're, when you're talking about religion, in the context of, say, why I say Ramadan and things like that, it's not just religion, it's a part of your kind of your background, your culture, your traditions.	alliance. Trust can facilitate disclosure	
Perceived judgements from clinicians during treatment	Aliyah Interviewer: And that must have been really difficult for you to, when you're seeking help to then enter a space where you're feeling judged. Participant: That because that's where, that's where it happens. Interviewer: Yeah. Participant: The performance you go in your judged and that's it. Interviewer: Yeah. Participant: You take on that performance role and then you're so far away from where you want to be at that, you know from the beginning. Yeah. Interviewer: Yeah, almost umm shuts you down and, and you're, yeah kinda on autopilot. Participant: Absolutely. Interviewer: Umm yeah. And do you feel in those moments of judgment that it was your faith that was being judged, or more that you, you were a South Asian woman or, the eating disorder? Participant: I think in terms of faith and as association, I think the moment that I had interactions with	Naming the unconscious bias. Participant identifying the harmfulness of unconscious bias during treatment, and how this can be sometimes inaccurately assumed by clinicians to go unnoticed. Linking perceived judgement as the trigger of performing the 'good patient' role. Identifying that if the person is performing a role when in treatment, then they are far from recovering from the eating disorder.	This extract was selected to show an example of the experience of judgement. Aliyah described a shutting down effect as a result of perceived judgement.

	therapies, there was a judgment, but it was not acknowledged or it was, it wasn't done in the right way and from, from, from the, you know, from the, from the onset, my back will be up because yeah.		
The influence of migration Stigma of mental health	Aisha Participant: I think yes if I if if I wasn't Muslim and I had umm my parents had more knowledge obviously cause one of my parents was born in Pakistan, so he didn't really have as much education as like let's say people growing up here. We learn about it in schools all the time, so the support he didn't really know how to support me, they didn't really understand it. Umm, but I think now that we teach it and if you were growing up now it's different if if. I think, yeah, I think it's not really talked about much and and Muslim communities that's not really seen as mental health isn't really a big issue. Well, there's an issue it's not umm. Interviewer: Umm yeah. Participant: It's just not really had to. Is like a taboo subject, basically.	Aisha perceived her family to lack knowledge due to the migrational history.	Aisha's account was included to illustrate the experience within a migrant family system and how this may influence the experience of making sense of having an ED. For instance, the silencing from stigma and lack of understanding.
Inaccessibility of therapy for non-English speakers Biases towards older adults with an ED	Fatima Participant: So yes, we did receive for different mental challenges therapy. I'm not saying it wasn't helpful, but it wasn't made accessible for me, so I cannot guarantee that it was 100% helpful because i didn't 100% use the service the same way others could access because of the language, because of the age, because of the biases. So this obviously if you go even to the GP if you speak uh about your issue is and you're able to express yourself is something if you are unable you know and they just check your paperwork. So I'm not saying you therapy itself is not helpful at all but I say it's not accessible fully for me. Interviewer: Umm. And you mentioned that age was also part of that accessibility issue.	Fatima recognised the quality of care is likely to have been different for those who are able to communicate in English compared to herself Clinician's reliance on clinical notes rather than communicating with Fatima An acknowledgement of the potential for therapy to be	This extract was included to highlight the experience of receiving treatment for an ED as a non-English speaker. This extract emphasises factors that may contribute towards clinician and patient power differences and negative assumptions experienced from this. For example, biases towards older age, educational status, ability to communicate in English and how this may impact someone's sense of self. Fatima describes a sense of feeling she had to overcompensate by asserting that she can 'read and write and

	Participant: Oh yes, 100%. Because older adult we have in general different needs and different time even to express ourselves. And whatever is said by a doctor, older people take it like it's been said by God because we don't have the things of challenging or, you know, ask further question. So, and that's all. And that is a thing. So, you know, respecting whoever study more than you. I'm not saying I am illiterate as I am able to read and write in my language and to have a proper conversation at a certain level but not in English.	useful in the treatment of ED if made accessible. Generational differences in how health related information from clinicians is received: Clinician's advice seen as God-like but also power difference in not wanting to question professionals Negative assumptions made about her abilities.	have a proper conversation'.

Appendix L.

Notes from member checking

Member Checking Session (notes)

General comments

One participant said that she did not think of the nature of her relationship with God but found it helpful to think of it that way and was accurate.

One participant found the theme of therapeutic alliance important.

Participants felt that the quotes from their interviews were accurately represented in the experiential statements

Participant comments:

"I agree with everything you have written. The only thing I would say is that some quotes are quite lengthy."

One participant wanted to add that "these ideas or ~~it~~ stereotypes stem from the portrayal of eating disorders in the media". "Developing a better relationship with God actually kick-started my recovery."

"There is also a sense of burden placed upon participants to educate their care team when there was a lack of understanding"

Culture and gender theme valuable.

Appendix M

Table showing examples of experiential statements for each participant

Participant	Experiential Statements
Maryam	• A persistence in the sense of difference within her cultural context. • The internalised societal norms and glamorisation of the value of thinness in a Western context, which contrasted with the shaming she experienced in Morocco towards her visibly thinner stature. • The minimisation and alienation felt in her identity as a Muslim woman with an ED. • The perpetual feeling of being a 'bad Muslim' which felt isolating and minimising • Her survival as a female in a male dominated environment • Acknowledging the competitive nature of her ED during the month of Ramadan • Developing her own understanding of her sense of self: missed opportunities to talk about her identity as a Muslim with an ED during treatment. • The distress and shame of culturally and religiously informed understandings of her ED.
Inaya	• Feeling punished by God for her sins leading to an inability to forgive herself. • The stress from the pressures of cultural expectations from parents • The acceptance in opting to not disclose the details of her illness to family members as a form of protection • The felt sense of disconnection with family Ramadan and Eid as triggered to the ED • The cultural silencing on mental illness and its impact on help-seeking • Her acceptance of family not understanding her ED • The trauma of being forced to engage in religiously informed treatment • A scepticism and lack of trust in mental health professionals • The internal conflict of wanting to achieve recovery but fear of disclosing elements of self during treatment • Advocating for peer support as a method of empowering others through the strength in sharing experiences
Fatima	• The fear of being perceived as radical for wearing a *hijab*

	• The persistence of feeling a sense of cultural difference • The neglect of her needs as a non-English speaker • The reliance on others and uncertainty this brings during treatment • Inaccessibility of treatment for an ED as an older adult and non-English speaker • The loneliness and social isolation as an older adult migrant • Disclosing having a mental illness to family as a threat rather than a comfort: the fear of being misunderstood
Aisha	• Her family's understanding of the ED through the lens of Islam and culture • The experience of relief from hiding the ED during the month of Ramadan • The internal conflict between fear from God not forgiving her and pull towards wanting to restrict • The journey towards better understanding her relationship with God and her illness: religion becoming a place of safety rather than root of fear • Her therapist's understanding of her culture and religion
Aliyah	• The social and cultural idealisation and glamorisation of losing weight soon after pregnancy • The negative sentiments towards weight gain during pregnancy • The parental guilt: becoming a healthy mother for her children • The worry of not wanting to be judged • The hypervigilance and self-regulation that occurs during treatment: the fear of being judged as a non-white Muslim female • The safety in receiving treatment from a Muslim clinician • Discovering a sense of 'solace and comfort' in faith • The distress of having an ED as a Muslim during the month of Ramadan • The dismissiveness of culture within treatment plans • The shaming from clinicians that occurs in healthcare documentation and letters

Appendix N.

Participants length of interview

Table showing participant length of interview

Participant	**Interview length (minutes and seconds)**
Fatima	68.22
Inaya	76.25
Maryam	51.49
Aaliyah	75.37
Aisha	53.56