Race, Ethnicity and Culture: what happens to these contexts when Family Therapists work with Childhood Eating Disorders?

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Abstract

Race, ethnicity and culture (REC) influence the meaning of food and eating. This research examines how attention and reflexivity of family therapists towards REC are influenced by the NICE guidelines (manualised, family-based treatment- FBT) when working in childhood eating disorders services. The guidelines position clinicians to focus on psycho-education and weight gain. Hence, the opportunity to reflect on differences and similarities when meeting families is often deemed unnecessary in the initial phase of treatment. This sets up a dilemma between saving life and being reflexive.

The study employs a qualitative, exploratory, multi-method approach based on online, semi-structured interviews with six individuals and two small focus groups of family therapists. Narrative Analysis (Dialogical/ Performance Analysis) was used to interpret the data from which structure, themes, identities, and contexts were drawn to address the research questions.

The analysis illuminated the participants' internal contexts and their connections with cultural practice. It also highlighted their external contexts such as team dynamics, FBT adherence, cost and efficiency. Wider societal influences were identified: the control of bodies, food and eating; the conceptualisation of risk and blame in modern society and in the NHS. Some unexpected narratives were elicited which showed the complexity of racism and the challenges present when addressing race, ethnicity and culture in this clinical context.

My findings show that the degree of adherence to FBT by family therapists, depends on their personal experience, resonance to emotional distress, confidence, team

priority and team support. Some participants demonstrated that therapists *can* save lives and be reflexive. Those who did not adapt FBT prefer the authority and certainty of the medical discourse. Nevertheless, as a systemic therapist, I believe FBT would benefit from adaptation in order for attention to reflexivity and inclusion of REC to be encouraged throughout the treatment process.

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1. Introduction

Britain is a multi-cultural society in which food and eating habits vary according to race, ethnicity and cultural traditions. Recent studies have shown a rising number of healthy children attempting to lose weight (Ahmad et al., 2022) as well as an increasing prevalence of childhood obesity (Office for Health Improvement & Disparities, 2020; Mayor, 2005). The incidence of anorexia nervosa is also increasing (Petkova et al., 2019). With globalisation and the increasing number of different food traditions in Britain, relationships with food and eating are becoming more complex as they are further influenced by the media, as well as societal and political values.

Eating disorders (hereafter ED) relate not only to food and feeding. They represent relationships between people and the contexts in which these experiences take place (Rabinowitz, 2019; Littlewood, 2004; and Dallos, 2006). Food and eating are influenced by complex family, social, culture, historical, economic and political contexts and dynamics (Caplan, 1997). The relationship between food and emotions varies between different cultures and within different families.

Yet there seems to be little expectation that the role and contribution of the traditions of food and eating in different cultures will be explored when treating ED. This is evidenced by the updated guidelines from the National Institute for Health and Care Excellence (NICE), published for the management of ED in 2017 (NICE, NG69)[1]. These recommendations were put together by professional experts, service users, carers and independent members of the public, and decisions were based on the 'best available evidence' for standards, safety, cost and efficiency. It recommends

[1] NG69 published in 2017 replaced the previous version of 2004, CG69.

Family-Based Treatment (hereafter FBT) as the first line of treatment. This is welcomed by most systemic thinkers as this places families in the centre of treatment and the provision of support to their loved ones. However, race, ethnicity and culture (hereafter REC) are not mentioned in the treatment recommendations. The only mention of ethnicity and culture is with other social difference markers, concerning the need to ensure "equal access to treatment". It is not clear why race is left out but, generally speaking, the term 'ethnicity' is commonly used in the UK to represent differences in heritage whilst, in the USA, the term "race" is used.

I am curious why there is no mention of REC under treatment advice, or anywhere else, in the NICE document given that eating is significantly connected with the REC experiences of families and individuals. It is no surprise, therefore, that this has impacted clinical practice because the guidelines have become the most influential context for treatment choices in ED services in all care settings across the country. Implicitly, this points to a collective decision, by a group of responsible experts and panellists in the field, to avoid race talk. I will use the following acronyms throughout this writing: REC for race, ethnicity and culture; ED for eating disorders; and FBT for family-based treatment.

For my research, I aim to explore and understand how REC are considered by family therapists who work in the field of childhood ED, how they work with the NICE guidance, and how they deal with the challenges presented by ED. I will begin with a family whose experience of therapy habituated them to focus on food and feeding. (The patient's name and details have been changed to ensure anonymity)

Sita has been suffering from anorexia since she was 14 and is under the care of Child & Adolescent Mental Health Services – Eating Disorders Team. I met her when

she had just turned eighteen and had been transferred to the adult service. Her parents were keen to continue family therapy but Sita was not. However, she attended for her parents' sake. Sita described her experience of family therapy as being aimed at support for her parents to give her food and calories, and she no longer wanted to do this. She wanted to feed herself independently. Her parents said that family therapy had enabled them to understand and support Sita's fear and anxiety around food. They were not sure what else could be beneficial about family therapy. Sita is the youngest of three girls of third-generation Asian descent. Her maternal grandparents came from India, and her mother was born and brought up in the UK. Her father was born and brought up in India.

Obviously, this is a simplified account. However, their experience reflects a focus on food and feeding without exploration of their wider contexts. This was important for saving her life but did not extend into conversations about family culture, values, or beliefs. The family experience of therapy was limited and it was of no surprise to me that Sita wanted to stop. After all, most patients with anorexia do not want to talk about food. Therefore, our discussion about food was not just about eating.

I set the context by introducing the idea that food represents many aspects of family life and culture. I wondered how the family felt about Sita turning 18. The parents felt that to them she is still a child. They still felt responsible for making sure she fed herself. Sita said she is now a grown-up. I realised Sita was referring to British cultural norms that define an 18-year-old as an adult. I wondered how this made the parents feel with respect to their own cultural backgrounds. We explored how food and feeding for Sita might change as she looks for independence. I used my experience of moving to the UK as an adult and having to 'cook for one'. This enabled the family to begin talking about their different experiences and positions

within their migration history. Sita became more engaged and reflected on her identity. The discussion continued with further exploration of family values, including the community influences and cultural heritage. They began to negotiate how care and support for each other can be shown across generations. This example from my own practice shows that a conversation about food with an emphasis on culture was the start of a better understanding between Sita and her parents.

An Initial focus on food and nutrition is expected in FBT. However, the topic of food appears to be reduced to the role of a 'medicine' for the purpose of weight gain. This view may be shaped by some patients who find conversations about food distressing, when the family members express high emotions (Treasure et al., 2007). It accords with the preoccupation for risk management by professionals and also with the effect of a manualised treatment approach that appears to move towards "safe certainty" (Mason, 2019, 1993) and being less reflexive.

However, to address REC issues, the therapist needs to be able to be reflexive about differences between families and herself, or at least reflect on what each of them brings to the therapeutic relationship. This is not a priority in the NICE guidelines and potentially compromises the opportunity to attend to the multiplicity of what food and eating might mean to a family. I think there is a need to make sense of how family therapists work with this polarisation of managing risk versus reflective practice.

Why am I interested in this?

I am Hong Kong Chinese and came to London in the 1980s to pursue my post-graduate training and career development as a mental health nurse. I had never

been so acutely aware of my Chinese identity until I lived in the UK. I suppose my physical appearance, my accent, and perhaps other cultural differences, positioned me as Chinese in the eyes of others. Then I realised that 'Chinese' can be from any part of the world so, ethnically, I am Hong Kong Chinese with a British colonial background. I know very little about mainland China. Still, I felt like an outsider in a foreign land, learning and adapting to different social norms while holding onto my roots.

My journey as an NHS professional, with the opportunity to train as a systemic psychotherapist, presented both challenges and support for my identity. It resulted in my gradual acculturation to becoming an insider within my profession. But I also connected with other aspects of life, such as starting a family, bringing up mixed-race children and becoming immersed in the British world that I had joined. Now I am moving towards retirement and I have become aware of another transition. I will, again, become an outsider as I consider the question of where I belong at this stage of life. Of course, it is not simply a question of being in an insider or outsider, but more of a challenge to find my place in a fluid and complex space.

My experience as a first-generation migrant contextualises my relationship with REC. My lived experiences have given me an acute sensitivity to migration and cross-cultural issues. When considering REC in relation to the treatment of ED I became aware of my own relationship with food, eating and feeding. This is highly influenced by my family culture. For example, my elderly father of 90 offered to fry prawn crackers for my young grandchildren when he heard that they were visiting. Prawn crackers are an ordinary Chinese snack and something that he can still cook despite his failing eye-sight. My father's desire represents our inherent culture habit of showing love and care through feeding. It is an example of how food represents far

more than just eating. Paying attention to food and eating, and to the way people talk about food and eating, can give an insight into culture, relationships and society (Caplan, 1997, p.6).

At work, I enquired, when appropriate, about how activities around food are organised and what food means to families. In this way REC issues were integrated into my discussions with families about food and refeeding. I am interested in how the contexts of other family therapists influence their consideration of REC issues in their work with families, especially in light of the NICE guidelines. I wonder how family therapists think about REC issues when risk management is such a high priority in treatment. However, I am aware that my viewpoint potentially may become my blind spot in this research.

In the next chapter, I present an account of the historical and current backgrounds of ED from the perspectives of psychiatry, family therapy and anthropology. I will discuss my position as a reflexive researcher. In chapter 3 I review relevant literature. Chapter 4 explains the methods I have employed in my research and my analysis. In chapter 5 I present pen portraits of the individual research participants and the findings both from the individual interviews and the focus groups. Chapter 6 discusses the findings in connection with the background and literature. Chapter 7 contains the conclusion.

2. Background

In this Chapter I focus on contributions from psychiatry, family therapy and anthropology to the past and present understanding of ED. I address key ideas, concepts and physical implications of ED, and how REC concepts and my personal experiences were used in this research.

2.1 ED as a medical diagnosis

The International Classification of Disease[2] (ICD-11) (WHO, 2019) places ED in the category of "feeding and eating disorders". ED includes four diagnoses: Anorexia Nervosa (AN), Bulimia Nervosa (BN), Binge Eating Disorder (BED) and Other Specified Feeding or Eating Disorder (OSFED). The last subcategory includes ARFID (Avoidance Restrictive Feeding Intake Disorder), PICA (eating non- nutritious substances) and Voluntary Regurgitation.

In this research I refer to ED as the first four diagnoses described by ICD-11 and mentioned above. This is to be consistent with the NICE guidelines (2017) which also defines ED in this way. DSM-5[3] (American Psychiatric Association, 2013) published by the American Psychiatric Association provides descriptive notes for gender and culture- related consideration on diagnostic issues (Attia, 2013). The subsequent text revision: DSM-5TR (American Psychiatric Association, 2022) added consideration of racism and discrimination on mental disorders (www.psychiatry.org).

[2] ICD11- International Classification of Disease, 11th edition, approved by World Health Organisation (WHO) in 2019.
[3] DSM-5: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by American Psychiatric Association in 2013.

This is of interest as it shows development towards a consideration of race and culture in the diagnostic process. In terms of actual content, ICD11 and DSM5-TR are similar except for the addition of Rumination Disorder in DSM5-TR.

2.2 Historical and current medical contexts of ED

ED have been known as a medical syndrome since the 19th century when it was written about by Laseque (1873, cited in Eisler et al., 2010, p.150) and Gull (1874, cited in Eisler et al., 2010, p.150). These authors both highlighted the role of family in ED. The earliest records of children with anorexia were by Collins (1894, cited in Lask & Bryant-Waugh, 2013, p.35) and Marshall (1895, cited in Lask & Bryant-Waugh, 2013, p.35) in the medical journal, *The Lancet*. Collins described a seven-year-old girl with food refusal and suggested there was a psychological component to her physical emaciation. Marshall applied the term anorexia nervosa to describe an eleven-year-old girl who died from starvation.

Bulimia Nervosa, was first described by Dr Gerald Russell in 1979. It is characterised by consuming a large amount of food followed by compensatory behaviours such as purging, using a laxative or excessive exercise (Russell, 1979). Binge eating disorder is eating an excessive amount food without engaging in compensatory behaviours and so patients present with the physical health problems associated with obesity. It was first described in 1959 but was only listed in DSM5 in 2013 and in ICD 10 in 2017. This delay may, in part, have been due to confusion between binge eating disorder and obesity. Obesity is generally seen as a lifestyle choice. Hence, binge eating disorder receives less attention although the prevalence is higher (Beat Eating Disorders, 2022). Hay et al. (2017) studied the prevalence of ED in an Australian population. They found that anorexia nervosa accounts for 8% of all ED whilst binge ED accounts for 22%, bulimia nervosa 19% and OSFED 47%. Of all ED,

anorexia nervosa attracts most attention because it carries the highest mortality rate (NICE, 2017; Fichter & Quadflieg, 2016).

2.3 Family therapy and ED

From the time that anorexia nervosa was first described as a medical condition, family dynamics were identified as a hindrance to patients' recovery. Separating the patient from the family seems to have been the dominant approach to treatment (Eisler et al., 2000). Despite this implied criticism, family therapy has become part of the psychological treatment for young people with ED since the 1970s. Different models have been used when working with families: the structural approach (Minuchin et al., 1978; Minuchin, 1974), the Milan systemic approach (Boscolo et al., 1987; Selvini-Palazzoli, 1974) and other therapeutic, approaches including attachment (Dallos, 2006, 2004), narrative (White, 1989; White & Epston, 1989), multi-family group (Simic et al., 2022 ; Fairbairn et al., 2011; Asen & Scholz, 2010; Asen, 2002 and Dare & Eisler, 2000) and FBT (Eisler et al., 2016; Eisler et al., 2010). Both the Milan and structural approaches use theoretical assumptions that certain family patterns and interactions are implicated in causing vulnerability to someone developing ED. This implies that family relationships are one of the contexts in which the illness develops. The family is seen to be a problem and therefore needs to receive treatment (Minuchin et al.,1978).

Further to Minuchin's ideas, post-modern thinking in systemic psychotherapy expanded from a first order to a second order position (Hoffman, 1985). Therapists were no longer observing the family pattern but recognised ED as part of the family system, influencing and influenced by the family. This meant that both the families

and the therapists' contexts were seen as constitutive and involved in transforming the therapeutic relationship and the meaning-making process. Cultural practice requires therapists to be reflective and reflexive, in a second order position, looking at themselves observing their clients. This justifies my curiosity about the therapists' positions and contexts in relation to REC and how they relationally influence each other.

Other developments in systemic psychotherapy include the narrative approach (Epston and White, 1992; White & Epston, 1990; White, 1986 and Foucault,1980) and the dialogical approach (Bakhtin, 1981) both of which position the family as a context for change, resource and strengths. Families are no longer seen as a problem or as being dysfunctional (Eisler & Lask, 2008). The focus has shifted to understanding how the family re-organises itself in a way that maintains the illness (Whitney & Eisler, 2005). Family therapy during this period began to focus on how the family adapted to, and adjusted to, life with ED or, unknowingly, compromised and so accommodated the illness. The relationship between professionals and the family has changed from one of family blaming to one of working collaboratively with families, understanding how they adapt and adjust to the challenge of living with the difficulties that an ED brings to their lives (Whitney & Eisler, 2005).

In the UK, the Maudsley Eating Disorders Service developed a systemic manualised family-based-treatment for anorexia nervosa (FBT-AN) (Eisler et al., 2016). Lock and Le Grange, from North America, also developed a manual which incorporated Minuchin's structural ideas (Lock & Le Grange, 2015 and Lock et al., 2001). In 2017 FBT became the recommended first-line intervention by the National Institute for Health and Care Excellence (NICE, 2017). Most eating disorders services opted to implement the Maudsley Family Based Treatment model (Eisler et al., 2016; 2010). It

is seen as systemic and flexible whilst the Lock Manual is seen as expecting strong adherence. The previous NICE guideline (2004) had also recommended family intervention and, currently, the importance of working with the family is not in dispute. Family therapy has become an integral part of treatment.

FBT (FT-AN) (Eisler et al., 2016) is based on systemic and medical principles and is organised into four phases[4]. Broadly, the first phase is to manage risk and enable parents to refeed their child. The clinicians are positioned as first order experts, staying outside the family system and looking into its members' experiences. This position implies the use of reflection. However, it does not necessarily encourage reflexivity, essential for cultural practice, during which clinicians are required to examine themselves, notice and reflect on the differences between themselves and the families, and then respond. When weight is stabilised, the treatment enters subsequent phases which the manual considers a safe time for therapeutic exploration. Therapists are expected to move into a second order position to be reflexive. It seems that, according to the model, this is the time for consideration of wider contexts such as 'race and culture' and other social markers are expected.

Although a manualised, linear, one-step-at-a-time approach offers "safe certainty" (Mason, 1993) knowing and being certain about what to do inevitably restricts curiosity. Furthermore, a focus on risk management to save life may also become a tool to avoid blame. Potentially, this will become an "*ideological domination*" of the institution when "*interest in cultural differences in the distribution of blame*" is

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[4] Maudsley Service manual for Child and Adolescent Eating Disorders (2016) FBT/ FT-AN: Phase one: establish therapeutic alliance to manage food, weight and risks. Phase two: helping families to manage eating disorder. Phase three: exploring issues of individual and family development. Phase four: ending treatment, discussion of future plans and discharge.

excluded (Douglas, 1992, pp.11-13). In its present format, the FBT manual leaves decisions about consideration of REC during treatment to the discretion of the attending clinicians.

2.4 Culture and ED

Hilda Bruch (1978), a psychiatrist and psychoanalyst, was one of the first to highlight both the changing culture of emphasis on slimness and the identity confusion in young women caused by contradictory demands originating in social values. Although, before 1990, because the incidence had been reported predominantly from Western countries, it was generally agreed that ED was a cultural-bound syndrome. Gordon (2001, cited in Nasser et al.,2001, p.4) did not agree. He and Nasser (1997) both argued that culture is not simply a link with geographical boundaries. Nasser proposed a "meaning-centred approach" to understand culture whilst Gordon argued for consideration of a culture-bound, or ethnic, disorder based on social dynamics. After 1990, ED began to appear in non-western societies going through westernisation, and in migrants moving to the West (Lester, 2013; Ma, 2005; and Lee, 1995). This removed the justification for considering ED a culture-bound syndrome based on geography and led to further debate about the role of culture (Littlewood, 2002).

Roland Littlewood, an anthropologist and psychiatrist, gave a comprehensive description of the cultural background to ED and its connections to gender, race, economics, social and historical changes (Littlewood, 2004, 2002). Eli and Warin (2018) reviewed the anthropological analysis of the diagnosis in the last three decades, emphasising person, structure, and bodily being. The focus became "*deciphering cultural logics*" (Eli & Warin, 2018, p.443). Studies in the cultural

phenomena of ED covered issues like "*the micro-scale of embodiment and lived experience*", "*relationality*" (Eli and Warin, 2018, p.445) and actions of patients, and between patients and their families, their social structures, as well as institutional practices within their culture (Eli and Warin, 2018).

A study by Becker et al. (2002) analysed the impact of prolonged exposure to television amongst ethnic Fijian adolescent girls through questionnaires and semi-structured interviews. They found the result of electricity cables being installed in some areas was the introduction of television. Seeing images of slim women led to a change in value about appearance and success. Slimmer women were seen as more competitive in the labour market. These media, social and economic changes led to disordered eating attitudes and behaviours. This highlights the influence of wider contexts on the risk of developing ED (Becker et al., 2002). It also shows that social and cultural considerations are relevant and concurs with the general acknowledgement that ED "*have a substantial socio-cultural component*" (Eli and Warin, 2018, p.444). Hence, looking beyond ED as an illness can open the exploration of changes relating to sexuality, kinship, and family, societal, economic and political identity and contribute to the possibility of relocating the symptoms back into their contexts and systems.

2.5 REC and reflexivity in Family Therapy

Family therapists are introduced to the concept of REC early in their training. Kenneth Hardy and Tracey Lazloffy's "Cultural Genogram" (1995) and John

Burnham's Social Graces[5] (Burnham, 2012 and Roper-Hall,1998), as well as other literature, reflect the importance of self-reflexivity in cultural practice and the consideration of intersectionality with other social differences (Crenshaw, 2018). It is mostly agreed that cultural practice in systemic psychotherapy refers to the reflexivity of therapists towards their clients' cultural backgrounds, how that relates to therapists' own lives and the cultural assumptions and biases that they bring to therapy (Roy-Chowdhury, 2021; Krause, 2012; Burnham, 2012; Pakes & Roy-Chowdhury, 2007; Urskine, 2002 and Hardy & Laszloffy,1995).

2.5.1 What is REC and how is it used in this research?

'Race', 'ethnicity' and 'culture' (REC) as concepts have been described by many in different ways. They might be regarded as a list of stereotypic characterisations based upon a number of assumptions (Fiske, 2017). For example, Chinese are like 'this' and English are like 'that'. Some recommended REC should be studied as combined or distinct concepts according to the contexts (McBride-Murry et al., 2004). Dalal (2002) described race as a discursive process of "racialisation" and not simply biological features.

In this research, I consider REC as relational: a set of social markers that are entangled and which, together, represent similarities and differences. To address REC issues, clinicians need to look into themselves, examine their own experiences, and be reflexive about their reflection. In the context of historical subjugation, such as colonisation and slavery, REC represents power, inequality, domination and

[5] Social Graces: GGRRAAACCEEESSS are acronyms for Gender, Geography, Race, Religion, Age, Appearance, Ability (Dis), Culture, Class, Education, Ethnicity, Employment, Spirituality, Sexuality and Sexual Orientation.

marginalisation that continues to exist in societies (Jones, 2000; Krause, 1998). When REC issues are examined separately, different dimensions arise.

'Race' is mostly seen as a biological difference, such as skin colour and physical appearance. But, genotype studies have shown that it is possible to have different physical features whilst sharing a similar DNA pattern (Caprio et al., 2008). Therefore, the idea that race indicates biological difference is now refuted. Other than biological features, race also represents geographical difference, country of origin, nationality, citizenship, right to stay in a country, privilege, power and other socio-political positions (Krause, 2021, 2015). It also represents a division and a hierarchy whereby white people hold power over the minoritised and hold them in a lower position (colourism).

Jones (2023, 2000) described race as not about biology, not class, not culture but "*A system of structuring opportunity and assigning value based on social interpretation of how one looks*" (Jones, 2023, 00:14:20). She went on to describe "*street racism*" which is when a person's race is identified or assigned by others. Individuals and communities are unfairly disadvantaged (black communities) or unfairly advantaged (white supremacy). This process "saps the strength" of the whole society through the waste of human resources (Jones 2023). So race can be seen as socially constructed, context dependent and changing over time. This has serious implications when it comes to health and social inequality and outcomes (Kapadia et al., 2022).

Krause quoted Amin (2010 as cited in Krause, 2021, p.2) about racism- "*the concept persists, as idea, as practice, as identity and as social structure*". Racism is not only political but is also internalised into peoples' minds and interactions as well as into

their cultural contexts (Jones, 2023; Dalal, 2002; Fanon,1967). The implications of racism, colourism, other forms of oppression, and power differences, continue to play out in our society through structure, ideas, practices, relationships and individuality. The recommendation for manualised FBT to be universally applied to all families, regardless of their difference or similarities in REC is a form of taken-for-granted practice that, quietly, may perpetuate oppression.

Ethnicity commonly refers to “shared identity” and “belonging to the same group” - sharing the same language, food, costume, ancestry, dance, flag, religion, etc. (Krause, 2021, 2015). Those both inside and outside the group contribute to the processes of creating, transforming and maintaining boundaries between the groups and these boundaries define their identities (Krause, 2021, 1998). The term BAME (Black, Asian and Minority Ethnic) has become dominant in describing the ethnicities of non-white people in the UK. According to Gunaratnum (2003) people do not exist as minorities but are “minoritised” by others and their social contexts. It is my preferred term and will be used in this study.

Krause described ‘culture’ as processes, contextual and relational. “*Culture is meaning with reciprocity between multiple perspectives*” (Krause, 2015, p.101) and goes on through “*the continuity of time*” (Krause, 2015, p.98). Thus, culture is not a thing nor a list. To me, it is a complex entanglement between the person and their contexts which are woven into the fabric of their social world and are within the person. Culture is inherited, embodied, relational and emotional; it is our heritage handed down from birth through the people or environments to which we relate (Krause, 2014, 2012). It is about meaning and is often beyond awareness. Some of it

is acquired and some of it is unconscious or "*doxa'*[6] (Bourdieu, 1998). In cross-cultural communication, reciprocity between people indicates the complexity of conscious and unconscious entanglement. Reflexivity can only address some of this and there is some we can't get to, like a blind spot. Therefore, at the very least, clinicians need to look into themselves to reflect and be reflexive. However, when culture is reduced to a list of values, beliefs, practices and traditions, it is vulnerable to stereotyping, assumptions and biases.

2.6 The challenge of ED services in dealing with issues of difference

NICE recommended FBT as the first line for treatment of ED. The Maudsley FBT manual therefore assumes a position of expertise and guidance about how treatment should be delivered. This offers safe certainty when clinicians are faced with an emaciated child and all the associations of physical danger, fear of mortality, distressed parents and a child who refuses or fights against feeding.

However, this universal approach to treatment presents a challenge to the practitioner when wishing to consider issues of difference (REC) at this early stage of treatment. So, REC considerations rely on the clinicians' interest and reflexivity. The decision to explore them is left to family therapists who are trained to pay attention to reflexivity and social differences.

[6] Doxa is our embodied pre-disposition of the world. It is taken for granted and unconscious. It is the unquestioned, internalised practical recognition of the social world (habitus) in which we live (Bourdieu,1998).

The lack of encouragement to do so has implications for the therapeutic relationship. This makes me wonder how family therapists relate to their cultural practice and how this fit with their service. Put simply, the NICE and FBT guidance prioritises feeding without advising attention to REC and reflexivity. The decision to consider these issues is left with each systemic therapist who is trained in how to pay attention to them. So, the question arises: do family therapists do this and, if so how? Do they complement or follow the FBT model in their practice?

2.7 Becoming an ethical reflexive researcher

As a researcher, I see myself as a 'background' to this study because my experiences and assumptions have an influence on the research process. In particular, my beliefs, subjectivity, and relationships with REC, intersectionality and food are directly relevant to the concepts being studied. Cunliffe (2016) highlighted the importance of being reflexive within the research process: being reflective both of the contexts and the power held as a researcher.

2.7.1 My relationship with eating disorders services

In the last few years of my NHS career, I noticed the way clinicians increasingly referred to what they could or couldn't do because of various policies, guidelines and recommendations. These were increasingly coming from NHS England, NICE and the Hospital Trust. It was as though clinicians were unable to think for themselves and were simply following authoritative directives. No doubt there is a need for clinical governance and standards but the power of these instructions carries constraints and affordances. I believe clinicians have a role in putting guidelines into

practice as well as making them fit with the needs of families. Families are not the same, not all one size, therefore some adaptation is necessary. In ED services, the NICE and FBT approach for all implies "safe certainty". However, it is also a constraint to curiosity and reflexivity. It seems therapists now provide the only voice in the multidisciplinary team capable of considering contexts, social differences and cultural practices in the therapeutic process.

2.7.2 REC and Intersectionality

As a migrant from Hong Kong, as described in chapter one, my lived experience draws me to REC and influences the way I see the world. I considered how my presence would bring an opening to these subjects and I am curious about the challenges faced by other family therapists when talking about cultural issues. I am mindful that others have different experiences and preferences when exploring aspects of social difference (Burnham, 2012). My own focus on REC may risk silencing other dimensions of social difference (Crenshaw, 1991), which are also important variables in making sense of culture.

Using myself as an example, I simultaneously belong to other social categories which intersect and place me in a position of privilege and disadvantage. Crenshaw's concept of intersectionality (1989) encourages us to be mindful of how our social categories intersect and how they can bring different discriminatory influences as well as differences in power. For this particular reason, it was important for me to look at how different aspects of my identity intersect and position me in this research.

Of relevance, I am a heterosexual, middle-class, divorced, Christian woman who has brought up two special needs children in a three-generations household. So, my social markers have brought different privileges and discriminations. In my ED

service, I represented the power of the NHS as an institution. But I also felt diminished by micro-aggressions such as when people gazed at me, and ignored or frowned when I spoke.

I am therefore aware of the complex intersectionality of culture, ethnicity, race, class, religion, gender, age, education, ability (dis), use of English and accent from my own contexts. Brah and Phoenix (2004) and Kleinman (1987) warn against the risk of categories. Brah and Phoenix support the idea of addressing entanglements of difference and attention to power. In this research, I will be observing intersectionality and will focus on REC without ignoring other social markers.

2.7.3 My relationship with food and eating

With regards to food, it is a Chinese idiom that says, “People take food as their heaven” (民以食為天). This reflects the emphasis on food in Chinese culture. It is deeply rooted in my family. I was an overweight child, as were all my siblings during childhood. I lost weight in adulthood. So, what does this say about the overfeeding of children in my family? Both of my parents arrived in Hong Kong as refugees from mainland China after WWII. My father worked as a ship’s captain and was away from home for prolonged periods of up to one year at a time. To a certain extent, we were brought up by a single mother. She came from a matriarchal family and put her hopes and successes into looking after her four children. Her parenting was about discipline. She cooked big portions, always making sure that there was more than enough. I think overfeeding represented the love she could not show.

Both my parents had lived through the Japanese invasion and the occupation of China when they were children. They spoke about food scarcity. My father remembered the desperate “hungry eyes” of starving people. My experience of being

overfed as a child has made me realise the complex associations between food and emotions in family relationships. Food is closely connected with identity, culture and unconscious social attitudes, and is loaded with metaphorical meanings (Caplan, 1997). Therefore, I am interested in how food is organised in clinical families.

As a young adult, I went on a diet motivated by the need to be the same as others. I suppose I had finally felt the rejection and the discriminatory gaze of others towards fat people in a competitive, commercialised society, against a background of stereotypical expectations of a woman's body. As a mother, I brought up two sons with special needs. I feel I can relate to the distress of a parent when their child is not well. My personal experiences make me realise the effects of wider contextual influences on how I relate to food and discrimination. Therefore, I feel I can relate to families who are struggling. I am aware that this 'knowing' position may inhibit my curiosity about narratives told by the participants. Of course, I cannot ever be totally impartial but I can be honest and open about my reflections. Therefore, the findings of this research will only be contextual, temporary, partial and contingent, and will not be claiming truth (Finlay, 2002).

2.8 Summary of background chapter

The benefit of exploring the background described above has made me realise the extent to which the manualised FBT approach to risk has positioned family therapists as first order practitioners. I realise that although family therapists are trained to pay attention to REC and to be reflexive about wider contexts, perhaps their ability to put the resulting understanding into practice is constrained or restricted. Eating is not only for nutrition, but it is inseparable from our cultural, ethnic and racial contexts. So

how do family therapists approach feeding and remain culturally sensitive when treating ED? Above all, how do we work with REC and manage risk? Pendry (2017) and Totsuka (2014) both described the challenges of REC practice for supervisors, therapists and trainees. I assume this is similar in the ED field and perhaps is perpetuated by the attention paid in FBT to the physical implications of starvation. In the next Chapter, I will review relevant literature in order to identify what is known about my research topic and to place my own research in a wider academic context.

3. Literature Review

I conducted a review to find relevant literature relating to eating disorders (ED), race ethnicity and culture (REC), systemic psychotherapy, and reflexivity. I searched an electronic database (3.1-3.3), and followed this with an examination of selected and recommended journals and books (3.4). I then re-ran the data base (3.5). All sections contain a short summary and the overall summary (3.6) includes the formulation of my research question.

3.1 Electronic database search through PsychINFO vis EBSCOhost

In 2018, I ran four concepts (table 1) through the EBSCOhost electronic database and obtained no result.

Table 1. Four Concepts with respective key words

Concept one	**Concept Two**	**Concept Three**	**Concept Four**
Culture	Eating disorders	Family Therapy	Reflexivity
Race	Anorexia nervosa	Systemic Psychotherapy	Sensitivity
Ethnicity	Bulimia nervosa	Family & Systemic Psychotherapy	Awareness
Migrant	Binge-eating disorder		Reflection

3.2 Database search results: REC, ED and family therapy

I re-ran the search by removing concept four (reflexivity), leaving the first three concepts – REC, ED and family therapy. This yielded forty-one articles. Three were relevant research studies and three were relevant conceptual papers using clinical examples and vignettes to illustrate ideas. All others were excluded because some of them focussed on efficacy, some were about other psychotherapeutic interventions and some were book reviews of no relevance. I will review these six papers (three research and three conceptual).

3.2.1 The three research papers

Chan & Ma (2002) investigated the meaning of food refusal through a single-case qualitative study. Eight family sessions with a Hong Kong Chinese family whose forty-year-old daughter was anorexic were video-recorded. These recordings were examined by two independent clinicians who found two themes related to food refusal. One was about disciplining her body and the other was about punishing her family (2022, p.52). Chan and Ma noted that disciplining the body was a similar theme to western findings. However, the additional theme of punishing the family (2002, p.55) connected with the cultural oppression of Chinese women who grow up being told they should "*obey their father when young, obey their husband when married, and obey their sons when widowed*" (2002, p.56). They concluded that becoming ill was due to suppressed anger towards her parents. She was punishing them for her sacrifice to remain and look after the family, according to the filial expectations.

Chan and Ma emphasised cultural contexts when attempting to make sense of the different meanings of food refusal.

Ma (2007, 2005) used two further case studies to show how she adapted her western systemic training to take account of a Chinese cultural context. She studied the self-starvation of a Hong Kong Chinese adolescent girl and illustrated the unique characteristics that arise from Hong Kong holding both eastern and western values and norms (Ma, 2005). She applied Micucci's family treatment model (1998), which specifically challenges "conflict avoidance" interactions.

However, she made specific adjustment to this American model to make it culturally appropriate. First, she made sure that family conflicts were discussed by allowing a "*gracious exit*" to "*save face*" (Ma, 2005, p.24). This enabled empathy to be shown for all involved by the therapist. Second, she addressed culturally specific rules such as filial piety to help adolescents take responsibility for their health. This allowed the parents to lessen their control. Third, she interrupted the "*excessive attention on eating or non-eating*" (Ma, 2005, p.24) thereby breaking the cycle of undesirable interaction, shifting food conflict to normal adolescent- parent conflict. This empowered the parents and promoted family members to take care of each other. Ma concluded "*throughout the process one must appraise and debate whether the treatment direction is guided by the family's culture, the therapist's own cultural frame, or by Western family therapists' voices*" (Ma, 2005, p.25). In that sense, she emphasised both reflection in action (Schon, 1992, 1987, 1983) and being self-reflexive. She was aware of relational positioning and the influence of cultural experience.

In a later paper, Ma (2007) suggested that a therapist and a client from different cultural backgrounds, with different values, beliefs and behaviours, may experience more challenges in developing a trustful therapeutic relationship. She used a case study to illustrate her struggle when working with an acculturated Chinese

adolescent in Shenzhen and described how Shenzhen parents made efforts to develop a personal relationship with the therapist, inviting them to meals, offering them red packets (lucky money inside a small red envelope), addressing the therapist as "*auntie*" and "*uncle*" and requesting them to see the family at home. Ma understood this because being made welcome into the family is a part of traditional Chinese custom which puts emphasis on "reciprocity" in a relationship. Ma described her ethical dilemma in how to respect these parents without breaching her professional codes of ethics.

Furthermore, she needed to manage her alliance with the anorexic daughter who saw the parents as "*dominating and intrusive*" (Ma, 2007, p.396). She resolved her dilemma by reflecting on her own acculturation process and considering how she is valued and accepted within Shenzhen culture. Ma was able to bring new experiences both to the young person and her parents to facilitate building a trustful relationship. So, reflection and reflexivity were the main features in her work. Ma advocated the need for "*cultural diversity*" and being "*ready to learn*" even when they are all Chinese (Ma, 2007, p.400).

In both of her papers Ma examined how western family therapy was adapted to fit the unique culture of Hong Kong and Shenzhen. She comes close to the participants in a way that Geertz referred to as being able to "read over the shoulder" (Geertz, 1973, p.452) and learn about the family. In the account of her clinical work, she highlighted not only the importance of cultural knowledge but also the importance of reflexivity in enabling her to adapt the western manual to local contexts.

These three case studies represent clinical practices that are unique to the described circumstances. Chan & Ma (2002) did not declare their ontological or epistemological positions, so it is left to the reader to decide. I think they took a positivist position because they gave the impression of objectivity, claiming truth by using two independent experienced colleagues to examine video recordings. Ma (2007, 2005) claimed that her epistemology is social constructionism and holds the ontological position of reality through reflection and reflexivity. Therefore, the truth in her findings is local, partial and co-constructed. Her research activities are the same as her clinical practice. I agree that her epistemological position was appropriate to make sense of working cross-culturally. However, her paper did not mention the risks and health issues presented by ED which can be significant. Therefore, my preference is to take a critical realist position which addresses not only the construction of the illness but also the realities of risk and low weight.

Interestingly, these papers are by the same practitioner who, like me happens to be, from Hong Kong. This is a place where east meet west and there is a rich mix of cultural differences. Her papers illustrate the importance of (1) culturally specific knowledge that influences Chinese families, (2) reflexivity about own relationship with culture and how that positions the families in relation to the therapeutic alliance, (3) cultural adaptation in clinical practice. These are the only papers on ED, REC and family therapy revealed by my literature search. I found no western research on ED and REC issues. This gap justifies further research.

3.2.2 Three conceptual papers

The first conceptual paper was by Di Nicola (1986) from Canada who described the theoretical positions of culture, language and affect. In this paper, he quoted work by Steiner (1975, cited in Di Nicola, 1986) which showed that the richness of history and tradition found in different languages may be lost in translation. He also quoted Sluzki (1984, cited in Di Nicola, 1986) who used family members to interpret conversation and a translator, separately, for explanation of the significance of cultural issues. Two clinical vignettes from family therapy work involving immigrant families with anorexic daughters showed that family functions can be mapped by attending to moments when there is a switch of language in families who speak more than one language. Di Nicola described this moment thus: "*code-switches made clear the structural positions of each family member*" (Di Nicola,1986, p.185).

In one example Di Nicola described a Greek family in which the mother ignored her husband. The mother asked the anorexic daughter to translate English into Greek. Therefore, he intervened by asking the mother to approach the father for translation, freeing the daughter from the triangulation. In an Italian family, the "code-switch" moment came when the two daughters spoke to each other in English and rejected Di Nicola's offer to translate the English to Italian. The daughters did not want to share their feelings with their parents. Di Nicola described the two daughters' positions as "*dutiful daughters in Italian*" and "*outgoing teens in English*" (p.186). He talked about attending to "*family process and cultural costume*" (p.189) when the use of language changed. Di Nicola adopted an expert position, using his clinical work to demonstrate previously published ideas. In this way, he is contributing to the body of knowledge about language switching during therapy.

The second conceptual paper discussed adolescence and mental health problems in immigrant Arab families in the UK (Timimi, 1995). Dr Sammi Timimi was a child

psychiatrist at Great Ormond Street Hospital, London. He explained the Arab culture as one which values loyalty and family. The father and older brothers have "*responsibility for the control of female sexuality*" (Timimi, 1995, p.144). Male elders hold the power within the family hierarchy. Somatisation is a common way for young Arabic women and adolescent girls to express their need for emotional care (Hafeiz, 1980 cited in Timimi, 1995). Food and diet are linked to health, comfort and pleasure whilst refusal of food is like a rejection. Fasting during Ramadan enables individuals to get closer to God and so refusal of food, and being seen as a good Muslim, disguises rejection of family care by food rejection. He concluded that health professionals need to collaborate with Arabs and Muslims to develop more culturally appropriate services. In this paper, Timimi offers authoritative insight into the social and cultural background to his psychotherapeutic work with Arab adolescents. Although he advocates a systemic approach to practice, his review of experience and literature is discussed from a psychoanalytic position.

The third paper illustrated the use of cultural systemic therapy in the treatment of anorexia nervosa in an Israeli kibbutz (Elizur et al., 1999). Living in a Kibbutz means sharing the group culture of a "self-administered collective community" (Elizur et al., 1999, p. 971) which includes responsibility for medical care. This resembles family dynamics which can both contribute to and maintain mental health problems but can also be part of the solution. The authors described the treatment of a thirteen-year-old girl with learning disabilities and anorexia nervosa whose suicidal ideas increased during inpatient admission. Therefore, a "*multi-culturally sensitive treatment*" a "*solution-defined ecosystem*" (Elizur et al., 1999, p.975) was organised with the kibbutz counselling committee, the kibbutz nurse, a treatment coordinator, the family, the patient and collaboratively with the medical and educational systems.

With agreement of the family, the patient joined a “home confinement programme” which had been developed by the kibbutz over twenty-five years.

The patient was “put on bed rest in a special room” with no visitors or social contacts during the initial two to three weeks, in a community facility. She was looked after by a medical team and a group of community aides who stayed in an adjoining room at all times. The patient was encouraged to self-regulate their own food intake without getting into conflict. Conversations with the patient about food, diet or weight were avoided. As the patient gained in weight, visits from her family and activities began. The aim of the programme was to provide “*psychic rest*” (p.980) for families and interrupt the power struggle over food, ensuring the parents are not blamed. Psychotherapy and family therapy started when the patient’s physical condition improved, and issues that existed before the onset of the eating disorder were then explored. This was similar to practice in the UK at that time. The authors believe this programme was effective in the kibbutz community because of their social and geographical cohesion. This paper advocates moving beyond “*simple ethnic description*” - not just the “*observation of sameness and differences*” (p.982) – and working with cultural diversity, applying this approach in different contexts, outside the kibbutz and in different patient groups.

These three conceptual papers offer diverse insights into the consideration of language, specific culture and community practices which are relevant to clinical practice. Together, they highlight that every culture has its own, specific beliefs and practices. They are a useful contribution to improve cultural awareness of specific racial, ethnic and cultural contexts, but it is also important to avoid stereotyping.

3.3 Database search results: REC with either ED or Family Therapy

I continued with the electronic database search using only two concepts at a time. "REC and ED" yielded 2754 articles. "REC and family therapy" yielded 3200 articles. "ED and family therapy" yielded 1849 articles. The large number of these articles suggests that there is overlap between these concepts that continues to draw interest. Going through them revealed that the literature comes from many fields not relevant to my research. I therefore focused on other resources, known or recommended to me, specific to my topic. These included papers from journals (family therapy, transcultural psychiatry, anthropology) books and relevant articles.

3.4 Further literature retrieved and reviewed

The following is a review of the literature I identified from either from personal knowledge or found following recommendation by colleagues. Four sections present combinations of topics that accord with the electronic search: ED and family therapy; REC and family therapy; REC and reflexivity, ED and REC. The final section is food, eating, ED and anthropology.

3.4.1 ED and Family Therapy

In the Journal of Family Therapy: Eating Disorder special edition (November 2017), four articles were identified. They are all from western countries: UK, USA, Canada and Australia. The key themes are about the efficacy of family-based-treatment, multi-family groups and other forms of therapy, searching for what works better.

In the first paper, Salaminiou et al. (2017) from the UK compared multi-family therapy with single family therapy for adolescents with anorexia. The study statistically analysed outcomes data collected from thirty families at different points during treatment: before, after three months and after six months. It compared the results with data from larger studies of single-family therapy. The conclusion suggested that multi-family therapy shows some promise as an additional treatment approach. Larger, randomised, studies for multi-family group treatment are required.

Forsberg et al. (2017) from the USA compared family-based treatment with adolescent-focused therapy for anorexia by correlating the treatment outcomes of each group with their respective parents' psychological symptoms, assessed using a standard questionnaire. The results showed that mothers with few or no depressive symptoms had children with the greatest improvement. However, parents' symptoms did not appear to negatively impact treatment outcome.

Dimitropoulos et al. (2017) from Canada, explored core principles of family-based treatment for adolescents with anorexia (FBT-AN). The study used thematic analysis of self-reported questionnaires collected from six focus groups. Each group was a paediatric team of five practitioners running a specialised ED treatment programme. Parental empowerment was found to be fundamental and imperative in phase one of FBT. This confirms the need to address any barriers to empowering parents.

Hurst et al. (2017) from Australia reported two case studies to compare Family Based Treatment for Bulimia (FBT-BN) with Enhanced Cognitive Behaviour Therapy (CBT-E). The families reported that FBT- BN is a platform for them to work together rather than leaving it to the young person. Conversely, CBT-E assisted the young person to manage cognition. The paper suggests adolescents with comorbidities

may benefit from combining both treatments and concluded that further research into augmenting CBT-E with FBT is necessary.

These four articles describe developments in the field of Family Therapy, asking if multi-family groups and family-based-treatments are more effective than existing treatments such as single-family therapy and CBT-E. These researchers took an empirical position, to work with what is observable in order to claim truth.

The first and second articles used quantitative methods and statistical analysis of outcome measures, scales and questionnaires. One was a randomised control study. Both took a positivist position to find truth and acknowledged their limitations including bias, small samples and lack of follow up.

The third and fourth were qualitative studies, one using a combination of focus group and self-reported questionnaires whilst the other used case studies. They yielded rich data of relevance to my research interest. In their study, Dimitropoulos et al. (2017) acknowledged that a number of other factors may have affected the result, such as culture, ethnicity, race, and gender. By considering such factors and their influence, I feel their position was one of critical realism, not only examining how FBT works but also remaining critical of other potentially influential factors.

I am struck that none of these four studies explored issues relating to REC, social difference, intersectionality, wider contexts, or self-reflexivity. The underlying assumption is, perhaps, that each person is the same. This generalisation reflects a one-size-fits-all approach which marginalises minorities whilst privileging the majority. Perhaps in the mind of researchers generally, REC is something that can be ignored rather than integrated into the lives of patients and families. This affirms my interest, as a family therapist, in exploring REC in the treatment of ED.

These four papers were written in the western world and show interest in working out what treatment is useful. However, writings from non-western authors are drawing attention to the cultural adaptation of western knowledge. I began to wonder how cultural adaptation is considered in services in the UK which is now a multi-cultural society.

3.4.2 REC and family therapy

Many scholars in family therapy have written about various aspects of cultural practice (Roy-Chowdhury 2021; Krause, 2019, 2012, 2010; McGoldrick & Hardy, 2019, 2008; Rober & De Haene, 2014; Wallis and Singh, 2014; Singh, 2014, 2009; Burnham, 2012, 1993, 1992; Totsuka, 2010; Pakes and Roy-Chowdhury, 2007; Divac and Heaphy, 2005; Falicov, 1995 and Hardy and Lazloffy, 1995). Broadly, family therapy training considers cultural competency as a combination of cultural "*awareness and sensitivity*". Awareness means "*cognitive function*" and sensitivity refers to responding emotionally - "*affective function*" (Hardy & Lazloffy, 1995, p.227). Both of which develop through addressing one's self: for example through one's own cultural genogram. The idea of Social GGRRAAACCEEESSS[7], jointly developed by John Burnham and Alison Roper Hall (Burnham, 2012, 1993, 1992; Roper-Hall, 1998; Burnham and Harris, 2002) is specified among the learning outcomes during the training of therapists and supervisors by the Association of Family Therapy (AFT). Family therapists are expected to be aware, sensitive and competent in working with issues of social difference. All the different aspects in the Social Graces constitute our identities, relationships and meaning making. Divac and

[7] GGRRAAACCEESSS are acronyms for Gender, Geography, Race, Religion, Age, Ability (Dis), Appearance, Class, Culture, Ethnicity, Education, Sexuality, Sexual orientation, Spirituality.

Heaphy (2005) advocate the development of “space for GRACES” in clinical, training and supervisory practice. Totsuka (2014) introduced a training exercise asking the supervisee to explore what aspects of social graces grab them, as ways to improve awareness both of their own preferences and how they communicate with their supervisees.

Pendry (2017) discussed how therapists often privilege a Eurocentric approach which marginalises the experiences of patients from different racial and ethnic cultures. He highlighted the difficulty in talking about race and racism because it is an emotive subject (2017, p.20) and he noted the preference for collaborative conversation in systemic practice. He described his own preference to raise race and racism issues. However, the concept of “collaborative”, which avoids imposing, has created a dilemma for him as a supervisor. He doesn’t want to colonise his supervisees with his power and agenda. However, he often wants to raise issues about race and racism when the supervisees do not. His dilemma invites us to rethink the concept of a “collaborative” stand (Anderson and Goolishian, 1992) which is not simply a space for “co-operative meaning making” as is widely accepted in post-modern systemic practice. Instead, for some, it may become a hindrance to uncomfortable conversations such as REC (Pendry, 2017).

I am aware that being collaborative has become a bit of a ‘mantra’ as if it is ‘the right thing’ and that it may potentially stops us from thinking. Therefore, we need to look out for ‘naive collaboration’, and not fall into the comfort of superficial collaboration. Rather, we should critically reflect on the structural influences which pre-determine what we believe or what we should do. Therefore, it is hard to be truly collaborative and the only thing we can do is be critical of ourselves and look out for our thinking, our feelings and our bodily responses that alert us, as was the situation with Pendry

who noticed his dilemma. By responding to resonance and being reflexive, we can turn to ourselves and question 'naïve collaboration'. We can speak up for REC or at least prevent it being pushed out by other topics.

According to Kenneth Hardy and Tacey Laszloffy (1995), in their work about cultural genograms…

> "…*culture and ethnicity are interrelated and distinct. Culture is a broad multidimensional concept that includes but is not limited to ethnicity, gender, social class and so forth. Ethnicity on the other hand refers to the group(s) from which an individual has descended and derives the essence of her/his sense of "peoplehood". Therefore, when all of the dimensions that contribute to culture converge (e.g., ethnicity, social class, gender), they form the whole of an individual's cultural identity*."
>
> (*Hardy and Laszloffy,1995, pp228-229*)

This description offers a conceptual connection between self and multiple social contexts. Culture is a concept that captures all the social contexts. However, John Burnham (2012) included culture as one of the markers in Social Graces thereby giving the impression that culture is simply another aspect in our social world. Burnham later critiqued that Social Graces has become a linear list, and so in order to create movement between each acronym, he used the metaphor "*collide-scope*" to create "*double description*" (Bateson, 1979, p21). He sees the list of social markers in the Graces as "*reflexively complementary*" and feels they should be used in a relationally reflexive way in order to bring up unvoiced and invisible aspects of difference (2012, p141). Nevertheless, in both the idea of a cultural genogram and in Social Graces, race (R), ethnicity (E) and culture (C) are undefined. This leaves it to

trainees and therapists to interpret what is meant. Perhaps that was intentional, thereby allowing therapists flexibility to relate to REC through their own contexts.

Therapists need to reflect on their own attitudes and assumptions (Cecchin, Lane and Ray,1992) and be reflexive about the different contexts that influence the therapeutic relationship (Pearce & Cronen, 1980; Tomm, 1988, 1987). Rober & Seltzer (2010) warned therapists not to colonise families with their own truth and reality either "*unintentionally or intentionally" (*Rober & Seltzer, 2010, p*.128)* according to their class, culture or gender values. They highlighted the need for therapists to be critically reflective about their own position and to listen to their own inner voice(s) (pausing and noticing) before reconnecting with the family. The limitation of self-reflexivity is our blind spot. Rabinow (2008, p.57) described the notion of "*observing the observers observing*". He implied that therapists ought to look at themselves from a meta position when observing their clients. This is more than self-reflexivity.

Ahmed (2004, p.6) described reflexivity as "*double turn",* first turning towards then turning away from oneself. Krause said, "*we can't know what we don't know about ourselves and our clients*" (Krause, 2012, p.14). She put forward the need for "*comprehensive reflexivity*" (Krause, 2012, p.9):

> "*That is to say*, *reflexivity which encompasses recursiveness between the different aspects of meaning, interpretation, and experience held or expressed by persons (either clients or therapists) as well as the self-reflexivity of both the therapist and clients vis-à-vis their own history, development, and background and the contexts in which they participate*."
>
> *(Krause, 2012, p.9)*

In other words, there is a need to be reflexive about the continuity of history from the past and about the potential for the future. Issues we are not aware of are brought into therapy by both therapist and client. The way we give meanings is influenced by our heritage and is handed down from birth through the people and environments to which we relate (Krause, 2014, 2012). Some of these meanings are acquired and some are unconscious.

D'Arcangelis (2018) called for "radical reflexivity" (p.339) and warned against unexamined liberal modernist ideas which can limit self-reflexivity. She pointed out the need to be aware of the influence of pre-determined structural positions. Foucault (1984, 1979) described how our lives are embedded in the dominant power of social, cultural, historical and institutional contexts. This power controls and objectifies us through the 'taken for granted' ways of being (Epston & White, 1992). Hence, we need to recognise and expose the influence of these subjugations on ourselves as well as how we subjugate others.

Rober & De Haene (2014) described cultural reflexivity as the examination of one's own culture and positioning with respect to the culture of others. They introduced the idea of "humanity" and believe therapists should examine their own "humanity and mortality" to create a posture conducive to working with families from different cultures. The term "humanity" is being critiqued for lack of clarity and for potentially being open to mis-interpretation by the privileged (Krause, 2014 and Singh, 2014). I also feel the word might potentially divert focus from REC but I do appreciate the posture of respect and, especially, being humane, which is required in any therapeutic encounter.

Asen (2019) highlighted that ED covers issues such as food, looks, weight, care, identity and control, all of which are specific to different ethnicities and cultures. His comment alludes to the importance of cultural consideration when working with ED. This is echoed in the thesis by Persaud (2017) where Dialogical Narrative Analysis was used to explore narratives of women from BAME communities recovering from ED. She produced a culturally informed practice guide to support clinicians in their work.

Given that most research interest in the ED field seems to be focused on efficacy, I am convinced that more research is required into the necessity of considering food, eating and REC. To add to this, I believe it is important for the therapists to explore their own narratives and reflexivity in order to avoid imposing their own known and unknown assumptions onto the families.

In summary, this section contains writings that are not primary research but reflect systemic ideas about REC in current practice.

3.4.3 Race ethnicity culture and Reflexivity

In the Journal of Family Therapy: special edition on Culture and Reflexivity (April 2018), six research papers were published. Two of them concerned competency in supervision and training and so are not directly relevant. The other four are described below.

Lee et al. (2018) used discourse analysis to examine cross-cultural encounters between a white therapist and a Pakistani immigrant family. Transcripts of recorded clinical sessions were analysed by independent therapists to identify significant

moments such as joining or negotiating. It concluded that critical reflexivity and self-reflexivity may unintentionally presumes the knowing position and introduce bias. Therapeutic encounters may then become *“disempowering and colonizing” (*p.176*)* Hence, therapeutic techniques of joining need to take account of their cultural and political contexts. This research points to a taken-for-granted practice that, if left unexamined, may become colonising practice. This is reminiscent of Pendry (2017) who highlighted how “collaborative” practice, if unexamined, can become marginalising (in previous section 3.3.2).

Yon et al. (2018) explored significant moments when therapists working in a specialist cultural service for black and minority-ethnic (BME) individuals challenged the family’s core beliefs. These moments were identified from pre-recorded clinical sessions. The therapists and the family members were interviewed by the researchers separately to discuss these. The data were subjected to thematic analysis and used to explore the effect on the therapeutic relationship. The study showed that the therapeutic relationship could have been maintained if a sensitive approach to difference had been used, in that, the clinicians were aware of both the family’s culture and their own cultural position.

Sametband and Strong (2018) examined significant moments, identified by the family members after their clinical session, where they felt they had successfully negotiated their cultural identities. The relevant segments from the routinely recorded clinical session and interviews with each of the family members became the data for discursive analysis. Nine immigrant families participated. The significant moment was recognised when the families began to talk about their cultural identities,

rejecting "*cultural membership*" being assigned to them by others. The researchers concluded that such moments, if recognised by the therapist, are therapeutic opportunities to explore the preferred cultural identities of family members. This adds to the literature which broadly focusses on issues such as acculturation (Berry, 2005), grieving the loss of culture or country of origin, living between two worlds (Giguere et al., 2010) or being stereotyped as "*kind of people*" (Hacking, 2006).

Hannon, White and Nadrich (2018) researched the influences of autism on the parenting style of Black American fathers through narrative inquiry. The emerging themes across the fathers' narratives demonstrated increased patience with their autistic child. This finding challenged the negative social stereotype found in available literature on Black fathers. Family therapists are encouraged to recognise cultural influences on the parenting styles of fathers as well as the societal influence of institutional and individual racism. Hanon argued that the ability of many Black fathers to develop patience with their autistic child originates in strengths developed throughout their life cycles as Black men.

These practice papers examined cultural issues, pointing to therapeutic alliance. They highlighted four points: (1) the assumption that the clinician's 'reflexivity' is the right way may become an unexamined practice which oppresses the family; (2) the benefit of being aware of both clinicians' and families' cultural positions when exploring and challenging cultural core beliefs; (3) the benefit of foregrounding the cultural identities of immigrant families; (4) the benefit of being aware of cultural influences on parenting involving Black fathers with autistic children.

Three of these research studies adopted a retrospective analysis of significant moments recognised in video recorded sessions of clinical interviews. Two (Yon et

al., 2018 and Sametband & Strong, 2018) added semi-structured interviews with the families. The methods of analysis varied: discourse analysis, thematic analysis, discursive analysis. The fourth research study is a narrative inquiry inviting Black fathers to talk about their experiences of parenting their child with autism. The emerging "commonalities" of the participants' shared experiences and interpretations of the fathers' experiences are identified as findings.

I note that thematic analysis (TA), discourse analysis (DA) and narrative analysis (NA) were used in these studies. DA was used more often which reflects its usefulness when examining how text and language are constructed to perform social actions, "talk-in-action" (Gale 2011). It offers opportunities to explore how identity, agency, personal power and control are relationally constructed by taking into account the dominant discourses. NA, on the other hand, examines stories of our experiences, lives, and identities, and the meaning and realities we give to our experiences (Polkinghorne 1995) as well as the social, historical and political contexts of the narration. Both DA and NA emphasise the researcher's subjectivity and their role in constructing and interpreting the research data. Both methods attend to the micro and macro contexts of the research data. However, DA is critiqued for not being able to capture what can't be articulated (Helps 2017), and it does not focus on the internal or meaning making process of the participant.

3.4.4 ED and REC

Of the six papers identified from an electronic search on transcultural psychiatry and eating disorder, only three are discussed below because the others are book reviews.

Becker et al. (2010) designed a self-report study that measured and examined dimensions of cultural change in order to assess how far acculturation was a risk factor for ED in ethnic Fijian schoolgirls aged 15-20 (see also 2.4 for earlier study by Becker et al., 2002). Exploratory Factor Analysis (EFA) was employed across an "*extensive inventory representing behavioural and cognitive domains*" (Becker et al., 2010, p.777) and showed acculturation to be complex and multi-dimensional. In keeping with their previous studies (Becker, 2004; Becker et al., 2002) ethnic Fijian adolescent girls may respond to changes in the social value of appearance and weight with disordered eating. Although not conclusive in suggesting that westernisation increases the risk of ED, it opens the debate to the possibility that social and political changes influence disordered eating and have a part in the process of acculturation.

The second paper (Le Grange et al., 2006) examined the eating attitudes and behaviours of South African adolescents and young adults. Three questionnaires (Eating Attitude Test – 26, Bulimic Investigatory Test, Edinburgh and Rosenberg Self-esteem Scale) were completed by 895 high school and college students of both genders. Their age range was 14 to 24 years. The self-reported racial categories were 58% white, Black 14% and mixed race 28%. Data were subjected to analyses of variance (race x gender x age). Measures of "*eating disorder pathology and self-esteem*" were not significantly different between the groups but a small number (3.5%) were considered to be at high risk. These were mostly adolescent females from both white and black heritage. In this study, ethnicity did not offer protection against the development of disordered eating attitudes and behaviours.

The third paper is a cross-cultural study by Emanuelli et al. (2003) in which mothers of young people with anorexia nervosa, attending ED clinics in Britain and in Italy, were compared. The authors used the Family Assessment Device (FAD) which is a 60-item, self-reported questionnaire to measure perceptions of family function in seven areas. The children were 10-18 years old. The data were statistically analysed by MANCOVA[8]. The findings indicated that British mothers perceived their family communication and role definition as being less healthy than Italian mothers. However, the Italian mothers perceived their families' behaviour control methods as less healthy than the British mothers. The researchers explained that the differences might be linked to a British emphasis on independence compared with the Italian emphasis on family life. Therefore, they suggest that cultural attitudes towards family life might influence anorexia nervosa.

All three papers were mixed-method quantitative studies using a validated questionnaire and statistical analysis. The first and second study looked at ED risk factors within the culture being studied. In the first, westernisation and acculturation appeared to have an effect on the development of ED risk factors in ethnic Fijian schoolgirls. In the second, three different ethnic backgrounds in South Africa were examined and there appears to be no difference between them in the risk of disorders eating. These two studies suggest that it may be 'change' rather than difference which is relevant for the development of ED.

[8] MANCOVA is a statistical analysis of covariance. It is acronym for "Multivariate analysis of covariance". It is an extension of analysis of covariance (ANCOVA) methods to cover cases where there is more than one dependent variable and where the control of concomitant continuous independent variables – covariates – is required.

The third study compared family functions in ED families and showed clear differences between two cultures. It has implications for family therapy practice in that treatment of ED needs to take into account the family's cultural background. This study would support inclusion of cultural consideration of all families with ED.

3.4.5 Food, Eating, ED and Anthropology

The history of studying food and eating in anthropology dates back to 1865 when E. B. Taylor suggested cooking as a human universal (Dirk and Hunter, 2012). The importance of culture in food and eating was examined by structural anthropologists in the 1960s and 1970s (Caplan, 1997, p.2) and produced important insights into and knowledge about the connection between food systems, health, identity, culture, unconscious attitudes of societies, as well as symbolic and metaphorical meanings. Food and eating are linked with social relations, power and inclusion (Furst et al., cited in Caplan, 1997, p.3) as well as historical, economic, political and wider societal structures (Goody, 1992). Food is seen as carrying memory and maintaining "*historical consciousness*" (Sutton 2001, p.170; Holtzman, 2009). Tierney and Ohnuki-Tierney (2012) proposed food as the basic element of cultural and social life. Studying food provides the possibility to understand the historical and current connections between cultures and societies, their boundaries, hierarchies, and class and power differences.

Roland Littlewood (2004) gave a comprehensive, anthropological description of the social, cultural, gender and political perspectives to ED, and how the control of the body has changed since industrialisation. Littlewood (2004, p.597) quoted Nasser et al. (2001) on recognising cultural influences on the different aspects of ED such as "*body imagery or women's social and family experience*". Littlewood went on to

describe how "*fear of fatness*" was closely connected with the identity change of women brought about by industrialisation and the "*development of eating as a leisure activity"* (Littlewood, 2004, p.597). Littlewood argued that "*modernisation*" is a context for ED because "*woman's identity is re-defined in a changing world*" (2002, p.79). He believed that women have become "*decontextualised and differentiated out*" from the "*social domain of nutrition, comportment, sexuality, kinship, economics, politics and religion*" and replaced by the "*internalization of social constraints into the embodied self*" (Littlewood 2004, p.598). Therefore, dieting, as the cause of ED, is "*only partia*l".

Littlewood (2002, p.80) proposed that "*Western women may 'possess' their bodies phenomenologically but they do not 'own' them*" because of the pressure and need to conform to social expectations. The influence of slimming magazines and the dieting industry creates a culture of dieting, exercise, and a preoccupation with health, body image, body shape and a desire to avoid becoming overweight (Littlewood, 2002, p.80). Cosmetic surgery has become available whilst overweight people are rejected for treatment by the NHS. Littlewood also quoted John Berger (2002, p.85) who described how "*Men look at women. Women watch themselves being looked at*" in the context of internalised male figures who become their surveyor. In modern society, disciplining the body against fatness represents self-control and achievement. Being slim has become medicalised as a "*fear of fat*" in anorexia (Banks, 1992, cited in Littlewood 2002, p.85).

In the last three decades, the anthropological field has moved on from debating whether ED is a culturally bound syndrome to one of understanding cultural logic. The present emphasis in ED is to reflect on the experiences of patients (Eli and Warin, 2018). I found a special edition on ED in an anthropology journal called

'*Transcultural Psychiatry'*. Although the following papers from this edition are adult-focused, they offer rich perspectives on cultural understandings of ED through the experiences of people with ED.

Musolino et al. (2018) used grounded theory, thematic analysis and an ethnographic approach to explore why South Australian women are reluctant to seek help. They cautioned that the medical approach may not always attend to individual stories and they advocated a cultural lens through which to explore "*desire*" located in "*gender, bodies and health*" (p.536). They highlighted a neglect in the cultural understanding of ED and what it means to experience desire and how desire shifts in different gender and socio-cultural contexts. Without such cultural understanding, the cycle of recovery and relapse continues.

Lavis (2018) drew on ethnographic and qualitative interviews to explore the relationship between "*not eating*" (p.454) and the desire to live with the illness. This comprised participant observations and interviews with service users, staff from the UK National Health Service and people from pro-anorexia websites. Participants' narratives suggested that anorexia made it possible to retreat into a "*numb and protective bubble*" (p.454), like "*self-anaesthetisation*" (p.460). Lavis concluded that these narrations represented a safe space in the world where they could feel better. She stressed the importance of moving away from giving attention to the anorexia itself towards looking at the distress and traumatic life events which underlie the illness and the desire to maintain it (p.465). I think this is rather similar to the systemic idea of exploring the contexts that are maintaining or constituting symptoms.

Ahlin (2018) presented an ethnographic case study of disordered eating in a female pharmacist from one of the North Indian provinces. The study described the Brahmanical patrilineality around the culture of arranged marriage. Alin argued that “not eating” may be “*an embodied expression of distress, related to the inability to fulfil filial reciprocity*” (p.560). Furthermore, he described this as a regional socio-economic development in which “*a young, unmarried and highly educated women*”, with opportunities for formal employment, may be in conflict with social expectations. The study highlights possible contextual contributions to the meaning of “not eating” within social, cultural, gender-specific and economic influences in one particular part of the world. In a different context (the UK) the female pharmacist would have been diagnosed as anorexia rather than just “not eating”.

Eli (2018) explored the embodiment and sensory experiences of people in Israel with a diagnosis of ED. She noted self-starving, bingeing, and purging as well as the visceral feelings of hunger, fullness, emptiness. She used the concept of “*liminality*” to think about the ED experience of turning inward to self and away from social contexts, linking these narratives to the idea of “*social suffering*” (Kleinman et al., 1997) in which participants’ misery is a response to “*violent and oppressive life conditions*” (p.489). Although ED is a serious medical condition, it requires more than just psychiatric treatment. Therefore, she proposed “*the need for paying attention to the structural conditions that shape eating disorders*” (p.491).

These studies from the special edition in *Transcultural Psychiatry* explored the experiences of people with ED and illuminated connections between individual experiences and the contexts that constitute and maintain ED. The methods involved ethnographic observations and interviews, and generated rich narratives for analysis.

3.5 Re-run of the database literature search in 2022

Prior to writing this chapter, I re- ran the original database literature search and found one paper that covered all four concepts, as described in table 1. This was a commentary (Iguchi et al., 2021) reporting the progress of adapting family-based treatment (FBT) for use in Japan. Two main adaptations were implemented to address "*systemic and cultural barriers*". First, during inpatient admission, the parents supervised their child's eating on the ward while previously they were excluded in order to avoid parental criticism. In accordance with FBT, parents received psychoeducation and learned how to provide meal support. Second, fathers were encouraged to "share responsibility" with their respective wives. Traditionally, the father is out at work and the mother takes full responsibility for the home. The model was adapted to accommodate some fathers who were reluctant to be involved. Instead, they were asked to support their wife and act as a "buffer" when conflict arose between the mother and the child. Comparing 30 FBT cases with 30 traditional cases where parents were excluded, the adapted treatment group achieved 85-90% of expected body weight, on average, four months faster than the traditional cases. Even though the difference was not statistically significant, FBT shifted the traditional approach of excluding parents. It also introduced externalisation of the diagnosis of anorexia nervosa as a theoretical framework which increased parents' empathy and support towards their child.

This research from Japan highlights the importance of how cultural "acceptability" and engagement by families in the treatment of ED can lead to improved outcomes. This makes me wonder how manualised ED treatment is being adapted and accepted by families from different cultures in UK. The idea of adaptation when

working with families of different cultures is similar to that previous mentioned in this literature review.

3.6 Summary

As noted, each section above ended with a brief summary. Overall, my review of the literatures covered a range of methodological approaches including both qualitative and quantitative methods: case studies, randomised control studies, retrospective enquiry of clinical practices, explorations of patients' experiences and focus groups. Some are single method, and some are mixed-method, including observations, scoring of questionnaires and outcome measures, analysis of clinical sessions recording. The epistemological position of these studies varied: social constructionism with reality being co-constructed (e.g. Ma 2005); positivist with the truth is there for us to find out (e.g. Salaminiou et al., 2017). No study declared itself to be working from a critical realist position i.e. looking at the links between reality and its construction in the social world. For me, ED has the reality of physical risks and suffering but is also influenced by a number of complex factors. My interest in exploring ED and REC requires a critical realist position.

This review process touched upon a wide range of literature and expanded my thinking on various concepts and methodologies. Together with the account of the background history (previous chapter) when considering how childhood ED has evolved over time, from social, medical and systemic perspectives, I noted the overlap and entanglement of these various aspects. I therefore decided to confine my attention to the wider contexts (NICE), the physical risk of ED, and how the

emphasis on efficiency may have influenced reflexivity and cultural practice by family therapists. Food and feeding, which is so relevant to ED, has been overshadowed by the dominance of manualised practice. The meaning of food and feeding has been reduced from “human universal” (Taylor, 1865) to medicine, as part of the first line of treatment. I conclude there is no literature reporting the entanglement of ED and REC and therefore I devised the following questions.

Research title: Race, Ethnicity and Culture: what happens to these contexts when family therapists work with childhood eating disorders?”

Questions:

1. How do family therapists in Children ED Services talk about their work with families and REC?

2. How do the risks of ED influence family therapists’ self-reflexivity about REC?

3. How do family therapists incorporate thinking about REC when working with the NICE guidelines for ED?

These three questions were designed to prompt participants to talk about and help clarify the areas of research that I am interested in. My plan, broadly, was to invite family therapists to describe their work with families and examine how REC and reflexivity are talked about in the telling of their experiences. The details of my methodology are in the next chapter.

4. Methodology

In this Chapter, I describe my ontological and epistemological positions and how narrative analysis fits with this study. I also reflect on my own position regarding the research design and how data were collected and interpreted. I created pen portraits of the individual participants. I used colour-coding and applied Dialogical/ Performance Analysis (DPA) to the narratives, some examples of which are included.

4.1 Epistemological position and why narrative analysis?

This research shifted from an epistemological position of social constructionism to critical realism during its course. In this shift, I was influenced by Hacking (1999) who gave an example of a refugee woman to illustrate the idea of social constructionism: her refugee status was constructed but the woman's suffering was real. In a similar vein, physical risk and suffering, for patients with ED and their families, is real but the idea of ED is constructed and influenced by many contexts. However, the reality of ED is not sufficiently addressed by social constructionism which acknowledges that reality is constructed in language within their contexts (Cronen and Lang 1994). Previously, as a social constructionist I used the concept of Domain Theory[9] in my practice (Lang, Little & Cronen, 1990). According to the situation, I moved between the three domains (see footnote) in order to manage the truth, right or wrong. For example, when managing risk, I follow the protocols which puts me in the domain of

[9] Domain theory described the movement between three positions: the domain of production, explanation and aesthetics (Lang, Little, Cronen 1990). When I am in the domain of explanation, I am critical of the construction of reality and explore multiple truths. When I am working with one reality, the right or wrong, I am in domain of production. The domain of Aesthetics is about being ethical and moral which should exist in our practice at all time.

production. Critical realism, on the other hand, is a paradigm that directly encapsulates the situation.

There are three levels of reality in Critical realism (Alderson, 2021). The "empirical" level is about understanding and analysing reality (epistemology). The "actual" level acknowledges that "*the world exists independently of our thoughts* (ontology)" (Alderson, 2021, p.49). The third is the "real" level: "*the unseen causal influences or mechanisms*" between truth and its construction (Alderson, 2021, p.49). Critical realism emphasises the consideration of how truth and its construction influence each other (Alderson, 2021, p.52). It "*avoids interpretivists losing touch with reality" and "positivists losing awareness of their theories*" (Alderson, 2021, p.48). It is also argued by Pocock (2015) that critical realism addresses the split between structuralism and poststructuralism and allows family therapist to account for their realist position. For me, critical realism takes into account other concepts in our social world. So, critical realism speaks to the nature of ED in which there is a reality of physical risk and a construction about its description.

Lawson (1998) states that the evidence we observe can come close to reality but is always a fallible, social and subjective account. My research focuses on the experiences of participants by examining their narratives. Reality exists in the dialogue between myself and each participant. This relationship is the one thing that can be considered a reality. So, I assume there is a relationship between myself and each participant, but there is always something more in and behind the dialogue which remains unknown. In that respect, critical realism values multiple truths and incorporates aspects of social constructionism as it accepts that there are different ways of getting to reality.

4.1.1 Narrative analysis

Bhabha (2000) wrote about “the right to narrate”- about the silenced voice being heard. He said to narrate is not simply a linguistic act but a metaphor of the fundamental human interest in freedom itself; the right to be heard, recognised and represented. Adichie (2009) argues that the power of a story can not only “*dispose and malign*” but can also “*empower and repair broken dignity*”. One of the assumptions of narrative research is that there are multiple truths, interpretations and possibilities (Squire, 2013). When people tell the story of their life they bring their experience, background, social situation, race, economic and political contexts into their narration. Therefore, examining a narrative about events, experiences and dialogues demonstrates the purpose of telling the story and makes sense of the events including the emotions, experiences, relationships, the hidden and unheard stories and the contexts that influence them. In particular, narrative research also seeks to reflect on how participants in dialogue co-create narratives (Riessman, 2008) as well as how people position themselves, position each other, and include their wider contexts.

Narratives are intimately linked with life. Humans, as a species, tell and understand stories (Bruner,1990). Ricoeur (1991) described how the concept of plot emerges from many incidents and becomes the one story. Life and story are linked by plots. Stories influence us through our social and cultural contexts. We learn about virtues through favourite characters, and about ourselves through imagined variations of our own narratives. For example, in the story of The Hare and the Tortoise (Aesop’s fable) two characters run a race. The hare ran quickly, teased the tortoise, stopped for a rest but fell asleep. The tortoise moved slowly, without stopping, and won the

race. To me, the hare represents arrogance through over-confidence whilst the tortoise represents endurance and success.

Every story teaches us something. Ricoeur (1991) referred to Aristotle's idea about how an understanding of narratives can reveal the practical wisdom of moral judgement. MacIntyre (1984) claimed that narratives construct morality but are time, culture and context dependent. Therefore, all stories can be seen as "*morality tales*". Ricoeur (1991) also refers to the influence of contextual factors in the construction and reconstruction of stories. He described how narratives are jointly told between speaker, listener, writer and reader. There is a relationship between "*life as a story in its nascent state and its symbolic translation into recounted narrative*" (Ricoeur, 1991, p.29). The study of narratives opens the possibility of understanding the narrator's experience of how they want to be understood. In addition, it reveals our subjectivities and our understanding of the relationship between the narrator, the researcher, the text, the audience, local and wider contexts, and the world we are in.

Narratives, according to how they have been studied, are broadly considered as event-based, experienced-centred (Patterson, 2013) or socio-culturally orientated (Squire, 2013). Small stories happen in everyday passing and canonical stories are performed within what is possible in local and national contexts (Phoenix, 2013; Georgakopolou, 2006 and Bamberg, 2012). Big stories are grand or meta-narratives that tell us about larger ideas such as social systems, class, history and structures, etc (Georgakopolou, 2006 and Bamberg, 2006). There are many methods and approaches, with different emphases, to make sense of the multiple layers that stories and narratives can bring. My study seeks the views of professionals in the field. There is a possibility that participants might feel they should hold back or say

'the right thing' to look acceptable. By inviting them to narrate their experiences and stories, I am more likely to generate data that are less canonical.

4.1.2 Trustworthiness, transparency and accountability

This research methodology does not claim truth. I use self-reflexivity and comprehensive reflexivity (Krause, 2012) to reflect on my influence on this research as well as on my consideration of the contextual influences of the social, cultural and political processes. This enables me to claim "*trustworthiness, transparency and accountability*" (Finlay, 2002, p.211). To ensure "trustworthiness", I have taken a reflexive position throughout, in my writing, reflections, supervision, examination of my own prejudices and my experiences. I have reflected on how these affect my design, interpretation and how my expectation of the outcome of this research study influences me (Finlay, 2002). I am aware that my perception and position are influenced by my experiences and subjectivity. However, there is always a blind spot which is outside my awareness. Wagner's comment (1981, cited in Krause, 2021, p.9) is one I found helpful: "*their misunderstanding of me was not the same as my misunderstanding of them*". This highlights the complexity of the space between one-self and others. There is something beyond what we are aware of because it is outside our consciousness. What we understand and misunderstand about others is not necessarily reciprocated by how they understand or misunderstand us. Therefore, we need to be alert to our own subjectivity, be self-reflexive and remain relationally reflexive.

Consequently, this research is incomplete, partial and emerging but it is trustworthy, transparent and accountable. For example, changing the epistemological position is a response to my self-reflection and reflexivity. It is a response to what I noticed despite my own resistance as a social constructionist practitioner. On noticing this

dilemma and reflecting on the pros and cons, and the limitations and strengths of each paradigm, I took an ethical decision to make the necessary change.

4.2 Research Design and Process

4.2.1 Ethics and data collection

This research was approved by the Tavistock Research Ethics Committee (hereafter TREC) in December 2019 (see appendix 2a). It is a qualitative exploratory multi-method study, initially designed to have two phases. A focus group with a maximum of six participants would generate areas of interest for the content of semi-structured interviews with six new individuals. However, the design needed to be amended as a result of the onset of the COVID-19 pandemic and the first lockdown in March 2020. Face-to-face meetings were no longer possible. Like most things during the pandemic, adaptation and management of uncertainty became a significant part of this research. Amendments to the methodology were approved by the TREC in April 2020.

The revised process also had two phases. The first phase now involved the individual interviews. Initially, six participants were interviewed separately using an on-line platform (Zoom). The first set of interview questions was informed by my own curiosity and the first literature review, which had shown a lack of relevant research relating to family therapy and REC in ED. Subsequently, a second round of interviews was arranged because, during the first-round narratives, I observed a lack of spontaneous references to food and eating. Each semi-structured interview lasted no more than one and a half hours (see appendix 3a- interview schedule).

The second phase comprised two online focus groups, each with four participants. The original agenda for these sessions was based on my research questions and was further informed by ideas, or responses that surprised me in the first set of interviews. Details of group exercises can be found in appendix 3b.

When I started the individual interviews, there was still a possibility that the focus groups be face-to-face rather than online. The new TREC approval allowed either, subject to how the pandemic situation developed. I had limited experience with online groups at the start of lockdown, but my online group experience increased during the pandemic. When the time came, the group participants preferred to meet online. Therefore, all data in this research was derived from interviews conducted on line.

During the course of interviewing and transcribing, I noticed that five participants talked about food and eating either as psycho-education or only in relation to refeeding as part of their treatment approach. I had expected that asking participants to describe their clinical work would result in them talking not only about their patients but also about their own personal experiences of food and eating. On reflection, I realised that family therapists in the ED field are primed to connect food with psycho-education which may have been why personal food stories did not emerge. I remember struggling during the initial interviews with the dilemma of whether I should ask directly for their personal food experiences or just let their stories unfold. I opted to listen, and to avoid leading the participants to say what I wanted to hear. Participants do not necessarily talk about what the researcher expects (Riessman, 2002). As none of the participants related personal experiences of food and eating during the first round of individual interviews, I discussed this with

my supervisor and planned the second round. These interviews focused on therapists' food and eating and connections with REC.

The data were collected over a period of twelve months, between May 2020 and April 2021. The first set of six individual interviews were held between May and August 2020. The focus groups were held in Nov 2020 and March 2021. The second round of individual interviews took place in April 2021.

All participants were recruited by snowballing or as a result of advertisement in the AFT (Association of Family Therapy) newsletter or through their ED special interest Google group. This was to avoid any undue pressure from the researcher during the process of providing participants with an information sheet and a consent form (appendix 2b and 2c). I also offered time to answer any questions that potential participants might have. The Zoom interviews were recorded and copied to an audio machine.

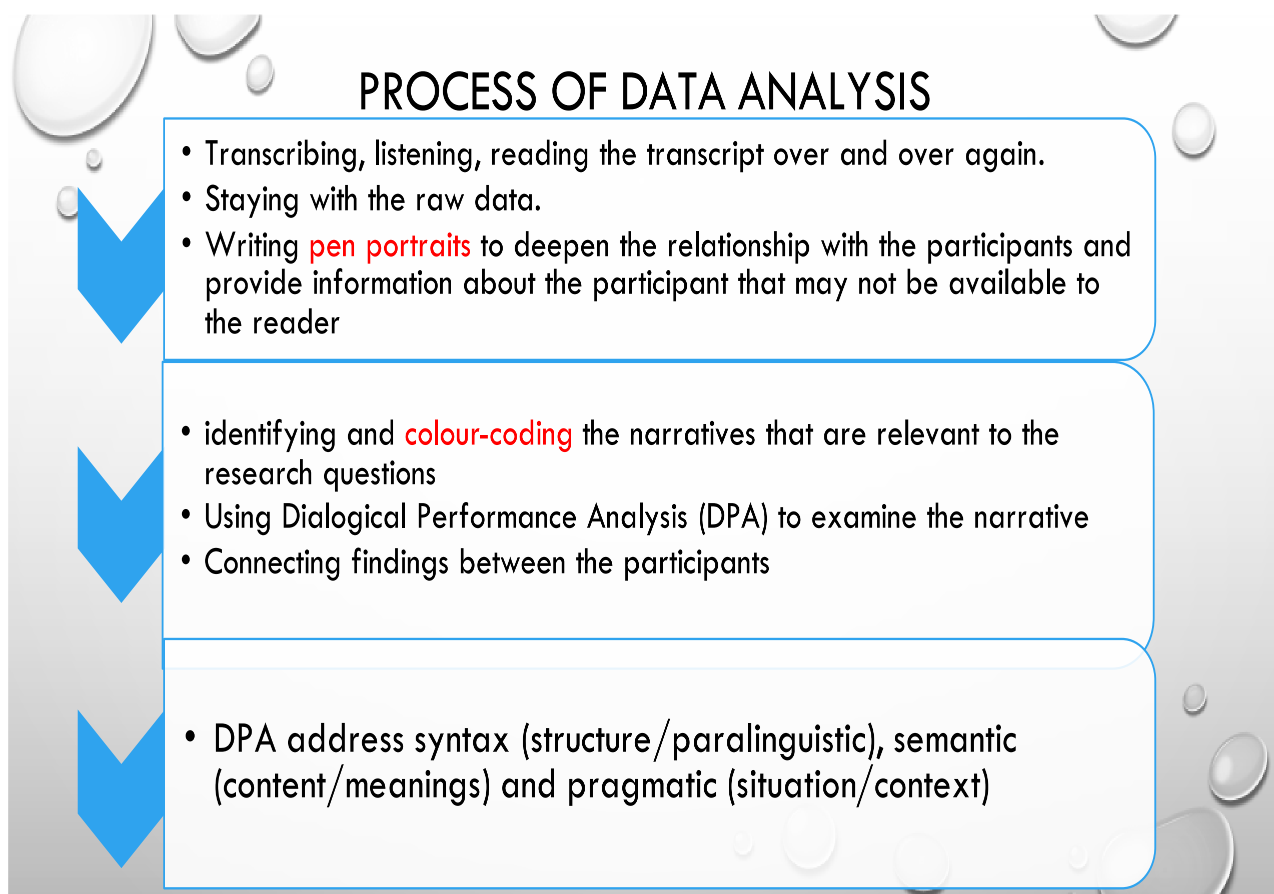
In summary, data collection started with my curiosity and the literature review. The response of individual participants evoked further questions which I developed for discussion at the focus groups. The second round of individual interviews were undertaken particularly to explore food and REC.

4.2.2 Data Analysis

Each participant was given a name to ensure anonymity. I transcribed each audio recording onto a spreadsheet, using the Jefferson Transcription system (1985). This method offers notation symbols that cover text and body language for both micro and macro analysis. The symbols capture expressive sound such as hesitation, pauses, emphasis, silence, breaths in and out, as well as other sophisticated turn-taking

conversational points. A list of the notations used and their meanings can be found in appendix 4a. They allowed me to use Dialogical/ Performance Analysis (Riessman, 2008) which examines the use of language, syntax and emotions during the interviews (see example in section 4.4.2).

Initially, I made reflective notes in a separate column, alongside the transcript, as I was transcribing. These were intended to record my own performance, such as my use of language, grammar, accent, and whether I was succinct or hesitated. However, I soon realised that this was diverting my attention away from the participants. I did not continue with this and concentrated my focus on the participants. However, I ensured that I continued to listen to how we influenced each other and observe what we constructed together. The process of data analysis took place in three phases as depicted in the following table:



4.2.2.1 Pen portraits

I created pen portraits (sketch impressions of the participants in words) to form a closer relationship with their characters and perspectives (Holloway and Jefferson, 2000; Golsteijn and Wright, 2013). Each was a qualitative, narrative description derived from the transcript, which allowed unseen components of the interview to come through. It offered me the opportunity to bring in contextual elements that were not in the excerpt but which shaped the positions of both the researcher and the participants. By writing a pen portrait, I developed a closer relationship with each participant and this informed my interpretation of their narrative as required by DPA. Pen-portraits provide interview information to those who don't have access to the transcripts (examples in chapter 5).

4.2.2.2 Colour-coding

In order to manage the large amount of data from the interviews, I devised a four-colour coding system for the text to identify different narratives: (1) black-- all narratives; (2) red- narratives that I considered striking; (3) green- narratives that I considered relevant to my research questions; and (4) purple- what I considered to be situated in and influenced by wider contextual influences (example in appendix 4b).

4.3 Dialogical/ Performance Analysis (DPA)

4.3.1 Choice of analysis method

During my Master's degree, I gained experience of Labov's structural method (Labov and Waletzky,1967 and Labov, 1972) to examine events and the Coordination of

Management of Meanings (CMM) (Pearce, 2007, 1994; Cronen & Pearce, 1985 cited in Burnham, 1986, p.22) to examine contexts. With this combination I explored the wider contexts and moral logic that influence our choices, meanings, actions and communication patterns. However, for the present research, I was looking for a single method that could embrace the examination of events, experiences and their contexts with consistency. I considered conversational analysis but found that this method is applied to conversations that happen in their natural environment. When I looked into DPA (Riessman, 2008), I found that it uses aspects of narrative structural and thematic analysis and examines the many contexts from an interpretative standpoint. I recognised DPA as a good fit for my requirements because it attends to the narrators' stories and meaning-making, the use of language and how it is performed, and the social contexts. It attends to experiences and events, whether they be neatly organised or less ordered (Riessman, 2002). In addition, it allows the exploration of multiple truths, including the interpretative contribution of the researcher, and examination both of the reality of experience and the construction of it. This is congruent with the critical realism position of examining "the real, the actual and the empirical" (Alderson, 2021, p.48) in both the reality of ED and the construction of the idea.

DPA is a form of narrative analysis described by Catherine Riessman (2008).

> "S*tories don't fall from the sky* (*or emerge from the innermost "self*"*);*
>
> *they are composed and received in contexts – interactional, historical,*
>
> *institutional, and discursive*- to name a few. *Stories are social artifacts,*

> *telling us as much about society and culture as they do about the person or group."* (*Riessman, 2008, p.105*)

Riessman described the nature of stories and proposed Dialogical/Performance Analysis (DPA) as a broad and varied interpretative approach to interrogate how talk is dialogically produced and performed between speakers. This method uses aspects of narrative structural analysis and narrative thematic analysis, adding consideration of contexts and the influence of the researcher (Riessman, 2008).

DPA has the advantage of examining syntactical, semantic and pragmatic aspects of conversation. It analyses the experiences of the narrator and the contexts that contribute to the narration. Therefore, it addresses the reality and experience of the participants who work in the ED field and identifies contexts that are influencing the construction of their experiences such as race, ethnicity and culture, power, language, socio-political aspects, as well as medical and systemic practices.

4.3.2 Theoretical position of DPA

Riessman (2008) draws on Goffman's idea of performance (1959) and Bakhtin's literary theory (1981) to explain the theoretical position of DPA. Goffman (1959), used a dramaturgical metaphor to explain how performance of identity composes, projects and negotiates with the world about who we are. In difficult situations, we present a desirable self to preserve "face". This performative aspect of talk takes place through language and bodily communication. Our identity is temporal and situational, and "accomplished with the audience in mind" (Goffman, 1959). In a more limited way, performance can be viewed as a narrator talking about an experience and evoking thoughts and feelings in the audience (Goffman, 1959). DPA

also attends to the listener's interpretation. Therefore, in using DPA the word 'performance' means more than just what the participants say or communicate but includes what has been evoked in me and other listeners, such as feelings, thoughts and meanings.

According to Bakhtin (1981, p.291) dialogue is situated in the relationship between people within their social and historical contexts. Words carry "*meanings and ideology*" based on previous experience. Therefore, words are "*polyphonic- multi-voiced*" (Riessman, 2008, p.107). They are never neutral as they carry history and traces of other utterances. Dialogue is also "polyphonic" as it contains not only the words and voice of the speaker/ author but also those of the listener/ reader as well as historical and social influences. The narrator "*no longer has the authority of a* '*final'* say" (Riessman, 2008, p.107) because this is shared with other characters in the plot. Every text includes many voices such as hidden politics, historical discourses and ambiguities beyond the speaker's voice. Consequently, language not only conveys information but carries the complexity of relationships, meanings, discourses, contexts and subjectivity (Riessman, 2008).

Riessman (2008) posits that the application of DPA is well suited for examining group exchanges, different speakers and symbolic voices. She illustrated this by giving an example of Lyn Mikel Brown (1998) who had applied DPA when studying the schooling experience of a small group of white, pre-adolescent girls from different cultural communities. Examination of their stories showed how they collaboratively performed and ventriloquised for each other. It also addressed issues of power between pupils and teachers which were situated in their gender, class,

social and political contexts. Riessman's illustration of DPA's applicability both to individual interviews and groups further confirmed for me that this was a suitable method of analysis for my study (Riessman, 2008).

4.4 Application of DPA to individual interviews

I read the transcript through three lenses[10]: syntactical (linguistic), semantic (content) and pragmatic (context) and developed a set of eight pointers[11] which I derived from Riessman's work (2008) on DPA: (1) use of speech & paralinguistic features; (2) why this and what is accomplished (themes, form and structure) ; (3) identity and use of self; (4) power difference; (5) reflexivity and subjectivity; (6) position; (7) emotions ; (8) contexts (local and wider). These categories were created to be used loosely and not applied as a list. They helped me to consider the many aspects of conversation by adding structure and rigour whenever I examined the reality of an ED and its construction, given that these are influenced by many contexts such as race, ethnicity, power, language, socio-political, medical and systemic practices.

[10] DPA examines (1) syntax- the use of speech and paralinguistic features; (2) semantic - look at meaning and content -themes, form (plot) and structure of the narrative; (3) pragmatic - local and wider contexts (dialogical environment, presence of competing speech, social, historical and political contexts).

[11] Appraised as adding clarity to the DPA method (personal communication) by Professor Corinne Squire, Chair in Global Inequalities, School for Policy Studies, University of Bristol, and Co-Director of the Association for Narrative Research and Practice at the Thomas Coram Research Unit (TCRU_ANRP), University College London. I was studying on a distance learning course about Narrative Research for an Associate Postgraduate Certificate from the University of East London, September 2020 to February 2021.

4.4.1 Identifying the narratives for DPA

In this research, a narrative is any account of personal experience told by the narrator (research participant) and includes both events and experiences. This is consistent with Patterson (2008) who proposed that narratives are:

> *"texts which bring stories of personal experience into being by means of the first person oral narration of past, present, future or imaginary experience."* *(Patterson, 2000: 128)*

From the transcripts I selected texts that relate to the participants' narratives about REC, risk and self-reflexivity, and working with the NICE guidelines. As previously mentioned, in order to deepen my relationship with them and to connect with their perspectives, I created a pen portrait for each participant and then colour coded the different narratives. The DPA pointers were used when considering the chosen narratives, as a series of prompts, when considering the chosen narratives to assist with examination of the texts.

For each narrative, I looked at the use of language with its verbal and paralinguistic features:

- expressive sounds, such as mmh, emm, breathing etc;
- repetition, to emphasise key moments or ideas;
- direct speech, including "I" or direct quotation of someone else to build credibility;
- verb tense and pronouns, to indicate the participant's position in their story telling (closeness or distance from the past, present or future);
- aside, where the narrator takes the listener to another context;
- rhetorical questions, to involve or to persuade the audience;

- creative, emotive and evaluative words, how the participant feels, their preference and their view.

4.4.2 Example of DPA of a narrative from individual interview (figure 1)

Figure 1 shows an extract from the narrative of one of the participants. Fiona described herself as white mixed. At the beginning of her interview, I asked how she felt about my research title. She described her experience of presenting at a peer workshop dedicated to REC issues. This was the first of three stories she narrated throughout the interview relating to this experience, which was evidently important to her. This is an example to illustrate how I used DPA to analyse the narration. For background, I was one of the tutors at Fiona's training. I noticed some degree of our tutor and student relationship was re-enacted even though we had not been in touch for many years. I felt Fiona wanted to be helpful to me and my research. At the same time, I wanted to be protective of her, especially when she spoke about her difficult experience. In figure 1 I have used yellow highlighting and text boxes to indicate where I have identified the use of syntax.

Figure 1: Fiona (participant 6/ P6) excerpt 1

45	P6	you couldn't be there for the emm (Fiona tutted) err the slot that I did I found it re::ally interesting and quite
		emm :: I felt that quite quickly it - obviously we were talking about our own social graces as well as
46		
47		families, and felt a bit, people, it felt quite personal very quickly. And that there were some defensiveness
48		and all sorts went on which was really, really interesting. So I think that's emm :: I :: guess that the
		connection. Emm if I can be more clear about it. For me, I am interested in talking about things that
49		
50		people find, seem to find difficult to talk about (Fiona laughed) (mmh) and I am interested in making the
51		implicit explicit, which is, can be very, really really challenging of course. Because I think that's emm,
52		(P6 tutted). Err a connection when we talk about culture particularly when we think about race.
53		I think people .hhh that's quite a lot of emm ::: ↑well I will say it :: my experience quite a lot of

1.Expressive sounds: hesitation, tutted, emphasis

2. Aside: Social Graces in systemic psychoth erapy

4. creative expression: implicit explicit

3. Emotive words: personal, defensiven ess, difficult, challenging

1.Expressive sounds: laugh, tutted

1.Express ive sounds: Breathe in, hesitatio n

Emphasis

5. Evaluative of avoidance

54		avoidance from people talking about it. Emm in a clinical sense, so yeah. I think those are some of my
		connections and what came to mind in thinking about, emm you know the research questions and
55		the, and the topic.
56	R	Mmh, I, I apologise I didn't make the afternoon. You, I understand you were presenting a piece of work
57		that you did, weren't you? It would be really interested to hear but you mention about once you
58		presented. You :: you you get a sense of defensive, the word that I heard.
59	P6	Yeah, yeah because it was about a white British family. Emm a kind of did a bit of a emm ::: what I was
60		highlighting in my emm piece was that emm :: I use two families. And one was a Muslim Pakistani family emm
61		British Asian and err my team err, ↑not always but yeah reasonably often, I find it happens a lot and
62		this is what I highlighted in the presentation, which they say what about, are there any cultural issues?
63		And err this happen so often when there is visible difference that people say. ↑Are there cultural issues?

7. Orientation: White British family, Muslim Pakistani family

5. Repetition and Evaluation: Cultural issues around family's belief

64		and they don't ask them that about, that about, a white British families (nhh). And what I was highlighting
		in this work that I was presented, the real challenge I had emm working with the family and there
65		
66		emm some of what I saw that were cultural issues. Emm around their beliefs, of course and, and
67		some of the, what made it err the work quite, emm difficult and you know ↑we make in progress
68		and it was okay and we got to a good place. But suddenly, for me it felt like, like a a real .hhh emm ::
69		yeah was a challenging piece of work. And when I TA::LK about some of this and talk about you know
70		my own graces and some of the interactions. And of course put myself there as well. Emm, the
71		defensiveness was about people thinking that I had, was a kind of othering the family. Emm which I
72		thought was really interesting (Fiona laugh) not everyone. Emm but there was some of that. And yeah.

8. Repetition /emphasis (line 65 & 69)

5. Evaluation: Cultural issues around family's belief

1.Expressive sound: breathe in & hesitation

3.Emotive

9. "I" first person position

3. Emotive words: othering

6. Expressive sound: signal ending

Use of language

Fiona used a range of syntactical features to assist her narration: (1) expressive sounds: she used laughter, in-breaths, hesitation, emphasis, and tutting;
(2) asides that, by bringing in Social Graces, transported me to a different context;
(3) emotive words e.g. ‘personal’, ‘defensiveness’, ‘difficult’, ‘challenging’ and ‘othering’; (4) creative expressions e.g. ‘implicit’ and ‘explicit’ to explain herself. (5) She evaluated the difficulties in talking about culture and race, and how people avoid this. (6) She signalled an ending by going back to the question or using expressive sounds. (7) Orientation: she informed me about the characters in her story: the white British family and the Muslim Pakistani family. (8) Repetition: she repeated to show emphasis. (9) In using the “I” first person position she showed it is her view.

This process of microanalysis of the text allowed me to come close to the emotions through paralinguistic features, and to examine the syntax from different positions: meta, self, participant and the audience’s position. DPA provides the opportunity to look at the participant’s narration and performance closely and examine what’s been evoked in me, as well as how our relationship reflexively influenced the co-creation of the dialogue.

Relationship:

It had been more than ten years since I tutored Fiona. Our paths had not crossed until the peer forum. I felt our previous relationship added familiarity and trust in this research relationship. However, I was mindful to make sure the interview did not turn into a supervisory conversation. She talked about this event at the start of the research conversation which suggests the experience had left a mark. I felt she shared the story with the belief that it was relevant. At the workshop she had been

presenting her ideas to peers. Fiona reminded me of “the slot” she did (45). I was there at the peer group workshop but left before her presentation. Her reminder took me to the memory of who else was there in the group.

What was said?

Fiona described her experience of being made to feel “personal very quickly”. There was a sense of “defensiveness” and “all sorts” (47). She performed a balancing act by saying it is “really interesting” before and after she narrated the emotional impact of what had happened (45, 48). She was showing lots of hesitation and repetition, and this was her response to my open question - how she felt about my research title. So, we were co-producing the narrative. I wasn’t sure what Fiona’s point was in the beginning but I sensed her vulnerability and became extra-attentive when I followed her story.

Fiona continued to explain what had been going on at that workshop. She attributed the topic to her interest in talking about “difficult things”, making “implicit explicit” and laughed about it (50, 51). She linked her feelings with the challenge in talking about culture and, in particular, race (52). “Avoidance” is a response she had experienced a lot from others because it is difficult to talk about (53-54). She then signalled the end. So, I asked about defensiveness. She explained her team is often asked “Are there any cultural issues?” when there is a visible difference (63) but not with white British families (64). She used two families: one, a Muslim Pakistani family and the other, a white British family, to highlight her point that white British families have cultural issues too. She saw cultural issues in a white British family around their beliefs. This family culture made the work difficult, but they made progress (65-67).

She evaluated her work with this white British family and felt the clinical work “got to a good place” (68) and “suddenly it felt like, like a real hhh emm ::”(68).

These paralinguistic features in her narration gave me the opportunity to get closer to the unspoken, emotional state and the representation of it. She intensified her speech and said “suddenly”, then she searched for words to describe how she felt. She took a breath in, as if she needed more air for her body, filling up her lungs or giving herself time to think. She went “emm ::”, hesitated and appeared lost for words. I felt she was feeling unsafe and unsure, as she recalled what happened at the workshop and was considering whether it was safe to tell me. She went back to the memory and explained more about what had happened. I felt she was cautious, perhaps concerned that I might misunderstand her too. I guess our previous relationship enabled her to take a risk in staying with the subject, and describe more about what had happened with the group. As her ex-tutor, I was feeling a sense of protectiveness and empathised with her narration. I was aware this may be influencing my listening and curiosity therefore I tried to be reflective and reflexive about our relationship and how my contribution might influence her narration.

She continued describing how she tried to be transparent with the group during her presentation at the workshop: she said “put myself there” (70). She then went back to “defensiveness” and felt the group had misunderstood that she was “kind of othering” the family (71). Fiona gave an explanation later (line 697-698, not in this extract) that the group had misunderstood her as being critical of the white family and so they became critical of her.

I remember feeling frustrated for Fiona and disappointed with the group at the workshop. They were a group of experienced family therapists who had come

together to explore REC issues. It appeared they did not create a sufficiently safe space to explore the important question that Fiona had tried to put forward. Reflexively, I reminded myself of my researcher position so as not to judge what had happened. This enabled me to step back and stay close to my role as a reflective, curious researcher.

What was accomplished?

Fiona presented a difficulty experienced when discussing REC, even with a group of experienced family therapists interested in the subject. She highlighted the importance of emotional safety and facilitation. She concluded that some members of the group had misunderstood her. It felt to me as if she was describing a theme along the lines of 'othering' and (in)visible difference, and the challenges when trying to discuss them.

Identities

Fiona described her ethnic identity as mixed race: white and other (I use the word other to ensure she is not identifiable). She is aware of the privilege she holds by being visibly white and speaking English without an accent. She is positioned by others as white but the invisible part of her heritage is not acknowledged by others, even when she tries to make it known. I felt her question about stereotyping reflects her lived experience as someone with mixed heritage, where part of her is being ignored.

She feels considerations of REC are always an important part of making a formulation. However, sometimes this can be more central than peripheral (not in excerpt, 575-576). For me, she highlighted the importance of considering the

intersectionality of REC with other social differences, for example, not only white-mixed but also being an immigrant, a woman, middle class, etc.

Professional Identities

In these different ways Fiona performed her preferred self, coming across as a reflexive practitioner. She connected her personal experience with her willingness to question the dominant discourse of stereotyping ethnic minority families. She positioned herself as non-blaming and curious about what had happened at the workshop presentation. She started and ended her story with the phrase "interesting" which sounds as though she is trying to be "politically correct", and certainly not wanting to be seen as critical of anyone. Phoenix (2008) described canonical narratives as a way of saying something in an acceptable way to cover the underlying feeling, without saying how it feels. I felt Fiona was careful in how she showed her frustration or disappointment, so I did not misunderstand or criticise her. It didn't feel safe enough at the time of the workshop presentation to reflect how she felt with the group. Perhaps she was still a bit unsure whether it was safe to be open in this research about how she really felt.

Reflexivity

I felt relief when Fiona was creating new meaning to her experience. However, it also left me imagining the discomfort and unease for her, and the peer group, at the time of the workshop. Personally, I would not have wanted to be in the position in which Fiona found herself. I suppose this reflects an inherent discomfort in talking about issues around REC. Some people might just stay off the subject, to avoid being misunderstood. This, arguably, is similar to what ED evokes when risk to health dominates. Therapists may just behave in a politically correct way by following

treatment protocols and guidelines to avoid criticism, and question less about stereotypical practice.

Local contexts

Fiona works in a predominantly white suburban area. The majority of her service users are from white British background. She questioned the stereotypic approach to ethnic minority families compared with the way white British families are viewed. The latter are not connected with cultural issues because there is no visible difference. One can argue she raised the question of equality and equity: cultural consideration for all families and rethinking the complexity of visible and invisible differences. Her question has the potential to transform practice.

Professionally, Fiona's presentation may have been misunderstood by her peer group as if she was looking for one truth, the right way of addressing stereotype. This illustrates the importance of setting a safe context for any sensitive or difficult conversations.

Institutional context

Fiona works in the NHS, a large institution with principles that aim to address equality and diversity, even though this is not very successful. The stereotypical practice of posing the question "are there any cultural issues" to ethnic minority families highlights the tick-box mentality in which staff are not encouraged to think about their personal values and beliefs but continue with stereotyping and categorising patients and their families. Kleinman (1987) described the problem with category fallacies and not addressing individual or collective bias and prejudice. As someone who has spent my entire career in the NHS, I argue that ensuring staff complete mandatory training on this subject, or learn the Trust guidelines and

principles, is not enough. The NHS is heavily reliant upon staff recruited from abroad, often from less affluent countries within the Commonwealth. The system is deeply hierarchical. Mandatory training without addressing personal bias and structural discrimination in the organisation is insufficient to address issues of diversity and equality.

Wider context

Fiona questioned the stereotypical practice in which people of white British ethnicity are not seen as having culture issues. This implies that white British cultural issues have become invisible because they are the norm. Most ethnic minority families are visibly different and not seen as the norm (Wallis and Singh, 2014). One can argue that the question "are there any cultural issues?" carries the historical representation of colonialism characterised by power over and oppression of minoritised ethnic people by whites. Therefore, the concept of 'REC' differences are attributed only to ethnic minority people.

To summarise, Fiona's narration showed the emotional challenges she experienced when raising a question about stereotypical practice in her field. When she talked about social graces (46), it created an aside which transported me to my own experiences. She described a feeling of avoidance from many of her peers when talking about culture and race (53-54) and the existence of cultural issues for white British families (65-66). Fiona highlighted the need to address culture with all families, not just minoritised ethnic group families.

4.4.3 Connecting themes from the analysis

All narratives identified from the transcripts were analysed by this process. Thereafter, I selected narratives that were connected with REC and identified the overarching themes. See appendix 4c and 4d.

4.5 Focus group analysis

Group participants were recruited in the same way as the individual participants. They were asked to describe their ethnicity to each other. The groups were given topics to discuss and they watched video clips of family meals to stimulate discussion. The design of the tasks was amended after the individual interviews when I noticed that the topics of food and eating had been relegated to "psycho-education". This left me wondering about the cultural meaning of food and feeding, as well as about resonance between therapists and clinical families over REC issues. As a consequence, the focus-group tasks included an exploration of food, reflexivity and practice (examples of focus group tasks, see appendix 3b). A brief description of the group participants is in the next chapter (5.4).

4.5.1 Analysing the focus groups

I started by listening to the recording, transcribing it into text and writing notes about my responses. I then identified the narratives in the text, and colour-coded the narratives that were relevant to the research questions. I then identified the themes.

The pointers for the DPA of group narratives (Brown 1998; see para 4.3.2 above) were as follows:

(1) reflect on my own position in the interpretative process;

(2) make sense of what the conversation was about -the overall themes of the narratives and research relationship;

(3) explore the first-person speech- how group members talked to each other, and spoke about themselves and others;

(4) identify the thematic content of the narratives- how narrators expressed feelings, in what form, who and what constrained them;

(5) note how they appropriate, accommodate and resist dominant narratives of themselves and their practice, including both syntax and wider contexts.

I then connected the themes that emerged from the identified narratives.

4.5.2 Example of DPA of a focus group narrative (figure 2)

Figure 2 is an example of an excerpt involving three participants from group 1. Bella identifies herself as black British; Cynthia is white Scottish; Amy is white British. Bella used the phrase “five minutes” to describe the time limit, often imposed during multidisciplinary team ward rounds, for contributors to make their point. I have used yellow highlight and text boxes to indicate where I have identified the use of syntax.

The topic highlights an inpatient team ‘ward round’ that is organised by a medical approach. Bella performed the scene, “look, probably got five minutes to get your point across in that setting” (583). She used a range of syntactical features:

1) exclamation; 2) creative language “five minutes”; 3) emphasis, repetition and showing excitement; 4) Expressive sounds. Everyone in the group became excited, and Cynthia said “YES, YES” twice (584, 586). This re-enacted our shared experiences of ward rounds, including my own. We were all transported to our past experience of attending a ‘ward round’. Cynthia was excited and shouted “YES,

YES" twice to show her excitement. Bella dramatised that more and described it as "almost like you are in, you are out, talk to the wall in some sense." (587-588).

Figure 2:

Context: Medical discourse and team relationship

"Five Minutes"

1.Exclamation: performing the start of the story

583 Bella It was also, look, probably got five minutes to get your point across in that setting

2. Creative language

584 Cynthia YES SS (Amy laugh)

585 Bella with no set agenda there

3. Emphasis and repetition; showing excitement

586 Cynthia YES, YES, YES

587 Bella with no set of agenda, so it's a sort of like, almost like you are in, you are out, talk to the wall in

588 some sense.

2. Creative language

589 Amy The hot seat (laugh)

590 Bella How can you respectfully, cross your point in your five minutes slot without marginalising (Amy yeah yeah)

591 or ( ) But, actually you know when you hear the, I don't know, the pathologising of the parent (Cynthia nhh), or

592 or whatever, which sometime are really great (Amy yeah, yeah) with, without actually saying no. We are

593 not been, been taken, not terribly effective but we are trying to be emm respectful of the family

4. Inaudible and expressive sound

594 members in a different way.

Amy ventriloquised by calling it “The hot seat” (589) and laughing. She enriched Bella’s metaphor with another. After group participants showed their engagement, Bella critiqued and ridiculed the lack of time to put across any point respectfully in five minutes (590) or to say anything regardless of whether it is pathologising the parent or about something good (591-2). She concluded that “we” are trying to be respectful but are not terribly effective (593).

What the conversation was about?

The ward round system was critiqued without being named but it was implicitly understood and appropriated by the others. This is a space where the medical approach organises how things are done. Bella is a respectful family therapist who considers different positions. Although she accepts her silent role in the ward round she challenges such marginalising practices by organising safe reflective multi-disciplinary workshops (489-490, not in this excerpt). Bella and the other group participants involved with this extract, conformed to the constraints of time and the hierarchal structure in order to get through the volume of work (patients) and the complexity of issues. We all laughed, with frustration, as it remains a dilemma.

Wider contexts

This experience of “five minutes” highlights many contexts that influence how the service is shaped and how care is delivered. The psychiatrist holds the expert and knowing position and leads the team. The multi-disciplinary team meeting is an attempt to flatten the hierarchal power difference between professionals. In my opinion, the name might have changed but the power dynamic has not changed much. Ward rounds are organised by time, efficiency, and to meet targets in a context of competing resources within the NHS. When workload is greater, the

stress is also higher- the more so because of the austerity measures implemented by governments during the last decade and during the COVID pandemic.

A patient's progress is usually measured by improvement of physical state and this becomes the focus when there is pressure on time. However, other aspects of psychological care are at risk of being neglected. Beverley, in her individual interviews, described REC is being "way down" the list of priorities. The focus group showed their resonance with the tension between workload, medical discourse and reflective practice by laughing together.

4.6 Synthesising narratives from interviews and focus groups

Findings from all three sets of data (first interviews, two focus groups and second interviews) were read and examined together. The similarities and differences, distinctions and connections, and how they illuminate each other, were considered. The result became my overall findings, as detailed in the next chapter, heading 5.5.

4.7 Constraint and Affordances of DPA

I recognised that attention to my subjectivity and reflexivity in the co-production of narratives between the participants and myself is important because DPA is an interpretative method that relies on researcher's subjectivity (Riessman, 2012). Inevitably, each participant and I positioned each other from our personal contexts and assumptions about each other. This influenced the research relationship and the narrations. We can never claim total reflexivity. Hence, when making interpretations, I

have been aware that they are from my standpoint, assumptions and prejudices for example, my positions as researcher, experienced therapist and member of a minoritised ethnic group.

DPA, through reflexivity and transparency, allows me to explain how I made my decisions about the analysis. Findings in DPA are created between the narrator and the researcher's interpretation, but there is a risk of researcher over-interpretation. It was important that I listened carefully to the participants (Squire 2013, p.59). Staying close to the data and noticing how I felt was necessary and worthwhile. Holloway and Jefferson (2004) highlighted that interpretation involving unconscious processes in research can risk getting things very wrong for the participants. This is because participants can't be expected to have access to their unconscious processes and neither can the researcher claim to be fully reflexive. For these reasons, DPA would not be appropriate for the analysis of psychoanalytical material.

DPA offered the opportunity to bring into the analysis other social markers such as gender, religion and class. Although the focus of the research is REC, I paid attention to the intersectionality of wider contexts that were relevant.

Furthermore, DPA has the advantage of attending to both the micro and macro environments, from the use of language to the local and wider contexts that influence the narration. Staying close to the narratives allowed me to balance my interpretative power, and to honour the trust of the participants in telling their experiences. I stayed close to the transcript (oral texts) for a long time, reading and writing about them, attending to the details of what was said and how. I was handling a large amount of data and remained at the level of description in relation to the stories. This presented a challenge when I had to move from description to analysis, and choose what to

include and what to leave out. I referred to the research question as a guide to decide which narratives to include. The narratives chosen for this chapter, to exemplify the process of analysis, were selected on the basis of the themes I identified to illustrate how I moved from describing the narrative, to its analysis and interpretation.

Finally, DPA was used for both individual interviews and focus groups in this research. This had the advantage of synthesising similarities and differences, and examining how the narratives and findings illuminate each other, which became the overall findings.

4.8 Reflections about the methodology and methods

When reflecting on the journey of formulating and constructing the methodology of this research, I noticed the recursive relationship between the data and the changes I had made. The methodology accommodated the need to be responsive and recursive and the COVID lockdown warranted a change of design.

I balanced my position as a curious researcher so as remaining cautious so as not to cross the line of leading the participants. At times, this held me back from being spontaneous and I felt I had missed opportunities to clarify or explore. As the participants had not talked spontaneously about food during the first interviews, the second round of interviews was an example of where I chose to give space to participants to talk about food and refeeding. It felt important to have a second round of interviews to make sense of why those data hadn't been forthcoming. I felt like I was going through a “swampy lowland”. The research felt messy and uncertain a lot

of the time, but somehow it has hung together because the epistemological position justified what was happening around it.

The main challenge of COVID for me was not only the need to reorganise my data collection process but also incorporating COVID 19 as the background of everyone's life at the time. Therefore, it became an unexpected and influential context of this study. I had to adjust my focus to embrace online interviews and include COVID as one of the contexts in the analysis.

Traditionally, qualitative interviews are undertaken face to face (Opdenakker, 2006). One of the limitations of this online research was the missing bodily responses and the feeling of being in the same room, in same dimension. At the time, everyone was new to online working, so the interviews went ahead without being clear about what extra attention would be required to accommodate the change. I did ask for feedback from the participants about their online interview experiences and all of them said they felt okay because they were one-to-one. I have no doubt there was some impact but probably not sufficient to be detrimental to the findings, because other aspects of communication were preserved.

As for the focus groups, I restricted the number of participants in each to make sure they could give good attention to each other. By acknowledging the missing element of embodiment, I trust this highlights the COVID influence on my research where everyone was required to adapt to online work. I felt that the atmosphere at the time was one in which everyone was committed to making online working successful.

Out of the fifteen self-selected participants, six participated in interviews and nine in the focus groups. They were all female. There was one black British and one British Asian whilst the remainder were from white British and white European backgrounds.

This was a qualitative study and so the findings are not generalisable. However, they are robust and trustworthy. It would have been nice to have been able to include a male perspective.

Finally, I appreciate that DPA has helped me look at the narrative texts in breadth and depth – through syntactical**,** semantic and pragmatic meanings and wider contexts – as well as listen to my own voices, prejudices and assumptions when interpreting the texts. So, the pointers, the pen portraits, the colour coding of narratives, listing and comparing what I found through tables, have been helpful in enabling me to analyse the texts systematically. I improvised and formulated these details of the process within a theoretical frame and allowed interpretative aspects of the method to come through. I feel that this approach could be a useful contribution to other researchers interested in using DPA as their method of narrative analysis.

5. FINDINGS

In this Chapter, I start with a brief pen portrait of each individual participant. I then describe the themes that emerge from identified narratives of the interviews and focus groups. Finally, I describe overall findings which are the connections between themes from all the narratives. At this point I need to mention that all participants and both focus groups used anorexia and ED interchangeably. Only on one occasion did a participant mentioned her experience with a bulimic patient (see Eve p.110). Therefore, with respect to my findings, discussion and conclusion, reference to ED implies only anorexia.

5.1 PEN PORTRAITS

Pen portraits of the individual participants (table 3) provide background to how I experienced them and how they influenced my use of DPA. They also allow access to information that is not in the transcripts or in the chosen narrative (Golsteijn and Wright 2013). Fuller versions are available in appendix 5a.

Table 3: Individual participants characteristics

	self-description of ethnicity	Years of experience as family therapist
Ada	European	5 -10
Beverley	White British	10+
Caroline	Eastern European	1
Diana	Irish	10+
Eve	European	10+
Fiona	Mixed race and white	10+

Ada (P1) is white European, and has lived in the UK for over five years. Cultural difference is a dominant reality for her as, like me, she speaks English with an accent. She feels "absolutely, one hundred percent", that discussion of REC issues is important because it helps families understand "where they are coming from, what they do and where it stems from".

In her work she sometimes feels her thoughts and feelings are organised by "her need to care" because her personal experience of food and feeding is about "caring". She attributes this to her family origin: previous generations made sure that "we care". As a therapist, she feels she has autonomy. She follows the FBT used in her team. At times, she questions what delaying exploration of REC-related issues implies. She feels supervision can become risk management.

Beverley (P2) is white British, holding both managerial and clinical roles. She joined the NHS from a social work setting and spoke passionately about social justice, racism and the multi-generational trauma of mental health service-users. She is surprised by the lack of acknowledgment in the NHS of the power difference experienced by families from minority backgrounds. She has confidence in the FBT treatment model and described many successes. Her curiosity is stored and addressed later when the child achieves a safe/ healthy weight. She delivers family therapy in a flexible way but sometimes feels her therapeutic relationship with each family is like social work when she has to manage risk.

Her mother and a sister had childhood anorexia. She believes she "dodged the bullet" during her teens when a friend encouraged her to eat. To me, this explains why prioritisation of refeeding sits well with her.

Caroline (P3) is white Eastern European. She recently qualified as a family therapist after working in an ED service for many years as a mental health nurse. She seemed more vulnerable and talked about her “foreign name”, her “accent”, and being questioned about English traditions. I identified with some of her narratives as I experienced similar questions when I first joined the NHS.

Caroline said being petite and slim is seen as being beautiful in her culture, and brings opportunities to marry a wealthy man. Reflecting on food and body image as she grew up was very personal for her. I felt she was both open and unsure when talking about this. Her core profession as a nurse still influences her: she sees “red” when it comes to risk and turns to “safe certainty”. However, she is aware that risk can be managed therapeutically, through exploration and curiosity, and realises that risk has “blinded her” to think less about REC issues. The NICE guideline helps her to demonstrate expertise in the ED field.

Diana (P4) is white Irish, and an experienced therapist whom I met many years ago. For her, Irish culture is synonymous with her (Catholic) religion. She moved to the UK as a child and noticed the differences between Irish and British contexts. She shares her identity as an Irish Catholic with clinical families as an invitation for them to talk about their own. One of her children has eating difficulties and was eventually diagnosed with Autistic Spectrum Disorder. She feels her personal experience has many similarities with families who struggle to feed their children. Being mindful of this, she does not take over the refeeding to avoid parental resentment.

Diana showed confidence in critiquing and adapting FBT. She values its focus on refeeding - stopping the child “from dying” - but uses it flexibly: in her words, “I don’t do one, two, three”. She feels not everyone, including family therapists, can talk

about REC. To her, it is not REC itself but the contexts, relationships and the way it is talked about that are important.

Eve (P5) is white European and spoke openly and frankly, just as I remember her: I was her clinical supervisor, many years ago, when she came to the UK as a clinical psychologist to undertake training in systemic psychotherapy. She described herself as a "diverse therapist" (therapist from diverse background) and considers herself to be an ambassador, both for her own culture as well as others. Brexit made her feel vulnerable, as if being tolerated in the UK rather than welcome.

Eating has many meanings to her including love, care, tradition, culture, nourishment and enjoyment. She connected with Marcel Proust who associated the tastes of food with memories of people. Her heart sinks when she hears a mother say she is sick of cooking and she feels extremely sad that a mother would feel that about feeding their child. She shares her experiences with young people, and likes working with families who have moved out of the re-feeding phase because she can be more explorative. She feels that everybody knows they should consider culture but is not sure that everybody has the same idea about it.

Fiona (P6) described herself as mixed race and white. I was her training tutor many years ago and she now holds a senior role. Her mixed heritage makes her aware of both her white privileged and "invisible minority ethnic" self although the latter is often silenced or ignored by others. When growing up she enjoyed the family ritual of staying together after meals despite her father being "very very violent"- on one occasion, he smashed the dining table at a mealtime. She works within the framework offered by NICE except when it does not fit the family. She and her team then use "formulation driven treatment" adapted to the family's situation, and they

tolerate the uncertainty of working outside the guidelines. She works towards encouraging patterns and habits that make families feel confident and comfortable enough to bring about some healthier change.

5.2 Themes that relate to race, ethnicity and culture (REC)

Four themes relating to REC - which will be explained in detail- were identified from the analysis of the narratives: (1) reflexivity and connection, (2) hindrance, (3) resistance and conformity, and (4) position of therapists. Tables that connect the narratives are in appendix 4c.

Each excerpt is attributed to the name assigned to the participant and is followed by the line number(s) in brackets which locates its position in the transcript.

5.2.1 Theme 1. Reflexivity and connection with REC issues

(a) Personal experience

Participants described personal experiences and connections with REC issues that position their cultural practice. These include migration, invisible and visible differences, accents, and wider social and political influences. Their reflexivity towards their own backgrounds and experiences connected them with REC issues.

Five participants have experience of migration. All said that it made them aware of differences and ready to address them in clinical practice. For example, Diana described the difference she had felt during her childhood as “awkward” (1176). She uses this experience to open conversations about differences. I was acutely aware of these when I first came to the UK.

All participants framed REC as being about differences between people. Some described these as visible whilst others described invisible differences. Fiona described herself as white-mixed and yet visible only as white:

> *"they include me in their group of like white British people. And I am like [Fiona laughed) no I am not one of you. So [Fiona laughing continued) I don't, like you but I am er, er, we are not the same. So don't, don't put me in your group [Fiona laughed] (mmh) So :: that does feel personal. That's only part of it, but that's you know obviously I am talking about visible difference, emm and assumption being made about that."* – ***FIONA*** *(169-173)*

Being seen as white British implied that the other part of her heritage had become invisible and was being ignored. Therefore, she advocates unpicking culture for everyone. For Caroline, however, her visibility was not being white but was her accent. Beverley spoke about power differences when dealing with patients and colleagues (88-89). Diana described religion as an invisible difference; her Catholic script being rubbed "into her skin" (49-50). She saw no distinction between religion and culture (85).

Two of the three European participants talked about their audibly different accents. One joked about her accent and the other apologised for it. Caroline described her "strong accent" as a audible difference to English people, with some advantage:

> *"Nn, yeah. And I guess I get you know the, .hhh with me ::: having a strong accent you know :: that I am not English (mmh), You know and especially for English people, so the <u>race</u> and ethnicity becomes visible↑. (Mmh) where is for other people, it is invisible. If you know what I mean, so kind of Yeah. So*

maybe it is easier to talk about it. Because I often, I often would, sometimes I make a joke of err a kind of bringing in ethnicity into the session by saying, well, you know err" ***-Caroline-*** *(318-322)*

Her accent made it easier to bring ethnicity into the therapeutic conversation but was questioned by English families, saying she is "someone not from here" (494-495, not in this excerpt). Caroline demonstrated the impact of the intersection between different social markers: her accent overshadows the privilege of being white. Ada actually apologised to me during her interview, saying "Sorry ( ) my English now" (508) when she thought she might have used the wrong word. Eve was the participant who didn't mention her accent but said that some families ask where her name comes from. She appreciates families who show interest in her ethnicity and gladly explains it (42). All recounted personal experiences highlight resonance with REC issues and evidently position the participants to connect with families and explore differences.

(b) Identity/ experience of dominance

Five participants talked about a change in identity when they came to the UK. Eve evolved from being a therapist from a diverse background to being an ambassador on the subject:

"when I first moved to London err, there was very much of arr a sense I have to conform and to comply with the dominant model. So probably my diversity didn't come into really very much. THEN I think I went (.) through a phase where I was finding my foot around it (mmh). ↑So, I didn't know how much I was allowed you know to bring it to the table.

> *How much I was really taking the risk to do it. And then I think steadily (.) it became the diversity (.) topic become more political issue when the Brexit came on as well (mmh)". -* ***Eve*** *-(35-40)*

> *"at [name of service) white British :: are:: workforce. This might, ethnicity in the team. And so, I feel I am becoming a bit of ambassador may be. So, I can see it is always me bringing that topic on the table (mmh). Emm, yeah, I think in my clinical practice again (.2) I became much more aware of the identity struggle"-* ***Eve*** *-(370-373)*

Eve described how she reclaimed power by speaking up for diversity. Others also described their identities and relationships with REC, showing awareness of privileges, differences, vulnerabilities and influences on their identity, to all of which they gave meaning and which influence their practice in different ways. Ada (364-370) avoids REC-related difference becoming "an elephant in the room" (367) by allowing herself and the family space to feel and sense what it means.

(c) Training (core and systemic) and clinical experience

All participants referred to REC in the context of Social GRACES (Burnham, 2012) as a theoretical frame for their clinical practice. Most of them mentioned intersectionality between REC and other social markers, such as religion, gender and spirituality. Eve critiqued the lack of literature and research about culture in the ED field - research samples being mainly British and white American (50). She described a national training conference which had only one lecture on cultural

practice, which appears to leave clinicians to improvise their own approach to its relevance.

Beverley trained as a social worker and Caroline was a psychiatric nurse. They both described how their core training influenced their attitude towards risk management. Beverley functions like a social worker when risk is a priority. Caroline said one's professional qualification can be on the line when things go wrong. Whenever she faces risk, Caroline sees "red" which makes it difficult for her to be reflective:

> *"whenever I am placed (researcher coughed) by a very risky group, registration where, where there is low weight or physical health complication or what. And risky behaviours, I often resolve into my safe certainty, safe position of a nurse, and you know and that's where ehh, I feel like whenever I, I am faced by red is much more difficult to be reflective and much more difficult to, to be able to ::: keep in mind the culture and Grace, and ethnicity and all those kind of things"*
>
> *-**CAROLINE**- (427-431)*

Caroline turns to the safe certainty of her core training experience, despite knowing that risk can be reduced by addressing wider contexts.

Three participants described adaptations of their practice that showed their experience and reflexivity. Diana described how she varies the order of the recommended treatment phases according to the family's developmental stage:

> *"how do I approach a hierarchical system with such knowing and truths :: and with little curiosity. Particularly in phase three of the treatment which I don't go one, two, three↓ but developmental stage. NO, yeah, so↓" - **Diana**- (53-55)*

Diana dropped her intonation (↓) twice as she ended her critique of FBT. In questioning the knowing position of the treatment model, she demonstrated reflexivity. Rather than being constrained by the model she works according to the developmental stage of the patient. Eve used the term “generic systemic approach” (219, see 5.2.3). Fiona described the idea of “formulation-driven treatment” (1154, see 5.2.3).

Of the other three who follow the model, Beverley has a strong preference for it because her core belief is “no one is going to get better” without gaining weight (981). She positions food as a functional medicine (984) which links with her personal experience of eating to avoid developing an ED as a young person.

(d) Wider social, historical and political contexts

> Wider contexts were identified by some participants as influences on their connection with REC issues. Caroline mentioned the gender narrative in her country of origin. Eve described how Brexit changed her identity. Beverley ridiculed the denial of racism in British society in the 80s when the McPherson report (1999) was published.

(e) Use of self & reflexivity

Five out of the six participants referred themselves when reflecting how they work with families. For example, Eve was asked by a devout Sikh girl “why you never wear trousers?” (171). Eve chose to be authentic by sharing her experience. She turned inward and then back to the patient (Lynch 2000). This empowered the patient to raise issues around femininity and was the beginning of her recovery.

5.2.2 Theme 2: Hindrances to considering REC issues

Whilst participants are drawn to REC issues, they also described influences that distract them. These include (a) personal contexts, (b) the physical risks of ED, (c) team structure and dynamics including funding, (d) prejudice from the wider contexts.

(a) Therapist's personal context

The participant's personal contexts influence their resonance and reflexivity with clients and families. Caroline described feeling angry because two divorced parents continued to argue and failed to prioritise their child's needs:

> *"But we were so stuck in the process of, you know proving that they are right ::: in that, the other person strong, that they were able to, eh help or help the young person. So that's when I think I took them home and I, ( ) I felt quite angry about it but also I felt, kept thinking how ::: how my approach could help, how I help them (mmh). (.4) and that's, that's partly down to, you know my belief and emm, not sure if, I believe it comes from my family from my culture or the child↑ is, should be a priority,"* ***-CAROLINE-*** *(443-447)*

Caroline realised her anger with the parents was related to her belief that they should be protecting their child and not arguing. Later in the transcript (456-461; 471-473) she reflected on how her focus on their behaviour could have become harmful and discussed this in supervision. Reflexively, she repositioned herself and become

more compassionate towards the parents. I noticed the family's REC background was left unexplored.

(b) Risk of death and physical complication

All participants described the importance of refeeding as a priority in order to save life (see 5.2.3 below). Three adhered to the FBT model and accept that the risk of low weight outweighs the need for REC consideration. Fiona described how she still has second thoughts about reflexivity following the suicide of an ex-patient. Her emotion was evidenced by a range of expressive sound, repetition and laughter when narrating her story:

> *"which is why I, emm, yeah. I needed to talk to other people about it, because it felt like. Reflexivity only got so far. It just felt like it was like, may be back and forth [Fiona laughed] back and forth (yes). And perhaps harder to think of anything … That was the dominant, which was more this kind of hopelessness and this, what we have done, what we have done [Fiona laughed] as much as we can. And what more can we do and it, as I said the hopelessness" -* ***Fiona-*** *(969-971, 975-977)*

She felt reflexivity was insufficient to help with her sense of hopelessness. She recognised the death of this patient had made her worry about the safety of other patients (979). I feel the level of her emotional arousal had become a hindrance to her ability to practice reflexivity.

Other participants described ways of managing the dilemma of addressing safety (need for weight gain) and exploration of REC. When Ada met a non-English family she wanted to address REC issues but was constrained by the FBT to delay this:

> *"And the fact, none of us, neither the trainee nor I are, are English. And we are automatically work ( ) start a dialogue about how it feels like to work cross culture, culturally. .hhh I think it is emm sometimes cannot really be explored, depend the, the very, very initial stage of the treatment."- **ADA**- (71-73)*

(c) Structural influence of the team (priority, dynamics and finance)

Each participant was a member of a multi-disciplinary team led by psychiatrists. Some were in more senior roles but they all acted as care-coordinators, responsible for risk and case management. All teams used the Maudsley FBT model which became context when organising their respective practices.

Ada worked in a team that prioritised weekend safety planning. She described how her one-to-one clinical supervision sessions were overshadowed by this:

> *"you need to make sure you got a good safety plan for all of them at the weekend. Sometimes supervision could feel like a risk management type of supervision. That then, most of the time I feel that I have emm, I need to have a specific question and start with these questions, and with these case in order to be able to have more of an exploratory self-reflexive, actually superficial…And then you feel it is quite a luxury to talk err eem, a little bit more or longer addresses all of those aspects of culture and ethnicity." -**ADA-** (721-727)*

Ada feels that talking about culture and ethnic issues has been relegated to a lesser priority and reflexive space for self-exploration has become superficial. Talking about culture and ethnic issues has become a luxury.

Beverley highlighted her team dynamics where REC issues are left to the family therapists because it is not seen as priority for the whole team. She worries that the wider team only pays lip service to race and cultural differences:

> *"And I worked in a very very big team and so you have those conversations maybe to your profession group or your closer colleagues. Emm so it is still there. Emm but maybe that is part of the, the worry is that, is there is a bit of lip service maybe to race and cultural difference, it generally."* ***Beverley (115-118)***

Furthermore, Beverley described how psychiatrist colleagues, who hold the power in some teams, do not engage in REC conversations (149-152, not in this excerpt). She presumed that this is because they feel they are treating everyone the same and that they don't believe there are power issues when dealing with ethnic families. Eve's experience of different teams has led her to conclude that REC matters can be kept alive in practice if team members are interested (Eve 367-371, 563-568).

Finance was mentioned by one participant only. Ada spoke about a perceived pressure to be effective within a short period of time which prevents the exploration of REC issues.

> *"I can see that there is pressure from a NICE guidance point of view to be effective in a very short period of time. And make changes as possi, as quickly as possible because there is also the element of financial aspect embedded in that (nnh). So, that are might make some clinicians feel that they really need to make changes as soon as possible without really being able to*

> *explore, or to attend other emm, ehh concepts. For example, diversity or culture that might be having as a hypothesis," -**ADA-** (619-624)*

An objective of NICE is to look at cost effectivity of treatment. So saving life and saving cost are both embedded expectations of FBT.

(d) Prejudice and assumptions from wider contexts

There were two narratives about mismanagement by general medical teams of minoritised ethnic families. In one, a Kosovan family, whose daughter had a brain tumour, was referred to the eating disorder service for weight loss. Beverley thought the mother was "dismissed" because her anxiety had been attributed to her experience of the war in Kosovo (281-286). Diana described an instance where a black family was wrongly referred for safeguarding because their daughter was distressed and of low weight (Diana 117-123). The family felt that their skin colour may have been a factor that influenced the referral decision. Both narratives illustrate the effect of prejudice and assumptions about REC in the wider NHS context, and the harm that can be done to patients and their families.

5.2.3 Theme 3: Resistance and conformity to the grand narrative of FBT

All participants accept the FBT rationale for prioritising feeding but there was variable adherence to the advice not to engage with REC considerations until weight gain has been achieved. Three participants said they conform to this guidance. Ada added that she defers REC considerations to a later stage. However, Beverley and Caroline gave no indication of working with REC issues when they described their work with families after the refeeding phase. For example, in her first interview, Beverley

struggled to think of any clinical work that relate to REC issues and attributed this to the COVID lockdown "*I am getting far less creative with my thinking*" (Beverley, 317). Eventually, she spoke about a Vietnamese girl of 16 years who attended the clinic on her own (452-456). The young person responded well to refeeding without the support of her mother who did not accept that her daughter has ED. Beverley was surprised that the mother did not want to attend and that the girl was not bothered by her mother's absence. Her description of this girl focussed on the girls' identity and her family's belief.

Three participants, Diana, Fiona and Eve, showed resistance to conforming to FBT advice. Diana said "I don't do one, two, three" (see comments about her reflexivity in 5.2.1. (c) - clinical experience). Eve used the term "generic systemic approach" to describe her adaptation when FBT is not suitable for the family of a bulimic boy:

> *"Because we felt that we couldn't use :: FT family base treatment basically. And there were much more suited for generic systemic approach as such."*
>
> *-**Eve**- (218-9)*

Fiona described her idea of "formulation-driven treatment" as an alternative when FBT is not working:

> *"we often use is you know, formulation-driven treatment (mmh) then. You know, that's what you, it cause to come down to. So you are trying to adapt, emm, to whatever that is, they are bringing. And you say okay, these models don't, don't fit at the moment. So we have to be in this kind of safe uncertainty position of where we go along, with this for a bit" - **Fiona**- (1154-57)*

In her adaptation of FBT, Fiona moves from the expert position of safe certainty to an exploratory position of safe uncertainty.

Although these three participants demonstrated resistance to FBT, they all show self reflexivity and attend to REC issues accordingly. They use reflexivity to explain their actions which strengthen the therapeutic relationship during treatment.

5.2.4. Theme 4: Position of participant in relation to REC

(a) Expert and/or equal to the families

All participants' narratives showed that they considered how they used the influence in their position. Their responses varied according to the complexity of the family situation, the severity of the risk presented by the ED, team expectations and how they use the FBT model. For example, Ada described a mother from an Orthodox Jewish background who had lost confidence in feeding her child. She positioned the mother as the expert about the mother's own family, and took a one-down and curious position:

> *"Mmh, I think they :: put them a position of ::: emm [Ada hissed] of of expert in their own experience. So I was having a one down position and really trying to be very very curious and open in finding ↑out, how their own cultural community and religion was shaping who they ↑were as a family and:: just the fact that I handed over, actually these emm ehh story."* ***-ADA-*** *(254-259)*

The process enabled the mother to feel understood and regain the confidence to lead her family.

Fiona described a situation where she positioned herself as an expert to mediate between the parents and the team. She persuaded the parents to feed their child and this avoided an admission.

> “*we were on the CUSP of having to think about you know using the mental health act. And having to displace the parent. It was quite yeah*”
>
> -***Fiona***- (420-421)
>
> “*emm based on making things happen and make decision, deciding you know what the medics were going to push with and what we would push with.”*
>
> -***Fiona***- (430-431)

In another example Caroline felt undermined when a white British family said, “you are not from here”. She used the NICE guideline to assert her expert knowledge of ED (495).

(b) REC as an external context

I noticed that the participants often referred to REC as an external context, either in the background or foreground, rather than it being woven into the fabric of the relationships within the family. Participants positioned ‘REC issues’ as an object, whether they existed or not, as if in competition with other issues. This was exemplified by Beverley who objectified REC issues as a “competing issue” (40) and “low down” (56) in priority (49-60). The situation is compounded by her psychiatrist colleagues who hold authority in the team but do not acknowledge the power difference between white patients and patients from minoritised ethnic groups (108-109). She highlighted a mixture of contextual influences on why REC has become invisible. This is similar to the situation in which Caroline did not notice that the

arguing parents came from different cultural backgrounds (5.2.2 (a) above), as if indeed they had no cultural background.

(c) Integrating REC into practice

Only Diana described integrating REC issues into food and feeding conversations. Her example was a Black African family her approach had led to successful re-feeding. This family said they felt respected by the team because their food, their dishes and their meals had been understood. This is an example where re-feeding and REC can be addressed at the same time, contrary to FBT and rather than considering a linear binary position of one at a time.

5.2.5 Unexpected silent narratives about REC

Diana and Fiona both shared difficult team experiences. I call them unexpected silent narratives which are of importance but can't be neatly categorised. They point to structural issues and difficult emotions around REC issues.

Diana shared a situation from when she joined the team in which she was called a "mad Irish woman" by a colleague, a "black African nurse", born in UK. This was followed by other incidents that made her feel uncomfortable. Diana cautiously told me that she had to be careful with what she was saying:

> *"YES (.) emm (.) and I think when I was working emm when I was working with emm. I think this is quite personal but it became professional as well. So I was working with a black African nurse (.) and she is*

> *lovely. Well, was. I have to be very careful here Charlotte in some ways. I am going to be open with you. When I was working with her, I came to the team. And she will refer to me as the mad Irish woman."- **Diana** (555-558)*

Diana felt that her colleague was racist towards her despite a perception that racism is only perpetrated by white people towards black people. I think her work context contributed to this, in that her team and organisation were by-standers. This is a structural issue, in which projection affected everybody regardless of background. The emotion involved led Diana to avoid discussing this with the nurse, and the issue remains unexamined and silent.

The second silent narrative was from Fiona who talked about what happened at a presentation when she questioned the stereotypic practice of assuming that cultural issues belong only to families with minoritised ethnic backgrounds (as described previously, see methodology 4.4.2). This hints at dominant opinions within the group which added to the challenge of discussing REC issues. Both these examples indicate the need for emotional safety and facilitation difficult conversations.

5.2.6 Summary of findings from REC narratives

All participants described personal and professional experiences that sensitised them to REC issues. Their experiences influenced their identities, positions and reflexivity in practice. However, the Maudsley FBT model, adopted by their services, limits curiosity about REC issues at the start of treatment. The more experienced therapists used FBT reflexively whilst the others were content to follow the model and feel empowered by the certainty it offers.

All participants recognised that ED carries a risk of severe physical complication. They all agreed with the importance of prioritising the restoration of weight which requires psycho-education and is seen as a practical task within the FBT model. Food consumption is reduced to a medicine instead of a social and relational activity. Family functions were recognised as important to enable feeding of children with ED. An exploration of the contexts for refeeding, such as family heritage, culture, way of living practices and Doxa (Bourdieu, 1998), is not encouraged by FBT.

Most of the participants talked about structural issues that influenced their team practice, such as the role of family therapy, power dynamics, and what was valued. The issue of workload - not enough time - is a barrier for everyone addressing REC issues. Participants felt that building relationships to explore REC issues requires time, sensitivity, respect and safety. These are compromised by high workloads, insufficient time for reflective practice, and the priority to refeed the child.

One participant talked about the lack of REC literature in ED, and the lack of expectation or encouragement to focus on REC. Therapists are left to fill in these gaps. On one hand, this encourages therapists to be creative. On the other hand, it demonstrates a lack of interest in this topic.

Finally, two unexpected silent narratives illustrate the complexity of REC issues in the workplace: relationships between colleagues and how REC issues can be discussed. The meaning of these is beyond the scope of this research.

5.3 Themes about food and eating

Four themes relating to food and eating were identified. These themes are (1) Emotional experiences with food, (2) Family dynamics around food, (3) Wider contexts and (4) Influence of food narratives on clinical practice.

5.3.1 Theme1: Emotional experiences with food

All participants used emotive words or expressive sounds when narrating how they felt, which simultaneously evoked feelings in me. I noted that their different experiences of eating and feeding were connected with loss, memory, love and care.

In response to my question about food experiences, two participants talked about losing their mothers when they were young children. Their narratives illustrated different ways in which their feelings are expressed through food. For example, Beverley hated her stepmother's cooking and longed for the familiar food of her mother or grandmother:

> *"Emm, and then there were remarriages, so there were emm different mother figure then who came in and cook their way. And I really hated the way my stepmother (Beverley laughed) cook. Emm, so there is a lot of emm (p2 hissed) longing bounded in food. You know that, you, having to get used to someone else's way of doing things (mmh). Emm, it is hard. And it really exemplify for me that, that loss. Emm, not having familiar food that my mum would have cooked or my grandmother (mmh) later on."- **Beverley-** (795-799)*

Beverley emphasised the word “hated” and then laughed. Food carries valency, symbolising her relationships with her mother and grandmother. Most participants recalled food within the context of their extended families. Eve compared her experiences with those of Marcel Proust, the author of “*In search for lost time*”. He described how the taste of madeleine cakes brought back childhood memories. For Eve, the taste of bread salad reminds her of her father and grandmother:

> *“I made something my grandma used to make, which is like a toast and bread salad. Something so simple, very very poor dish, is nothing sophisticated but again the taste been the same for, I don't know. I probably tasted it for forty years (Eve laughed) of my life, emm but every time I eat, I have that. I can't stop thinking about : grandma or my dad you know. The memory will still bring me there (mmh).”- **EVE-** (828-830)*

Eve described how food makes her think of people she loves and misses. Her narration was evocative. As I was listening, I was transported to my family parties where special food like dumplings and noodles are served. This highlights that food and feeding are more than eating: they can evoke memories, emotions and family experiences.

5.3.2 Theme 2: Family dynamics around food

The participants’ narrations about their food experiences showed different family relationships and dynamics. These included control and authority, parentified children, self-care, protection, love and care, confirmation and loyalty. For example,

Beverley described how there was no allowance from her parents regarding her hatred of fish so her grandfather sneaked into the dining room and ate it for her:

> *"Emm, I do remember sitting in front of a plate of smoked haddock for several hours because I hate fish. And my grandfather sneaking into the room and eating it for me. Emm, because he could see I was, you know I just hated the taste. But there was no emm ... But I just hated fish, but there was no sort of allowance for that."-**Beverley-** (739- 744)*

The positions of Beverley, her parents, and her grandfather, in this story show the dynamics of their relationship. Perhaps, it was loyalty to the family value of not wasting food which led to the parents' rigidity and an inability to see the child's individuality, her likes and dislikes.

Fiona described how mealtimes were usually fun except when her father "cast shadow" on the family meal (1642). This was because he could be "very very violent" (1935). She and her siblings were expected to eat everything served to them. One of her sisters ate anything her siblings didn't want (1643-46). I interpret this as her sister's way of minimising any conflict that may have upset their father.

In contrast, the remaining four participants did not mention much about their mothers, other than the fact that they cooked. It seems that they were taken for granted because there was a sense of normality, security and predictability. These different responses illustrate family dynamics of acceptance, resentment, adaptation, awareness and management.

5.3.3 Theme 3: Contexts- social, culture and historical

Participants also brought situational contexts and cultures into their narrations. Ada described the gendered expectation that women would cook and feed. She described a family ritual in which she and members from three generations of her family came together regularly for “long Sunday feasts”:

> *“emm, where women would be in the kitchen organising, preparing, serving and looking after, emm looking after others. Both the, mainly in the extended family, in the family but also the kids. There will be emm, there will, there will be an atmosphere that there, especially auntie, or grand, my grandmother will keep or arrrh, make, will, will want to make sure that we eat a lot. And and regardless of how much we eat, it is never enough. That there was, this aspect of yeah, caring and looking after.”-* ***ADA-*** *(844-849)*

Women look after everyone by making sure that they eat “a lot”. Reciprocally, everyone would eat to appreciate the food made for them. Eating represents the appreciation of those who prepare the food whilst preparing food represents giving love and care to others. However, this relational dynamic of giving and receiving food through feeding is interrupted in families with ED.

Beverley also described how women in previous generations were expected to stay at home to look after the children whilst the men went out to work. Caroline talked about how a woman’s beauty is based on how slim she is; how being slim would open the possibility of marrying into wealth. Ada, Beverley and Eve talked about

food scarcity during the second world war. They pointed out how people in different cultures related to food shortage. This included the importance of not wasting food, portioning, and how food was a luxury which needed to be shared within the family to show care and closeness.

5.3.4. Theme 4: Influence of therapists' food experiences on clinical practice

The participants' food narratives showed how their food experience can influence practice. Two had unpleasant experiences and described how they influenced the use of self. Beverley positions herself as a strategic therapist, putting herself into a "different sort of zone" following the FBT model (Beverley 385, 1087, 1105). Fiona described how her mealtime experiences (5.3.2) position her practice:

> *"I think that evokes in me the sense of right (P6 laughs) this is really contain it, be the, be the container for the parents really, listen etc. And start to move towards okay, err action and advocacy. ...Emm, yeah. So its, it's a bit, I don't want to sound detached, but it's a bit like noticing it and letting it kind of wash over but not being swept along with it. Because we know that's not helpful (mhh). Probably the best way I can describe it."- **Fiona** (1945-1947, 1950-1952)*

She describes how she listens and is able to contain the parents' distress before leading the family to action. She called this position "neutrality" (further on 2038). It seems both Beverley and Fiona take an external, mostly first-order, position.

The other four participants talked about awareness of their food experiences when working with families. Diana and Eve described resonances evoked by what the

families present, and this enabled them to position their responses. For example, Eve described feeling sad towards mothers who say they are feeling sick of cooking:

> "*So when I hear, and I heard it quite a few times actually. When I hear mainly mothers say ↑OH I am so sick of cooking .hhh, my heart sinks more or less and I have to really be careful not to give it away (mhh) Ehh yes, I think I feel quite sad about those families where the meaning of food is been so deprived, so impoverished that again feed feels like, feeding almost feel like a chore. In ( ) , there is no enjoyment, no pleasure nothing.*" ***-EVE***-*(993-997)*

Eve's reflexivity re-positions her to hide her feelings and avoid coming across as blaming. Further on, she talked about finding ways of using these feelings therapeutically (1007-1010).

Ada wondered how her expectation of parents being able to feed their children influences her therapeutic relationships. Diana described how her experience of feeding her own son, who had eating difficulties, enabled her to connect with parents. However, she is aware of not taking over their role. Lastly, Caroline is aware that her experience around food and body image are remarkably similar to that of her patients. Therefore, she makes an effort not to congratulate young people who have lost weight.

5.3.5 Summary of findings from food and eating narratives

When participants were asked to talk about their experiences of food, eating and feeding they all gave examples from their family experiences, describing how they felt, and how their family members related to each other in their respective dynamics

around food. Their narratives also referred to the social, cultural and historical contexts of their experiences. They showed varying degrees of the use of 'self' which demonstrates the influence of self-reflexivity on their practice. The links between food and their emotions were activated when given space to reflect during the interviews. However, in FBT practice, food is framed as medicine and psycho-education which de-activates the valency that food can represent.

5.4 Focus groups

Brief description of group one:

The five participants were all female. Two were white British (Amy and Davina), one was white Scottish (Cynthia), one was white Latino (Eleanor) and one was Black British of African descent (Bella). They were supportive and respectful of each other. They took turns to contribute, often helping each other to develop their thinking and to articulate ideas. I observed that two were more open and expressive. The others expanded on what was said and identified with each other. Together, they talked enthusiastically about structural issues such as team relationships, workload and medical discourse.

Amy is the only one who brought up, on several occasions, the tension around meal times with clinical families. I felt her urgency to find a solution for that. On one occasion there was disagreement between two participants but this was respectfully resolved by discussion. On the whole, the discussion remained within the boundary of the group exercise.

Brief description of Group two:

The four participants were all female: two were white British (Helen and Ivy), one was white Irish (Faith) and one was British Asian (Gabby). The balance of contributions was weighted towards three with longer clinical experience. The fourth (Faith) positioned herself as newly qualified and seemed comfortable listening to her more experienced colleagues. I felt it necessary, on several occasions, to invite her into the conversation.

The three vocal group members discovered they were linked by experiences relating to premature birth. Two were mothers of pre-term babies and one had, herself, been born prematurely. This may have created a greater sense of closeness between them and explains why their conversation was engaged, with lively questioning and mutual support. It was as if they knew each other.

This group talked mainly about the therapist: self, ethnicity, and personal view, and how these influence relationships with families. They were intimate with each other by sharing how personal stories and experiences linked with clinical practice.

The following themes were identified.

5.4.1 Theme 1: Reflexivity and connection

Two group participants talked about their minority racial background. Four talked about the intersection between their white privilege and marginalised experience. Two talked about their emotional connections with feeding and three talked about their interest in REC issues.

Bella and Gabby, the two therapists from minoritized ethnic groups, described their sense of responsibility to improve cultural practice. Bella used the term “Black

professionals" (96, not in excerpt) and talked about structural discrimination against people with ED from different cultures:

> *"Emm, yeah and it's almost like, like just something about it doesn't mean that anorexia or different eating disorders don't cross culture. But they do, and everybody knows that. It isn't discriminate against emm, you know different communities or culture. there is something around why other conversations still difficult to have within team. Emm, some of that might be about medical model, some of it <u>might</u> be about emm, I think the makeup of the teams I think."*
>
> *- **Bella-** (882-887)*

Bella commented further that clinical teams do not always reflect the communities or cultures they serve, and conversations about structural discrimination are difficult. She said the Black Lives Matter movement has opened possibilities to reconfigure the service (102, not in excerpt) so she is positive about developing a service that allows young people to see therapists that look like them.

In a similar vein, Gabby wondered why she is the only therapist from a minoritised ethnic group in a big diverse city (1084). She aspires to seeing more ethnic-minority families appearing in educational video clips and as 'graduate parents' in the multi-family group. She thought this would be reassuring for new minoritised ethnic group families using the service (1020-1023).

Four participants acknowledged their white privilege but also highlighted their connections with REC issues through other social markers such as differences in ethnic background, sexuality, heritage and appearance (skin tone). Cynthia talked

about growing up in Scotland with an English mother where she had to manage complicated class and culture differences (986-988). She feels the need to be aware of cultural differences between white people in the UK.

Davina introduced herself as a lesbian parent (44). Ivy talked about her white skin which hides her black heritage and leaves her in “no man’s land” (1103). She feels “the pinch” of racism and “othering” practices. Helen feels her olive skin was often the reason why she was mistaken by others as Persian or Turkish, which makes her feel othered (1111).

Ivy and Gabby had very premature babies that were separated from them after their birth. Ivy described the experience of seeing her baby at the “cusp of life and death” and this connects her with parents who are desperate and in fear (237-241). Gabby felt helpless; delivering breast milk to the hospital in the middle of the night was all she could do (227-231). Helen said, because she was “very premature” (223-234) her mother told her about parental worries which explains her empathy to parents.

Amy, Faith and Eleanor did not relate any personal stories but spoke about contexts that have increased their interest in REC matters. Amy is white British and works in a predominantly white area. The staff are from different racial backgrounds (841). Her interest is to “unpick” family culture and other interconnected issues such as gender and religion. Faith, who is white Irish, referred to her experience of moving between Ireland and London, which has increased her awareness of differences. Eleanor, who is white Latino, did not refer to her lived experience of migrating to the UK but shared the fact that her Masters dissertation had been about REC.

5.4.2 Theme 2: Hindrance to REC practice

The group participants discussed several contexts which hinder their work with ED, such as the medical model, workload, and managing risk. Bella made a joke about "five minutes" (583-594, discussed previously in 4.5.1) and ridiculed the little time for clinicians to share their views during ward rounds. Her clinical lead told her there is no time for reflective space because the workload had increased during the COVID pandemic (703-706). Bella turned to self-care, ensuring a reflective space for the multi-disciplinary team (905-907). Davina also spoke about the increase in workload. She described how hard it is to be reflective when exhausted, like "your brain is shredded" (671-672). Her creative language emphasised the limited capacity for complex considerations.

Amy described how the medical approach with FBT offers certainty but shuts down curiosity when managing physical risk. Things can be missed:

> *"with an eating disorders. Emm, you know, so it's that, oh okay, so you know their blood test is come back like this, so we have to do this, we have to do that. So emm, its sort of familiarity makes you feel like, maybe you know what you are doing but in, in a way that's not necessarily good thing because it might stop you being curious about, may be other things that might be going on. So, yeah, yeah, maybe" -**AMY-** (340-345).*

Other participants supported Davina's idea that ED presents a "double block" to curiosity (435-437). She referred to the difficulty of dealing with the emotional distress of the ED family and the simultaneous need for sensitivity (self and relational reflexivity) to explore REC issues through eating. Omission of the latter in FBT reduces the emotional challenges to therapist, especially for less experienced therapists looking for safe certainty.

Ivy, Eleanor and Helen discussed other issues that hinder REC conversations including: therapeutic skills, anxiety or ignorance, and insufficient time. Ivy described an occasion when the clinician overly enquired about culture:

> *"the clinician has, was so overly enquiring about culture that it completely alienated the family because the family said, 'For GOODNESS sake whatever you call it, my daughter has got an eating disorder, can we just get on with it? And so there is that"*
>
> ***-IVY-*** *(829-830)*

This excerpt showed a lack of reflexivity. REC had become an agenda, like a list. When REC exploration is imposed, out of sync with the family, it points to misuse of power in the therapeutic relationship. There is a need for sensitivity and skill in addressing REC. On the other hand, Ivy and Helen both expressed concerns about the lack of REC enquiry which can result in "alienating" practice. "Ignorance" or lack of understanding about a family's culture (354- 357, 376-377) risks disengagement, which creates anxiety in the team. Safeguarding processes may be initiated as a result.

Eleanor said her non-systemic trained staff are expected to deliver in accordance with the medical and family model. There was "not enough time" in her supervisory role for non-systemic trained staff to have meaningful conversations about REC matters (742-748). Therefore, she feels she does less than she would like to.

5.4.3 Theme 3: Resistance and conformity to the grand narratives of treatment of ED

Helen, Ivy and Amy questioned, or showed their resistance to, the grand narratives of team practice. Davina, Gabby and Ivy spoke about the value of working in a multi-disciplinary team.

Helen used creative words and metaphors to describe what she called the "crystallising moment" in her career. This was when she realised that the FBT manual approach did not suit a Muslim family. She said she "blew up" the manual and was not going to try and make it fit (1037-1038). She described the team response as a "massive rumble":

> *"And it created this massive kind of rumble in the team. Well why you just going to do that for one family, why they are so special blablablablabla, and I say well why is everybody else SO special. Why is difference, so dangerous [Gabby mmh] and it were, it, yeah. I, I, completely agree with what you are saying Ivy. It is hard."* ***-HELEN-*** *(1039- 1042)*

Helen defended her decision by questioning why difference is so dangerous. She has since moved to another area and her new team has a cultural reflexivity group which looks at training and non-othering ways of working with families (further on in 753-754). Helen used expressive language - a "whitewash" - to describe FBT and illustrated this with an example of a St Bernard dog. The metaphor describes a western family parenting style of working alongside their child. This may alienate families who have different culture norms about dogs or different understandings of

what St Bernard represents (1060, further on in the transcript). Ivy described the "othering culture" of her inpatient unit (635). She works around this by running lots of supervision groups for staff, providing space to discuss their feelings and the influences of culture (835-836). She described her colleagues as a "very white British team" (833) which thinks it is addressing culture, but isn't.

Amy said she works in a predominantly white area and yet the team, despite being from "different racial backgrounds" (821), does not do anything different for ethnic minority families (826-829). She questioned whether it is conforming to the dominant narrative of white middle-class families. She feared they are losing curiosity about how FBT fits different families (826-833).

In contrast to the "five minutes" ward round discussion raised by Bella (see 5.4.2a), Davina, Ivy and Gabby spoke about the importance and their appreciation of working in a multi-disciplinary team. Together, they highlighted the benefits of working within a medical framework. For example, Ivy talked about the importance of a paediatric ward offering respite to families in crisis (950-951). Ivy and Gabby also felt it was too risky to work privately without the support of their team (942-945, 957-958). Davina described the support she had from her team when she had a complaint from a family (645-649).

5.4.4 Theme 4: Participants' position in relation to REC, food and clinical practice

Participants in the two focus groups spoke about the influences on their practice: food and eating, their REC background and other life experiences. They all positioned themselves as reflexive therapists in their practice.

Reflexive Therapist

In group one, Bella, black and British, positions herself as an advocate for prioritising reflective practice. This includes attention to REC matters, as well as kindness to self and attention to contexts. She described the importance of sticking to the “normative routine” in systemic enquiry so that REC issues come out organically (Gp1:903-904). She expressed concern that REC has become just “a thing”, a lip service which does not meet the needs of the families (Gp1: 723-727).

In group 2: Helen, Gabby, Ivy and Faith position themselves as relational reflexive therapists working with tension, whether at mealtimes or with families from different backgrounds. Helen talked about naming the tension, the emotional tone, and described how families were invited to comment on how it fits with them (Gp2: 597, 606-607). She described the space for meeting families as a middle place, a space where hypothesising, formulating and reformulating comes from hunches (Gp2: 681-685). Gabby talked about taking a second-order position, using what resonated in her and throwing this into the open for the family to respond. She checked how the family felt (Gp2: 601-605). She said the space for meeting families is not one in which to go wild but is where the therapist can wonder, think and step back from asking questions (Gp2: 686-689).

Ivy preferred a less direct, softer, more subtle approach when meeting minoritized ethnic families. She enquired what happened at dinner time, noting similarities and differences, not pointing out that the family was different and thereby othering them (Gp2: 494- 499). She listened more carefully to the family’s voice and learnt about them (Gp2: 657-660). She called this an “active” space, a space to figure things out, somewhere between similar to and different from the family.

Faith positioned herself as self-reflexive and relationally reflexive by considering similarities and differences when meeting the families. She shared her ideas and worked things out with the family (Gp2: 681-682). She also advocated thinking about the process or the resonance with families (Gp2: 691-695).

Helen and Ivy are both white British and described their experience of assumptions made by others because of their skin colour. Helen talked about being asked if she is Persian or Turkish because of her "olive skin" (1109-1116). She used emotive language - "you are not from here" - which gave her a "snapshot" of what it is like to be othered. She positioned herself as an advocate for culturally reflexive practice, especially in her team where everyone is white British. Ivy described how her black heritage is hidden because of her white skin. She used creative language and repeated her position of being in "no man's land" and feeling "the pinch" of racist practice (1098-1104). She offers "lots and lots" of supervision (835-836) to encourage her team to reflect and talk about REC issues safely.

<u>Resonance and Empathic Therapist</u>

Gabby and Ivy showed empathy to parents because of their personal experience of having premature babies (Gp2: 237-241). They resonate with experiences of separation and the helplessness of relying on the hospital. Cynthia used creative language to describe her reaction - "frozen and like fear" (Gp1: 363) - when watching one of the family meal videos because it reminded her of the tension in her own family. This is an example of how she used her bodily feeling to inform her exploration of emotions and issues with clinical families. She also used creative language to talk about "tripping up" when working with the same culture. She

described how Scottish people may have very different values and compared herself with families from other part of Scotland (964-972). She positioned herself as sensitive and aware of the complexities of working cross-culturally.

Eleanor talked about her own family rituals at mealtimes when growing up (Gp1: 419-425). She positioned herself as reflexive practitioner who is curious. She checked her assumptions and ensured she remained curious about clinical families' mealtime rituals.

Faith used expressive words, like “threatening or scary” (Gp2: 857-862), to describe the similarity between trauma and culture work. She feels that the use of reflexivity, like uncertainty in trauma work, is necessary for cultural work. Therefore, she expects her team to extend their trauma work skills into cultural contexts.

Ivy positioned her own family as caring and resourceful. She used expressive language - “Oh, my God” - to describe the talent of her grandmother who, in the face of poverty, was able to create “amazing” food (Gp2:221-225). She connected this experience with the importance of respect for a family's culture.

Gabby described her experiences of being brought up in a Muslim household with a white British carer. Since a young, she has been aware of the diversity of cultures around food (Gp2: 291-296). She encouraged families to “re-engage and trust” their own cultural position, even when feeding treatment might lean towards a western way of eating (296-302).

5.4.5 Summary of findings from the two focus groups

Anxiety around ED and REC

Both groups talked about the challenges of cultural practice because it requires sensitivity, creativity, as well as the safety and support of the multi-disciplinary team. Davina named a double block to curiosity: one being the risks presented by the ED, and the other being the need to be extra sensitive when exploring cultural difference. Concerns about getting it wrong were clear. They all appreciate the support of their multi-disciplinary team, even though they may be frustrated by a lack of reflective space. These illustrate the constraints and affordances of FBT in attending to REC.

Therapists' reflections

Participants talked about their own experiences of meal times and how they related to the highly emotional and conflictual tension of the clinical families meal times. They described how they made sense of the resonance, connecting with their own family meals, rules and bodily responses, and how they use the resonance reflexively to work therapeutically with families.

They commented on their therapeutic stance and skills when working culturally. These included: sticking to systemic practice; exploring the family's script, routine and boundaries; allowing race and culture issues to come out organically (Bella, 907); avoiding "othering" families by "jumping in with a big culture question" (Helen and Ivy, 494-499); allowing sufficient time for meaningful conversations (Eleanor, 836-839); and having the confidence to stay in uncertainty when opening up cultural conversations (Eleanor, 856-861).

Helen and Ivy talked about the risk of families disengaging because of safeguarding and alienating practices caused by a lack of understanding of cultural differences (372). Helen described being challenged by her team when adapting the manual to make it culturally appropriate (1037-1039).

Wider contexts

Participants discussed the effects of increased workload due to the COVID-19 lockdown, clinician exhaustion (671-672) and the lack of time for reflective and cultural practice (724).

5.5 Synthesising all findings from individual interviews and focus groups

The following is a synthesis of three sets of data: (1) summary findings of participants' narratives about REC (5.2.6), (2) summary findings about relationships to food and practice (5.3.5), and (3) summary findings from the two focus groups (5.4.6). Their similarities and differences, distinctions and contradictions were noted with reference to the research questions to become the overall final findings.

5.5.1 Overall finding 1: The role of self and reflexivity

All participants said that consideration of REC is important. Their narrations showed their systemic practice, even though they didn't always explicitly describe the concepts they used. I noticed their use of self, reflections, resonance, self-reflexivity in action, and relational reflexivity with families. They also commented on how they can be hindered or distracted by team issues and wider contexts which draw them away from what they are sensing and feeling.

5.5.2 Overall finding 2: Constraints and affordances of the FBT

The participants agreed that the medical approach within the FBT offers safe certainty as well as emotional containment for families and clinicians. However, this 'right way of working' simultaneously closes down curiosity and reflexivity.

Participants agreed that the decision to explore REC issues was left to the family therapist in a context where risk and weight restoration are priorities. The FBT provided no encouragement to address the relevance of REC. The findings point to consideration of REC being influenced by participants' personal and clinical experiences, team narratives and team priorities.

5.5.3 Overall finding 3: Lack of team interest about REC

Attention to REC issues varied from team to team. There was no specific correlation with the makeup of the local population, the geographical locality, or the diversity of the team members. Team recognition of the importance of REC depended upon contributions from clinicians' personal and professional interests, and the ability to support and motivate each other. Others described a lack of shared multi-disciplinary team interest and its adverse effect on the REC practice.

5.5.4 Overall finding 4: Representation of food is reduced

Food narratives told by the participants included emotive and rich conversations about their family experiences. However, conversations about food with clinical families were noted to be difficult because they brought up tension, conflict, fear and distress, especially when associated with mealtimes. Food had become a medicine and a short-hand for refeeding or psychoeducation in the FBT model. This discouraged family therapists from exploring the meaning of food during the refeeding phase, which not only narrowed the understanding of what food might represent to that family but also reduced their connection with the strength and resilience of their own culture to support the refeeding process.

5.5.5 Overall finding 5: Discomfort and confidence in talking about REC in ED

Various concerns were raised about bringing up the subject of REC. These included insufficient time and the need to be sensitive when tension around refeeding was high. Participants' personal experiences mirrored the bigger picture in which discomfort existed at every level of the social world when talking about REC issues. The omission of race and ethnicity considerations in respect of white families is consistent with literature which describes white being seen as the invisible norm, despite always being there to show the difference (Wallis and Singh, 2014).

5.5.6 Overall finding 6: Power and risk of dominant narrative

Three participants made different adaptations to the dominant narrative (FBT model) in order to address REC according to their reflexivity. The consequence of delaying REC considerations was argued by one participant as being a possible hinderance to developing the therapeutic relationship, which made the refeeding process more difficult. Two participants said they adhered to the model but did not talk about consideration of REC in the subsequent phases of treatment. This showed the influence of personal contexts and, might also have been, the influence of the dominant narrative carried through to other phases. One participant chose to follow the dominant narrative because this was expected by her team. Although she complied, she felt uncomfortable because her reflexivity led her to question the appropriateness of delaying an REC conversation.

5.5.7. Overall finding 7: FBT as a medical and systemic model

Although FBT is a medical and systemic model for treating ED, the focus on refeeding has discouraged reflexive consideration of REC exploration during the first

phase. The participants who adapted FBT to include attention to REC issues showed it can be successful during the refeeding phase.

5.5.8 Overall finding 8: Social, historical and political influences

Participants brought up a number of wider contextual influences. These included the Black Lives Matters movement, racism in UK society and its effects on access to treatment, staff recruitment, marginalisation, ethnicity and culture issues, as well as other intersectionality markers. The COVID-19 pandemic brought unexpected death, loss, grief and fear, in addition to financial and employment worries.

5.6 Synthesis of the overall findings

The eight overall findings illuminate each other and I have identified three areas that are relevant to my research question for further discussion in the next chapter. These are (1) the dilemma between saving life and being reflexive, (2) the therapists' personal contexts and (3) adaptation of FBT model. I will also include discussion about the unexpected narratives revealed by using DPA because they are relevant to structural and team issues regarding REC.

6. Discussion

This research set out to examine what happens to REC when family therapists work with childhood ED. In other words, how do risk and family-based treatment (FBT, the first line treatment recommended by NICE) influence the self-reflexivity and cultural practice of family therapists. I found the dilemma between saving life and being reflexive to be a key issue: risk influences whether therapists conform to or adapt FBT. All therapists in this study said attention to REC is important. However, this is not encouraged in the first phase of FBT, although it is undertaken by some therapists if deemed appropriate by their self-reflexivity.

An important area arising from my research is the tension created by the FBT manual between saving life and being reflexive, which is an issue central to clinical practice when working with ED. Other issues for discussion are adaptation of FBT, clinicians' reflexivity with food and eating, and the two unexpected REC stories. These areas emerge from the eight themes (overall findings) described at 5.5.

The first phase of FBT focusses on refeeding to save life. It is the intention of the manual to deliver a behavioural outcome approach. This discourages reflexivity and consideration of REC but the overall decision remains with the therapist as influenced by several contexts (personal, professional, team, institutional). The dilemma between saving life and reflexivity (FBT) encompasses safe certainty, safe uncertainty (Mason, 2019, 1993), risk and blame, emotions and tensions, service standards and efficiency. As an introduction, the following diagrams illustrate the positions of safe-certainty and safe uncertainty as implied by FBT.

Position of safe certainty in FBT: recommended for the first phase

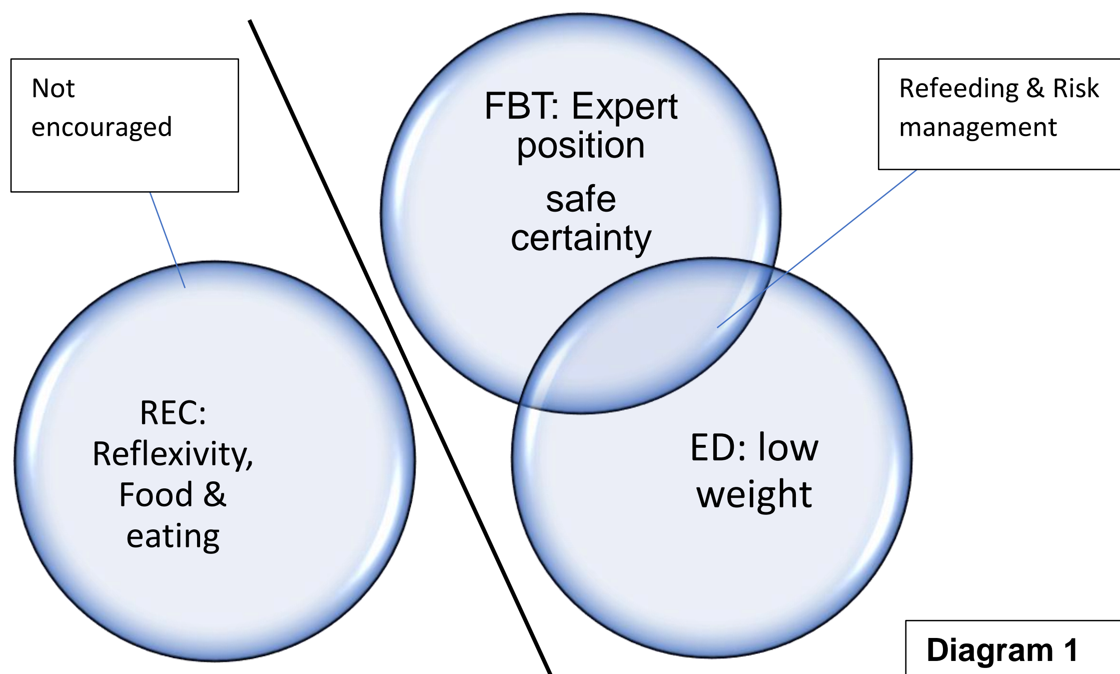
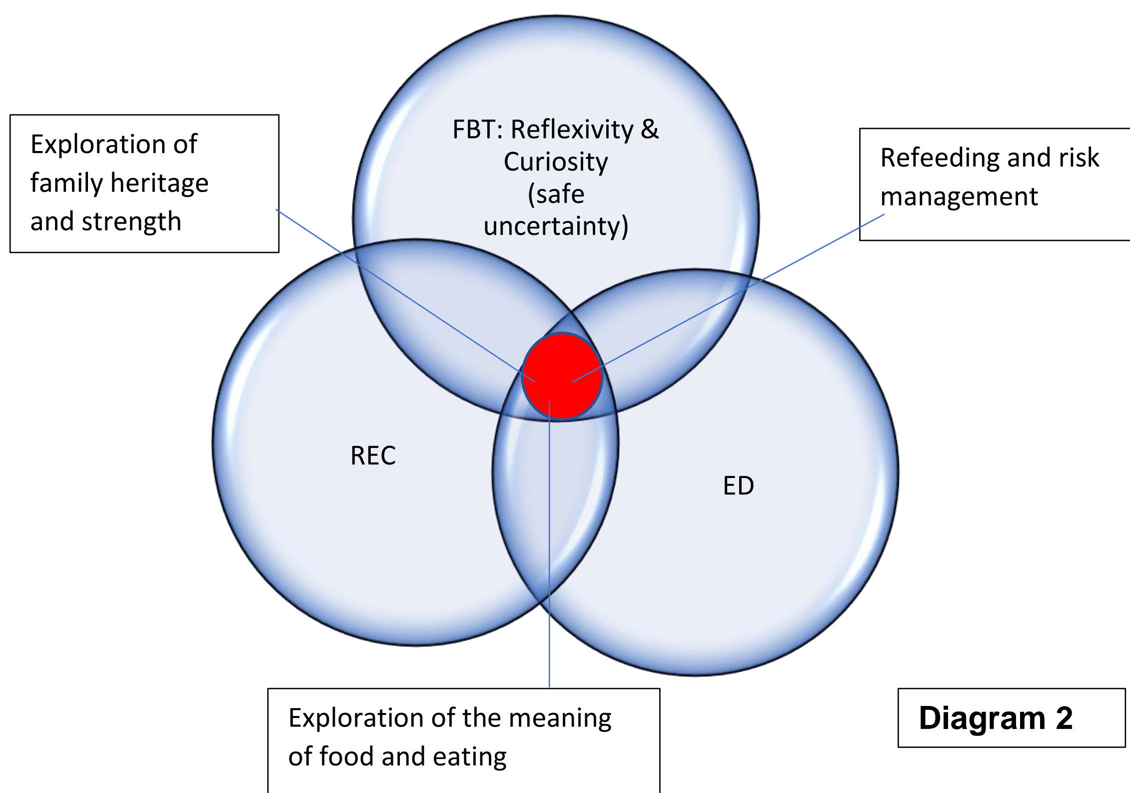


Diagram one illustrates the *exclusion* of REC and reflexivity from the first phase of FBT. It shows the intersection of treatment position with ED symptoms only (the two overlapping circles FBT & ED), resulting in refeeding and risk management without the involvement of reflexivity, REC and cultural understanding of food and eating.

Position of safe uncertainty in FBT: recommended for subsequent phases

Diagram two illustrates *inclusion* of REC and reflexivity after phase one. The three intersecting circles encompass the area where refeeding, risk management, reflexivity, consideration of family heritage and strength, exploration of meaning of food and eating meet.



<u>FBT: Saving life and reflexivity</u>

ED and, in particular, anorexia nervosa has the highest mortality rate of all mental health illnesses (Fichter & Quadflieg, 2016). The patient is often acutely unwell and there is a severe threat of health damage. Understandably, saving life and refeeding is the focus of FBT by closing all other exploration to concentrate on feeding (safe certainty). Exploration of REC and other social markers is deferred to subsequent, safer, phases – a position of "safe uncertainty[12]" (Mason, 1993) which allows curiosity, some risk taking, reflection, reflexivity, and exploration of differences when

[12] Mason 1993 described a framework to consider safe certainty, safe uncertainty, unsafe certainty and unsafe uncertainty in therapeutic process. It complements the thinking behind the first and second-order position. It described the safe certainty as the expert position of knowing how to keep things safe. Safe uncertainty is the position that allows some risk taking by clinicians: curiosity, being respectful, reflective and explorative, opening different possibilities.

there is no longer a threat to life. The challenge for family therapists in the first phase is that they are reduced to a behavioural solution focus and potentially miss the opportunity to engage families through their REC backgrounds. This may access the strength of the family and the cultural meaning of caring for their child through feeding. Systemic therapists are trained to work with both positions and use their reflexivity according to the situation.

Wampold & Imel (2015) described therapeutic alliance[13] as the most important factor in psychotherapy success. They posit that effective treatment relies on an effective therapist, and does not depend on adherence to a protocol (p.159). Furthermore, culturally adapted treatment, compatible with the patient's cultural beliefs, is more effective (Benish, Quintana & Wampold, 2011). This indicates how important therapists' self-reflexivity is in creating therapeutic relationships conducive to cultural work. This supports participants who privilege cultural conversation in the first phase of treatment in FBT.

Family therapists are familiar with the practice of self-reflexivity, also referred to as the 'double turn' (Ahmed, 2004, refer to 3.4.2). The first turn is to yourself, to notice bodily responses and resonances, and how these connect with personal experiences. The second turn is back to the client and, with this self-reflection, noticing their influence on the interaction. The therapeutic relationship begins when therapist and family first meet. Self-reflexivity has the potential to improve the engagement process when the family is highly distressed by the ED. All participants commented that they valued space to reflect on their work but it is not always

[13] Wampold & Imel 2015 described therapeutic alliance as the combination of therapeutic relationship, expectation of therapy and the task of therapy.

possible because of time and other constraints. Two said they felt their team only pays lip service to reflexivity and exploration of REC.

ED is not just a physical illness but comprises complex physical and mental difficulties with a substantial social- cultural component (Eli and Waring, 2018). This means that treatment needs to attend to the body as well as general life issues. The linear phased approach of FBT offers clarity and 'knowing what to do' but it implies there is only one 'right' way. This is a dilemma for some family therapists because reflexivity is part of their ethical code and training expectations (AFT Blue book 2015 & AFT Code of ethics and Practice 2020). That said, the FBT manual was welcomed by many family therapists, including myself, because it recognises the importance of family as a context in supporting the child's treatment in addition to eating to stay alive. For minoritised families it would seem obvious that an understanding of their culture and the meaning of food and feeding would be vital for treatment.

My findings show that all participants appreciate the structure of FBT. However, half of the individual interview participants did not restrict themselves to the linear approach in order to practice reflexively with what the family presents. As a result, they were able to demonstrate attention to REC and other social markers in phase one as well as throughout the treatment. They practiced self and relational reflexivity and adapted FBT to fit the needs of families. Conversely, three participants who adhered to FBT accepted that saving life is the focus and that REC considerations can be delayed. However, only one of them took REC into consideration in the narration of their clinical work, even in subsequent phases of treatment. It seems that

the other two may have unknowingly positioned REC as less of a priority throughout treatment despite believing its importance.

Safe certainty

The focus on refeeding in FBT not only stresses the importance of saving life but has the advantage of providing safe certainty to the clinicians. The expert and 'knowing' position, and the directive of what to do, allays the anxiety of clinicians in the face of threat to life and parental distress. It is also in line with risk management and reducing the risk of litigation for the institution. Furthermore, FBT as the NICE recommended guideline, provides authority for clinicians new to the ED field. Caroline talked about quoting NICE to justify her expertise when faced with doubts from a family because of her accent.

In fact, it could be argued that exploration of REC to facilitate feeding might become a distraction from the priority of refeeding, as if it is intellectual talk or "*pretend mode*"[14] (Robinson, 2010, p.10). This points to the complexity of ED which requires an experienced therapist to use reflexivity and recognise what is going on in the therapeutic process. Safe certainty addresses this dilemma by avoiding this or any other distraction, particularly when team resources vary. However, the knowing expert position diminishes curiosity, which reduces the exploration of differences, missing the opportunity to tap into the cultural strengths of the family.

[14] Pretend mode is described in Mentalisation-Based Therapy for Eating Disorders patients with symptoms of borderline personality disorders. Patients can dutifully do what they think the therapist wants. In pretend mode the thoughts are detached from feelings and from external reality. This can go on for months and years, with therapy becoming completely ineffective. So, early recognition is needed to avoid therapy become useless and waste of time.

Another issue with the FBT model is its implication that the same treatment is applicable to all families. Hence, clinicians who follow the model are at risk of treating all families as if they are the same, especially when the patients are at risk. This position runs across the whole treatment system, including NICE, whose role is to provide advice on treatment excellency. REC are only seen as equality issues in the NICE guidelines – "*equal access to treatments*" – and are not mentioned at all in the treatment section (ng69, p.5). The research evidence that shaped the NICE recommendations is closely linked to western research that focusses on efficacy – what works – rather than how it works. Two participants remarked on the lack of research into REC and ED. "Race and culture" are only mentioned as contexts for exploration later in FBT and all participants in the study understood FBT as implying that it is not appropriate in the first phase of the treatment.

Risk and Blame

Another aspect of the focus on saving life, as advocated by FBT, is minimising risk to avoid blame. Two participants talked about stepping back into their respective core training roles when dealing with risk (see finding chapter 5.2.1 I as well). Beverley keeps herself safe by submitting to the service expectation and Caroline also finds it difficult to be reflective in high-risk situations. She fleetingly said "registration", which implies the serious consequence of losing her job and career. So, risk is no longer just about the life of the patient but also an issue for the clinicians. It is like an emotional response that over-rides reflexivity, even though Caroline is aware that reflexivity has a part in addressing risk.

Furthermore, the care-coordinator role, in a perverse way, has made the clinician liable. It is an example of 'blame' circulating in the system and easily landing on the individual clinician, rather than addressing the 'culture' of the institution (MacPherson, 1999). This echoes with Douglas (1992) who described risk management as a "*protection*" but also a "*blaming system*". "*Every death…*" comes with a "*threatened prosecution*" (Douglas 1992, p.15). This is one reason why, in the ED field, clinicians stay close to the protoc–l - to avoid being complained about or sued. This is at the expense of reflexivity and its benefits to the therapeutic relationship.

The focus of saving life is not only about feeding but risk management in line with the expectations of the service and the institutional discourses of the NHS. The distribution of blame is transferred from psychiatrist to care coordinator, or shared between them. Douglas (1992) is frustrated to see that "*cultural difference and the distribution of blame*" is not included in risk analysis. In other words, Douglas believes risk should not be considered absolute, as it is not simply a science with measurable behaviours, but is subject to hidden influences such as institutional dynamics. For example, the Macpherson report (1999) on the investigation of the murder of Stephen Lawrence identified institutional racism in the Metropolitan police. This led to the Race Relations Amendment Act 2000 (legislation.gov.uk) and illustrated how blame was found to be distributed across institutional, societal, legal and political contexts.

This speaks to the FBT refeeding phase where risk is treated as absolute: food and feeding are prioritised over issues of REC. The contexts for refeeding practice are ignored. Consequently, anyone who does not follow the model will halelf to blame if something goes wrong and may be blamed by the service and the institution for not

following the guidelines. The trust may be subject to the cost of inpatient admission or potential litigation. So, deviation from the guidance and safety provided by the manual can be a reason for blame to be attributed to the clinician.

Attempts to control risk lead to a focus on behaviour and this makes it difficult for therapists to be reflexive. Fiona, a seasoned therapist feels able to incorporate reflexivity into managing the risk of death, not being constrained by the manual. However, she talked about the need for supervision and team support in those situations, so as not to be solely responsible for deviating from FBT. Giddens (1991 as cited in Coser 1992) advocated reflexivity and reflection to make sense of risk, choice, trust and doubt, to allow our identities to develop. Thus, saving lives in the ED field is more complex than just refeeding or focussing on psycho-education. When we understand the multiple layers of influence, we can be reflexive about un-named discourses and emotions in the system.

Emotions and tensions

High emotions are evoked by the urgency of saving life. They add to the distress of a child who refuses to eat as well as to the distress of parents trying to feed their child. The FBT manual offers containment and certainty to both the family and clinician facing emotions which include anxiety, battle for control, fear, anger, guilt, blame and so on. Such distress, together with the sensitivity required by the therapist to explore REC issues, were described by Davina in her focus group as a “double block” to curiosity. Therefore, deferring cultural practice allows clinicians to cope with these emotions in the system, particularly during the initial phase of treatment.

Currently, consideration REC when saving life appears to be an ‘all or nothing’ thinking style which is common when there is heightened anxiety such as the fear of death. FBT reduces the emotional arousal of the clinician by taking control of their practice. Staying calm is comforting but is at the risk of losing reflexivity and REC considerations. This can be seen as a complex enactment of the patient being controlled by ED, benefiting from low weight at the risk of losing their life. Bruch (1978) described Anorexia Nervosa as the solution for a young person who is seeking to control their lacking sense of identity. So, the issue of avoiding emotion and seeking control is not only between the patient and their body, at a micro level, but also entangles other systems including the relationship between the patient and their parents, and between clinicians and the manual guide. This is a complex enactment of control being exhibited at many levels of contexts.

Conversely, the discomfort and fear of talking about REC issues are not only related to personal contexts, ethnic identities and clinical experiences, but are also inherently related to racism and the existence of inequality. This makes REC conversations in the ED field hard or even avoided as the FBT defers these issues to a later phase. Removing REC considerations from the first phase implies that eating and feeding are neutral behaviours and not culturally dependent. Hence, in her focus group, Ivy talked about a more subtle approach, scaffolding the exploration of REC issues through meal conversations. For her, exploring culture is integrated into feeding, and she avoids jumping in with a culture question that may have the unintended effect of “othering” the family. I consider this to be ‘saving lives with reflexivity’, integrating REC matters into saving life conversation, being reflexive and

sensitive to self and to the family's emotional state and contexts.

Service standards and efficiency

Participants' narratives described how interest in REC needs to compete with other team priorities. They illustrated the pressure for efficiency in response to time constraints and increasing caseloads especially since the COVID-19 pandemic. This is in keeping with recent national data. The incidence of ED in children and young people has increased 90% in the last five years (RCPsych, 2022). This report also showed that hospital admissions have more than doubled in the same time period. Early intervention has been incorporated into FBT to reduce hospital admission, to be cost-saving and to reduce the long term effects of ED (NICE quality standard, 2018). Pressure on services remains high despite funding allocated through the NHS Mental Health Implementation plan 2019/20- 2023/24 (2019). Health Commissioners rely on NICE guidance and so FBT has become the template for the standard of care and efficiency, and for shaping services. Streamlining or expanding the team has implications for job security and job opportunities for professionals. These structural issues influence clinical practice. Overcoming marginalisation of REC considerations relies entirely on the reflexivity of family therapists.

Furthermore, FBT has implications for professionals in the team, who are not trained in reflexivity or have no experience of systemic practice. Using the manual without reflexivity, consideration of REC or intersectionality may create a work culture that moves away from valuing reflexive cultural practice.

Therapists' personal contexts

When working with ED and REC issues, reflexive therapists look into their own experiences including those related to food, eating, family, REC, professional training and practice. The following examples of self-reflexivity showed how personal contexts can have different effects. Beverley who believed she avoided developing Anorexia, is a strong supporter of refeeding and delaying all other considerations. She did not connect her personal and food experiences with her current practice. This appears to be a 'blind spot' for her and may be protecting her from re-experiencing difficult emotions around feeding. Contrastingly, Ada, who migrated from Europe and practiced autonomously in her previous job, was obliged by her current team to compromise and delay REC exploration. Her reflexivity enabled her to notice the conflict between the team's expectation and her preference to explore REC issues for a white migrant family and this created discomfort for her. These examples illustrated disconnection (Beverley) and connection (Ada) with personal contexts and their impact on clinical practice.

Being self-reflexive about cultural differences and attending to the power dynamics between family and clinician can also be helpful in empowering parents to take charge of refeeding their children. Without reflexivity and awareness of differences, behavioural change may be less effective and can potentially impose assumptions onto the family (othering) as discussed in one of the focus groups. In such circumstances there is a risk of stereotyping and discrimination.

Therapists' connection with food and feeding

In the first round of individual interviews, the participants all described food and feeding as "psycho-education". I was surprised that nobody connected with their own experiences of food and eating, despite dealing with ED. Caroline came close by talking about body and appearance in her culture. This is the reason I organised a second round of interviews, specifically to explore personal food experiences and how these influence practice. Rich personal stories were narrated about the participants' relationships with food and about their connections with their clinical work. I conclude that this is because participants have not been encouraged to think about, to talk about or to be reflexive about their own food experiences in their professional work with families.

Anthropological perspectives on food

As a result of exploring therapists' connection with food and eating, I took an interest in REC's connection with both through an anthropological lens. Humans need food to survive and patients need food to replenish their bodies. The FBT model frames food as "medicine"- a cure for the illness. Clinicians deliver psycho-education so that the family and patient understand starvation and how it can be reversed. The approach is practical, and aiming to help parents stay calm and not react to the emotions or conflicts that arising from their child's protests and resistance.

Anthropologists have written extensively about connections between food and REC. Pat Caplan (1997, p.1) highlighted that food "*reveals our social and cultural selves, as well as our individual subjectivities*". Mary Douglas (1966) suggested that food

and eating are symbolic of a particular social order. Sibal (2018) argued that exploring the meaning of food is an exploration of culture. She described how food and eating implicate family relationships, roles, rules, and traditions. Food is one of the most important parts of religious ceremonies, showing respect within communities and obedience to religious commandments about how food is prepared.

Anthropologists have the luxury of reflective thinking about food and REC, but they do not need to address the life-or-death issues of re-feeding in ED as discussed above. The question is, how would linking food with REC issues help to save life? My family therapy training in ED took place two decades ago, before the development of FBT. We reflected on the meaning of food in our own lives and in family relationships. Reflexivity was seen as essential in our work with young people and clinical families, central both to saving life and considering REC issues relating to food and eating. However, in the current climate of pressure on time and resources, FBT now directs clinical management of ED. This reduces clinicians' anxiety by focusing on saving life. Unfortunately, it misses the opportunity to incorporate literature from other cultural studies.

Unexpected narratives

My research invited therapists to talk about themselves, their own cultural backgrounds, and their work as professionals. I knew this would not be easy as they might have felt vulnerable, expressing only "*canonical narratives*" (Phoenix, 2013, p.73): articulating "*what it is acceptable to say and do in their local and national cultures.*" Therefore, I chose DPA as the method of analysis which enables the

performative and interpretative aspects of narrations to come through (more about DPA is in the methodology chapter, under 4.3.1. & 4.7). Two unexpected narratives, that do not fit neatly into my research, but connect to REC in other ways, emerged from the interviews.

In the first, Diana described being called "a mad Irish woman" by a black nursing colleague in her team. Although white, Diana felt this was a racist comment, because she felt her Irish heritage was being attacked (see 5.2.5.). There is a history of discrimination against people of Irish origin as exemplified by notices such as "No dogs, No blacks, No Irish" which were still common in the 1980s. The second was when Fiona sensed an atmosphere of "defensiveness" within a peer group of family therapists following her presentation at a workshop. She had presented her view that REC issues are not just relevant to families from ethnic minority backgrounds but also to white families (see 4.4.2).

Diana felt unable to speak to anyone, isolated and diminished. The situation did not stop until the black nurse needed performance management for other issues. They continue to work together in the same team but the issues between them remain undiscussed. Fiona said the event made her feel misunderstood because her question was about stereotypic practice. Both situations illustrate how difficult it is, if not impossible, to talk about race issues or racism when personal background and team relationships are involved. This points to the need for self-reflexivity, emotional safety and support when exploring issues of REC. Arguably, one might expect therapists to be able to find ways to hear each other and discuss such matters.

The further aspects of these unexpected narratives are important and require more consideration but, because they relate to the complexity of racism, structural

discrimination, power dynamics and positioning (Davies and Harre', 1990), they are beyond the scope of this research.

Adaptation of FBT model

Here I want to consider expanding the use of reflexivity in the FBT model. Current advice is that exploration of REC is deferred until after the refeeding phase of ED treatment. The manual did not prevent some of the family therapists in this study from successfully using reflexivity to consider REC issues in this phase. However, the overall view of the multi-disciplinary team plays a role as shown in the following examples. Helen, in the focus group, described being questioned by her previous team when she adapted FBT for a Muslim family. She said that was difficult because her colleagues did not accept her justification as culturally sensitive. She has since moved to a team that is interested in cultural issues. Ada described her dilemma about wishing to adapt the model to practice reflexively with two parents from different European cultures. This contrasted with her team who did not support the exploration of REC at the refeeding phase, in line with FBT.

In my literature review I found two examples of adaptations of established treatment models. One (Inguchi et al., 2021) described changes made to FBT to treat ED in Japan (see 3.5). These were structural and made to accommodate local culture which is different from western hospital practice. This increased parental involvement, in line with local customs. In the other example (see 3.2.1), Ma (2005) used reflexivity to adapt an American model, originally designed to break the cycle of conflict and control in family therapy involving adolescents (Micucci, 1998). Ma successfully accommodated the culture of a Hong Kong family into treatment.

According to her "*One must appraise and debate throughout the process whether the treatment direction is guided by the family's culture, the therapist's own cultural frame, or by Western family therapists' voices*" (Ma, 2005, p.25). To me this means being reflexive about all possible influences throughout treatment.

The success of using food as medicine to save life is highly influenced by family culture. This indicates the importance of using reflexivity to explore the cultural meaning of food for all families, whatever their race or ethnic origin. This was the point raised by Fiona, in her workshop presentation, when she described the stereotyping of families from minoritised ethnic groups, as if white families do not have cultural contexts.

Currently the FBT manual places clinicians in first order position, as experts in the refeeding phase. My view is that all family therapists, even in this position, should be encouraged to use their expertise to engage the family reflexively, looking into similarities and differences between themselves, to optimise the therapeutic relationship between them. Parents will then feel respected and supported in how they feed their child.

Some participants in this study confirmed the value of engaging families and enhancing feeding by addressing family culture. Other participants declared their support for the FBT without adaptation by pointing out that it is difficult to be reflexive and consider other contexts (REC) when faced with the stress of a life- saving situation. The additional idea of exploring culture in this tense situation may be seen as too difficult and inappropriate because of the need to be sensitive and avoid further upset to the family (the double block to curiosity). Safe certainty is considered an important aspect for control. Caroline considered risk a threat to professional

registration, and others agreed that there is a risk of being blamed and/ or sued if things go wrong. This supports the need for safe certainty, not only for patients but also for therapists who want to feel safe. Personal experience, strength and vulnerability can be a hindrance or a connection to reflexivity.

However, the narratives of Diana demonstrated how adaptation of FBT and saving life with reflexivity was possible and essential in her work with a Black African family whose daughter had a very low weight. The family had been wrongly referred for Safeguarding by the hospital before reaching Diana's team. Diana felt that the family had been "traumatised" by that experience and that exploring what happened was essential for the therapeutic relationship. She was also aware of how her "position" as a white professional may undermine people from certain REC backgrounds and, in particular, this Black African family who had been treated unfairly.

> "*I was very cautious about, how I am positioned (.2) would, may be undermine people from race, culture and ethnic backgrounds. (nnh) So there is that position of emm, how do you create the relationship that meant to be you know, an allegiance and rapport-* ***Diana*** *(95-98)*
>
> *"What was they like us to be thinking with them. Whilst also thinking alongside we got a very sick child. (nnh) you know. So Yeah." -* ***Diana*** *(99-100).*

Diana adapted the FBT to address both feeding (saving life) and being reflexive, exploring REC issues right from the beginning of the treatment. She listened to the family's safeguarding experience reflexively, with respect and empathy. This enabled the parents to talk about how their race and skin colour might have influenced the service they received. She also explored their cultural food and "their dishes" to

identify what is “safe food” for their dinner. This resulted in the child successfully regaining her weight. The parents wrote a thank you letter to the team.

> *“Well they talked about respect and about, thinking about their race and culture an important influential aspect in the treatment as well. Emm, as you know their sense of food, you know.”-* ***Diana*** *(151-152)*

Other participants, Ada and Eve both talked about the value of reflexivity in enhancing life-saving refeeding work. Ada talked about cultural and family influences on her belief that parents should be able to feed their child. She described how she became curious about how this belief may come across to parents who struggle to feed their child.

> *“Because again my personal experience has been, especially growing up that yeah there is no way that you could just leave the table having eaten two grapes, and that be considered actually as meal” –* ***ADA*** *(1200-1201)*

She realised during the interview that sometimes she might come across “a little impatient” (1196). She began to wonder how her belief influences the way she communicates her expectations and how parents might feel and respond to her (1239-1241). She concluded that she needed to talk with families about how it makes them feel when they experience her expectation that they should be able to feed their child. This showed her understanding of being relationally reflexive with the family and how this would avoid undermining the parents.

Similarly, Eve described how her cultural and family influences affect the way she thinks about food and cooking. She feels sad for mothers who say they are sick of cooking for their anorexic children.

> *" .hhh my heart sinks more or less and I have to really be careful not to give it away (nhh). Ehh, yes, I think I feel quite sad about those families."*
>
> – ***Eve*** *(994-995)*

Eve feels that she has to be careful as she is aware that her sadness may come across as criticism.

> *"Sometimes I don't know how to (Eve hissed) make this sadness that are therapeutic in a way. Because otherwise perhaps the parent may feel criticise, or am probably worried that I am projecting my own feelings on the child as well. So I kind of tend to be very careful. Before I use it, you know before I use my own self-reflexivity, let's say (nnh)."-* ***Eve*** *(1007-1010)*

Eve went on to talk about how she can use this feeling therapeutically. This showed she recognised the importance of being self-reflexive to avoid the perception of judgement by parents struggling to feed their child.

These examples support my argument that 'saving life with reflexivity' enhances the possibility of successful treatment. Without reflexivity, psycho-education can unknowingly reinforce the parents' sense of failure- not doing it right.

As someone from a minoritised ethnic group, noticing similarities and difference is my everyday life and positions me to advocate the importance of REC considerations. I position myself as 'in between' what I was in my country of origin and what I have become in my host country. If I were a service user, I would appreciate my cultural background being understood. This would give me confidence in the service and enhance my trust in the 'expert' advice as appropriate for feeding my child. Therefore, it is my view that therapists should adapt the FBT model to the needs of every family they meet.

Systemic position

The systemic approach has a long history of attending to behavioural patterns and their contexts. The split between saving life and its contexts, arguably, is about the need to control refeeding when all parties feel anxious and uncertain. I believe this split needs to be closed to ensure that life-saving is done inclusively and safely for all families, whatever their backgrounds. This can only be done through reflection and reflexivity, without which safety may, in fact, be compromised - especially if refeeding is applied as a neutral task. Paradoxically, when we are feeling unsafe, we actually need to be more curious, more reflexive, and pay more attention to wider contexts (Cecchin, 1987; Cecchin et al., 1992). Therefore, I believe there is a need for meaningful conversation with our medical colleagues and multi-disciplinary teams, to create a shared understanding of this split and its implications for saving life safely.

Krause (1998, p.140) used a metaphor to question whether culture is the “icing on the cake” or the “ingredient of the cake”. To me, culture is the ingredient and not an add-on. I imagine most family therapists would agree. I would like to extend her metaphor to include race and ethnicity because the concepts of REC are entangled. Race brings our attention to discrimination. Ethnicity draws our attention to communities, groups and identity. Culture gives meaning to food and the refeeding process. However, in practice, systemic thinking often considers REC as aspects of the Social Graces, as if part of a list. The acronym is, indeed, a list which is used for convenience. If we conceptualise REC as ingredients that make up the family, then we are more likely to integrate behaviour (feeding) with heritage, and not address race, ethnicity, and culture as add-ons.

Contributions, limitations and recommendations for future researchers

My study makes a contribution to reflexive practice not only in the ED field but also in the methodological position of research. Throughout this study, I attended to my subjectivity and maintained a reflexive position to challenge my blind spot. For example, I was reflexive about the participants' lack of connection with food and feeding when talking about their practice. Had I not been reflexive about that I would not have added a second interview to explore their reflexivity about their own eating and feeding. The second interviews provided important contributions about how the participants' thought of themselves when working with food and feeding.

Another example is that in response to my reflection about the schism between social constructionism and positivism, I changed the epistemological position of this study from social constructionism to critical realism. As a consequence, I was able to explore the unseen mechanisms between eating disorders and their constructions (Alderson, 2021). Methodologically, this is an important contribution for researchers who need to think about the benefits of understanding the connection between reality (illness/ suffering) and its constructions.

These two examples show that this research is trustworthy, transparent and accountable (Finlay, 2002). The research does not claim truth but the findings are emerging and contribute to existing practice. This research encourages family therapists to reflect on saving life with reflexivity, adaptation of FBT, consideration of REC and how these can be integrated into food and feeding conversations.

However, there are some limitations in my study. The main challenge was dealing with the COVID pandemic. The study was conducted online rather than by face-to-face interviews. This means that the bodily embodiment experience in the interaction

between researcher and interviewee was missing and relied on the restricted frame of what the computer screen provided. Eating Disorder, in particular, so obviously implicates the physical body, I was not able to include embodied communications and predispositions in my observations during the interviews. This limited the connection, resonance and ability to tune into each other, such as with emotions and bodily sensation. Another limitation is that the data does not have the voice from a male or other gender orientations; all participants were female. Having a wider gender voice will thicken the perspectives of the findings, potentially adding father/ male experiences. Future studies may need specifically to consider recruiting male participants as well as being conducted in a face-to-face environment.

As for the future of this study, I would like it to become a catalyst for team conversations. In fact, one participant has already asked for a copy of the research questions and interview schedule with the aim of using these for discussion in her team away day. She told me her intention was to develop a shared narrative with the team. In similar manner, I envisage my research questions and findings can be adapted to facilitate team dialogue and be a focus for away days.

Furthermore, future researchers may explore family experience of receiving FBT specially how their REC is considered. This can be done through interviewing family's experience or perhaps reviewing video recording of clinical sessions to explore moments of significance from both family and family therapists' positions. This would means adopting the use of video recording if it is not already part of their current practice.

Implications for supervision and training

This study has implications for training and supervision of current and future therapists working in the ED field. For example, Ada described clinical supervision being organised by the need to talk about risk management. This leaves little time to explore, reflect and be reflexive about REC issues. Eve talked about the lack of literature and training in REC, even in national training workshops for ED. I believe it is important that the FBT manual does not become the only systemic training material in the field. Family therapists need to maintain their abilities to critique the constraints and affordances of how they use the manual. They also need to consider how reflexivity is inhibited or incorporated by risk and manualised practice, in order to enhance the life-saving focus.

It is important that supervisory practice and training needs to become more purposeful in reflecting the tension between certainty, curiosity and reflexivity. My findings have highlighted the importance of empowering family therapists to develop the team narrative about reflexive practice in the way they work with REC issues when using FBT and when managing risk. This can be facilitated by arranging team discussions and away days such as illustrated by one of the participants who asked if she could use my research questions.

I am aware that cultural change in teams treating ED will be slow and incremental. In the process of creating change, a team needs to be able to share and think together. I think the first step would be to create reflective space for therapists to think about themselves and to consider how their team expectations and FBT influence their practice. Therefore, training and supervision will have a key role in this.

7. Conclusions

In concluding this research journey, I would like to pause and reflect on what I found before saying hello to the future. I set out to explore what happens to race, ethnicity and culture (REC) in family therapists' reflexive practice when working with childhood eating disorders (ED). I am interested in how family therapists respond to risk and in their use of manualised family based treatment (FBT) which is recommended by NICE. My findings lead me to argue for "saving life with reflexivity." I believe reflexivity is essential from the beginning of treatment so that attention to REC is not relegated to a later phase of FBT. Establishing a clear link between refeeding and the family's heritage will draw on strengths from the family's REC background regarding food, feeding and parenting. This arguably will provide a quicker route to weight gain. By deferring such considerations, FBT is treating REC, along with other social contexts, as if they are add-ons. Therefore, I am calling for adaptation of the FBT model specifically to include attention to reflexivity and inclusion of REC throughout treatment.

In this study all family therapists agreed that saving life is the priority. Furthermore, their training to use the FBT manual has led them to understand that they ought to delay reflexive considerations of all contexts, including REC, until weight gain is achieved. This polarisation, of saving life and being reflexive, is a dilemma for family therapists. Participants' varying degrees of compliance with the manual indicated a number of influences on their practice. Some were able to be reflexive about REC from the start of the treatment and continue throughout. They did not feel constrained and demonstrated confidence in adapting the manual. A participant who usually complied with the manual described a situation in which her reflexivity led her

to question the appropriateness of delaying an REC conversation. She chose to follow the expectations of her team and address REC later. This shows that peer-group pressure can be a deciding factor and that any changes have to be incorporated at the level of the team and the individual clinician.

Other therapists said they adhered to the model by delaying REC exploration but then did not indicate, in their narratives, that they picked up REC considerations subsequently. Their personal contexts were influential in this disconnection from REC exploration, despite their interest in, and recognising the value of, REC matters. It seems to me that the underlying message of the FBT manual, which does not prioritise exploring REC issues in the initial phase, may be carried over into subsequent phases of treatment as if REC is not important.

The variations in cultural practice found in my study illuminate the power and influence of personal experience, team structure, team priorities and the expected role of the family therapist. These contexts are entangled with, amongst other things, the risk of being blamed when things go wrong. Emotional distress and physical risks create anxiety that can lead to defensive practice. Following protocols and guidelines provides reassurance. The stresses and tensions of dealing with a life-threatening situation are a further justification for adherence to the knowing expert position of FBT because it provides direction and security (safe certainty). Being told this is the right thing to do can be reassuring to some parents although others may find it difficult, if not impossible, if the contexts of the eating difficulties are not addressed.

Participants in the focus groups highlighted their emotional tensions when working in the refeeding phase with ED families. The distress from ED and the sensitivity

required for REC conversations were described as a “double block” to curiosity and reflexivity. They acknowledged that, theoretically, to overcome this double block would require them to be “doubly curious”, meaning the need for more reflexivity and more sensitivity. Some of the participants showed that this is possible, addressing feeding and family culture from the start of treatment. This supports my contention that the treatment manual needs adapting.

Very little has been written about REC and ED so I hope my research contributes to critical thinking about cultural practice in the ED field. The FBT manual, with its discouragement of reflexivity during re-feeding, will remain the way family therapists are trained to work with ED. I believe family therapists need to retain their autonomy to respond reflexively, and attend to REC as appropriate. I believe it is important to explore the biological, social and cultural issues around ED and not just learn about systemic techniques such as delivering a genogram, sculpting, and mealtime supervision. In other words, I feel there is a need for family therapists to address the ‘schism’ between medical and systemic discourses. Whilst benefiting from the safety and structure offered by the FBT manual, we need reflexivity and curiosity to establish the therapeutic relationship and the links with REC, food and feeding.

Therefore, I propose a higher contextual change by adding REC/ social markers as ‘descriptive notes’ to the FBT manual to give clinicians appropriate encouragement to attend to these from the beginning of treatment. The imbalance of the NICE guidelines, which does not include the role of REC in treating ED, will thereby be redressed. These descriptive notes would not tell professionals how to consider REC matters but, at the very least, they would reduce therapists’ current dilemmas around feeling unable to explore REC during the refeeding phase. However, such descriptive notes would need to be used carefully, to prevent REC becoming part of

a list and being discussed as a tick-box exercise. The FBT manual would then be inclusive of REC in the first phase. It is my hope that this research will catalyse two further conversations: first, how family therapists can exercise reflexivity when saving lives in ED services; second, how family therapists can support cultural practice in solution-focused and expert modes. Third, family therapists and their team be more reflexive about their relationship with food and eating, and its influence on clinical practice.

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APPENDICES

Appendix 1a-1h: Transcript for all individual interviews and focus groups

Appendix 1a: Transcript for participant 1- Ada

1			
2	R: Researcher		
3	P1: Participant1- Ada		
4			
5	R	Hopefully it will do its job you know.	
6	P 1	Lovely.	
7	R	First of all (P1's name) thank you for agreeing to participate in the research and consent to the recording,	
8		you know. Emm we never met before, have we? I don't think we have.	
9	P 1	I don't think so, I was trying to remember reading your name to be honest. But I don't think so.	
10	R	No problem. I just kind of make sure that I am not so, if we have met you know like whether we	
11		recognise each other. But it also says something about confidentiality. Our conversation is private	
12		and confidential, even in another setting we ever met in the field of family therapy, which is so small.	
13		So not be coming, like what we say to our patient. We will allow to recognise each other but none of	
14		these will be, in anywhere if you know what I mean.	
15	P 1	Nn, your name is familiar and I wonder if you have work with (name of a family therapist) from	
16		(hospital name). May be this how I have	
17	R	(name of the therapist) yes.	
18	P 1	Perfect, I was working with her, may be we have emm, then did one of these systemic forum once.	
19	R	Right [yes. We might have met before then. Yes, forgive] me if I don't remember (laugh).	
20	P 1	[I think lovely]	
21	P 1	No no no, I mean its been a long time.	
22	R	Because that's why I say the world is small. So (exactly) that's important that you know, when we	

23		talk to family that our conversation stay where they are, kind of things.	
24	P 1	Of course.	
25		And er, so er that. If any of our conversation arise that you might refer to our family, or patient or any	
26		clinical material, you might chose to use, you know another name or like when I transcribe	
27		it. I make sure that they are different from what you are saying.	
28	P 1	Of course.	
29	R	If you say a patient's name, I will just bracket a patient rather than say the, whatever you say. I just remind	
30		you. ( ) Er you probably remember ( ) and so come back to the, the interview itself em a, this is the	
31		research about ::: like family therapists experience. So, there is no right and wrong. It actually	
32		privileging your story and your experience, your field (Nh) so don't feel that you have to give me the	
33		RIGHT answer, you know what I mean. So you can say anything you like, it is a point of view and your experience, that's	
34		what the research is about arr multiphony, you know kind of multiverse. Is that okay?	
35	P 1	Absolutely.	
36	R	I am certainly no expert, expert in the field. That’s why kind of inviting people to get their view from	Our relationship
37		everybody. So err, shall we start then?	
38	P 1	Absolutely.	
39	R	Okay, so I have about eight questions, so I am hoping to aim for up to about an hour and a half. So	
40		obviously if you feel you need to explain clearly what you are saying or I might ask you, help me to	
41		understand. So, are you okay if we go over a little bit of more or less kind of thing?	
42	P 1	I have no problem at all from my end, no worries at all.	
43	R	Okay, thank you very much.	

44	P 1	Of course.	
45	R	Okay, emm so shall I start then. If I start with, do you have any question before I start, rather than me	
46		keep talking.	
47	P 1	Ahh, not necessarily at this stage. Everything has been very clear, your flyer, your initial description, so	
48		not at this stage. Thank you.	
49	R	Okay, thank you very much. So the first question I have in mind is to, can you talk about how you feel	
50		about this research title. The title is race, ethnicity and culture in family therapy with children with	
51		eating disorder. When you see it, how did that feel?	
52	P 1	Emm, I think it felt, it felt positive. There is also element of optimism and hopefulness when this	
53		discussion around diversity cultural err umm at present. Because this can be quite tricky when you	ED organised by
54		work in an eating disorder field that you are so much organised by the physical and the medical risk.	
55		That you tend to postpone this conversations, of course it always have it in your mind from er	
56		systemic formulation point of view and when you come up with your initial hypothesis about these	
57		family. But I think yes it provokes positive emotions because I think this conversations and dialogue is	
58		vital in our field.	
59	R	So are you , is it possible to say a bit, give me an example or situation you were in perhaps how that	
60		feeling you mention about, you have to suspend those kind of thinking in order to be focusing on the	
61		:: clinical situation?	
62	P 1	Er .hhh for instance emm arrh I ::: I supervise a family therapy trainee who works with a family	story of delaying REC conversation
63		whereby arr Dad is Italian, Mum is French and nnh their kid initially present the, to our clinic, log very	
64		low weight and and urgent need for weight restoration. In order to be able, of course and move away	Consider Culture as approach not

			Method or technique
65		from the danger zone. So it was emm, the initial focus of the work was organise so much by the need,	
66		actively turn things around, the re-establish of more regular eating pattern and the parents were asking a lot	
67		of psycho-education. What we need to do? What works, what doesn't work? Lots of practical advice,	
68		is very narrow down focus of the session on managing the physical risk. That we both felt, what my	
69		trainee and I that we were delaying the conversation about the meaning of having an eating disorder.	
70		The meaning of having to parent the kid in a certain way in order actually to manage risk from a	
71		cultural point of view. And the fact, none of us, neither the trainee nor I are, are English. And we are	
72		automaticly work ( ) start a dialogue about how it feels like to work cross culture, culturally. .hhh I think	process of engagement
73		it is emm sometimes cannot really be explore, depend the, the very very initial stage of the treatment.	
74	R	Nnh, do you mind if I ask whats the cultural background of yourself and your trainee?	
75	P 1	Of course, I come from Greece and my trainee as a Swiss and also is Greek.	
76	R	Right, so all the difference were in the room but the eating disorder is er, is becoming the main focus.	
77		Exactly.	
78	R	So (.2) when you mention about you and your trainee, eh talk about afterwards that you felt you have	
79		to delay that conversation. Was there a time you were able to pick up on those conversations.	
80	P 1	Yes, and I always find very important, both in supervision with my trainee but also my own supervision	
81		with my line manager and supervisor that er, regardless of whether you have this conversation in every,	

82		every opportunity with the family. You do think about it from (yes) a systemic point of view and if you	
83		need reflect, and it :::was helpful to have this conversation for instance with the trainee, because	
84		it was an invitation for her to reflect on cultural expectations about parenting style when a family ( )	
85		lives with an urgency or something they would be dealing with anyway in this developmental stage,	
86		that the kid was, at. And er I think you need, starting have this conversation in the context of, from	
87		supervision to a team meeting. I think eventually becomes, eh even easier to, for for, for clinicians and	
88		trainees to start having this conversation with the family. So yes it eventually happen, and I think it	
89		gave the family and the parents good opportunity to reflect on differences. First of all, when it comes	
90		to managing the risk.	
91	R	It is a kind of finding the timing to, when it is the timing for that conversation.	
92	P 1	Its finding the right timing, and also finding the parents' readiness to have this conversation. Because	timing and readiness
93		sometimes when they are dealing something very frightening for the kids were very physically	
94		compromise. They might, they have felt that the expect, the clinical case for example of mine. They	
95		might have felt that may be, this is redirecting the focus a little bit of what we need to deal with.	
96		So there is something about timing and its something about therapeutic relationship when it feel safe	therapeutic safety to explore
97		to explore cultural differences, and when alongside emm the element of readiness. The parents will	
98		feel this is a good time to start that, attending and addressing all of those elements.	
99	R	Mm, so when you say, well I introduce the word timing but when you mention readiness. You know	
100		what might be the things that you will notice and that make you feel that the ready, ready moment?	

101	P 1	When ::: you might start sharing how some of your thoughts, some of your perspectives as therapist.	
102		Er hypothesis, using your own exam:::ple of becoming er, for example, Greek therapist and how I have	
103		experienced that, emm parents, for example my Greek culture dealing with certain situation. Or	
104		similar situations, and then. I feel, it feels right or wrong as a timing. It's the emotion that you have got	emotional tuning
105		( ) and parents that you work with might be willing or keen on continue this conversation. Rather than	
106		gently polite re-directing the focus. And you can not put pressure on actually, you you do have your	
106		own agenda always in the session. But whether that feels right, and whether that go, well with flow	
108		of that particular session and whether parent might want to bring into therapy that particular week.	
109		So it is a different story, may be this is quite abstract answer but I think you kind of feel and sense	feel and sense.
110		whether it is a good time, whether they are ready. Or they are willing.	
111	R	Do, can you remember the time you actually start to having, pay attention, bring the conversation into	
112		the err race ethnicity and cultural area. I am hearing that you always have it in mind. In waiting for the	
113		timing and then when you sense timing is right. Just wondering emm what would be, what actually	
114		happen? What were the parents' response and their child and?	
115	P 1	So, I can use another example that I was working directly with a family. That a mum was second	P1 give an example
116		generation Nigerian, having migrated to the UK and er, the key er so a fifteen year old was born in the	use of self as immigrant
117		UK. So I had the hypothesis that they, mum's perception of an eating disorder and was a :::probably	

118		different to the kids. Er perception of what the difficulties, the the she was dealing with was. So :::	
119		I use again my own example in saying how :: different sometime my current generation emm use on	
120		mental health might be compare to the previous generation actually, views on general mental health.	
121		And I am wondering whether this is something that emm these family also experiences. When we	
122		work together, we think together with you as a family for instance. Do we all have the same views on	
123		what mental health related difficulties might be? What an eating disorder might be? And :: I remember	
124		that emm that gave some space to mum, and saying that it is a western illness which couldn't really	
125		resonate that well with her and that, the example of her own family. Well that was a little bit traumatising	
126		for the kids to hear because (nhh) there was an element of emm having mum, having the tendency to	
127		dismiss of the difficulties that, the kid was experiencing and then the kid feeling that mum wasn't really	
128		understanding or was not trying to understand what the individual ehh, emotional experience for that kid was.	
129		So mum was putting it back to the context (nhh) while the kid wanted, actually to be heard. And say I am	
130		struggling regardless it is western world or whether non-western world. So I guess there is something	
131		about how you, how you choose, when you choose with which families you decide to have actually,	
132		these initiatial sharing of your hypothesis whether this could be something the family might be keen on	
133		continue to explore.	
134	R	I think that nicely lead into my second question which is like I have, the question is can you tell me a	

135		story from your practice where race, ethnicity and culture were central? Do you think the example you	
136		just said is something central, you know?	
137	P 1	In, in the field of eating disorders? (Yeah) Yes, (.2) I would I would say so. Because it ah ah. I do have a	
138		personal experience of migration and how, of course they ::: the system and the context that I leave	
139		and I am located within, organises a lot. And construct the meaning. So I understand that the kids are eh	
140		perspective (nnh) is very different to mum's. And whether mum might be actually carrying along with	generational difference in migrant family
141		her for, ever she is coming from. That doesn't necessarily mean that describes the kids experience.	
142		So I think it is very important, validate the differences, to really give time for each family member to	
143		express what they coming from and whether OR, the systems, and the the the contexts that the family	
144		located within, might not be equally important for everyone in the family because of the different generations.	
145	R	Nnh. So when you explore those thing that you, you you experience yourself to the family, what's	
146		their response?	
147	P 1	When I was sharing my own emm experience of migration. (yeah) I think this, this has open up actually	Use of self open meaningful conversation
148		meaningful therapeutic conversations. Not only with this family but with other families because it has	
149		an elements of solidarity as well. And share understanding (yeah) and it is something about, emm meanings	
150		of being privilege if you are white. Compare to black communities or whether really means if you are	white as privilege
151		second generation or first generation. And where power does it bring into the room? So, and then	
152		there would be very well conncected to the power of the eating disorder might have? Is this	white power/therapist power/ power of

			eating disorders
153		communication of other and spoken for example power differential within power, then the family, the	
154		society. So I think it ( ) in fact, so far has opened up therapeutic conversation, meaningful but again	
155		it is something about the therapeutic rapport that you have with the family (nnh) you can not start	rapport
156		emm conversations like this, which can be VERY emotionally triggering if arr you are still at the first	
157		stage of the treatment where you are trying to make sure that risk is going to be safe. The family is	
158		still trying to think and feel whether they can trust you or not. So after therapeutic trust has been	
159		established then I feel that most conversation is possible to be meaningful and productive with the	
160		family that we work with.	
161	R	So this is like the different from early on you say about the French couple, French and what's the	
162		mother ethnicity?	
163	P 1	French and Italian Dad.	
164	R	Italian Dad you know. And you know like, that one was like use, needed to have like eating disorders	
165		question and then you bring in the race ethnicity culture. This one you start with the race ethnicity	
166		culture connection. And then what happen to the eating disorder conversation?	Linear model logical, how can we hold both systemic and linear model
167	P 1	The second example didn't start with those conversation, it was after (ahh) the first phrase of the	
168		treatment that therapeutic trust had been established and knowledge that you have after you have good	
169		therapeutic rapport, so, so far my experience with those examples when it comes to open up	
170		conversation around culture and diversity, usually doesn't happen early on in treatment.	
171	R	Nn Nn, so its more like the illness talk, about the focus first.	

172	P 1	Exactly. It is like a lot about risk management. And of course, if something is emm quite err a present	
173		in the session. For instance, err having very <u>different</u> cultural background in terms of organising the	
174		parenting style. And if that is having potentially or possibly counter productive impact about	
175		consistency and boundaries, <u>when</u> comes to feeding the young person. Then of course you find the	
176		way, you try to find the way to address sooner than later.	
177	R	Nm, do you its relevant to address those race ethnicity culture in, if its is illness focus?	
178	P 1	Again it is the stage of the treatment (yeah) of course. Absolutely, one hundred percent because how	
179		we could help the family, get the better understand of where they are coming from and what, yes,	
180		what they do, where it stems by.	
181	R	So, so the specific about working with eating disorder, family with eating disorder with children with	
182		eating disorder. How you think family therapy is relevant to them.	
183	P 1	Family Therapy as an approach?	
(20.3)184	R	Yeah, like you say they come very worried. They want eating disorder conversation, it could be	
185		anybody in the team. I am being provocative here.	
186	P 1	Of course, of course. So how family therapy effective to the field of the eating disorder?	
187		I , well if, if the young person is that severely unwell and that physically compromise. That itself has	
188		an impact on cognitive function and also of course motivation and insight. So (.2) again, again that itself	
189		minimises, limits the ::: the capacity if I can use these words, to work independently.	
190	R	Any word you like. Because its your [experience you know. It is not like. I am not trying to say	
191	P 1	[( ) nnh	

192	R	there is a right way or a wrong way. It is completely your view your experience.	medical discourse (responsibiltiy/ blaming)
193	P 1	Nnh, thank you. So yeah I mean that lack of insight, motivation because of err impair cognitive	
194		function err yeah. Actually organise a little bit the young person's lack of capacity to be able and work	
195		on their own, on their recovery. And the role of family therapy for me is sup, sup:::port, because it invite	
196		parents to care for their child. It invites parent to show that they will do everything needed, in order to	FT role is to support, invite parent to care
197		help their child's recovery. And when the parents feel more confident and comfortable and capable.	
198		Because some they actually feel that very de-skill when they first come to us. Emm, that eventually	story about parent first arrive the service
199		sends a great message to the kid because the kid can trust their parents and then when they altogether	
200		they have worked together turning things around and getting to better stage. And that experience	
201		I think its something, one of the greatest learning point from therapy that they can take it along with	
202		them because altogether as a team they manage to actually manage the urgency. And the urgency	
203		really think together how they can support each other. And especially how the kid can be supported	where is REC in this?
204		by the parents in order to move forwards. So I guess that ::: therapeutic opportunity gives	
205		therapeutic ( ). That examples give a therapuetic opportunity for the family to reflect on what	REC gives therapeutic opportunities
206		communication would look like? What relationship they would like to have? And this is something	
207		that they take it along with them forever.	
208	R	When you mention about team? Who are your team? Other than family therapy team? Yeah. < Not	
209		not who, but a kind of like, not necessarily name but kind of who are they?	
210	P 1	is it referring to the team I work in?	

211	R	Yeah, in your service (ahh) in your team you know.	
212	P 1	Yeah, is emm the (name of the service) based in (area). It was called (name) and now is called (name)	
213	R	So your team, who are the? Psychiatrist or	
214	P 1	The MDT (yes) the psychiatrist, outpatient team and also the (name) the intensive treatment	
215		programme and I am only based in the outpatient team. Consisted of psychiatrist, consultants, and clinical	
216		psychologists, family therapists, mental health nurses, dietitians. Ah and, and trainees, family therapy	
217		trainees and psychology trainees. We got our admin team and assistant psychologist as well.	
218	R	So, that's a big team.	
219	P 1	It's a very big team for sure.	
220	R	So early on you were mentioning about er opportunity, the timing and the risk management you know.	
221		Can you tell me an example where you work with and, and what happen with the kid?	
222	P 1	An example?	
223	R	Yeah an example where er race ethnicity culture, families, eating disorders. A piece of clinical work that	
224		you work with, you might like to tell me about.	
225	P 1	Emm, an example of all of those have been explored and addressed.	
226	R	Ehh, any of your work experience that you like to tell me, a piece of work that you, you would like to	
227		share, where race ethnicity culture and eating disorder is relevant.	
228	P 1	Nnn (.2) so I think I would like to use a clinical example from a previous work place if thats okay.	No case come to mind from this service
229		Emm, I was working at (name of service) and arrh it was a eating service as well. It, I think (.2) always	but something from previous work
230		I was working with an arrh Jew:::ish family, emm nnh upper middle class, arr born in the UK and	
231		I was I think I ended up having a conversations with them in. It is, now that I am talking about it I think	

232		the role of family therapy was quite different in that team compare to our team in (name of service).	
233		Because and I guess they organise quite well, why was may be more able to have this conversation	
234		early than later because there was already consultant involve managing the risk. There is already a	
235		nurse and nursing team or a mental health nurse managing the meal plan. And then I was have	
236		the role of family therapy in that team was really to explore emm dynamics and relationship and	
237		communication from a systemic psychotherapy point of view. I think that itself creates a context	
238		that allowed ↑me to be able and start attending actually to these, emm :: conversations sooner and I hadn't	context allowed me to explore
239		thought about this before. Emm, so with that family I was, I think I was feeling that I was having quite	previously argue it was the 100% thing to do
240		difference, a lot of difference, there were a lot of differences culturally between me as the therapist	
241		and the family. And I think that itself was something that was coming up in my own ideas in my own	
242		prejudices in my own actually understanding of the family. And I think that if I hadn't really address it ↑in	
243		the session, it would have got in the way. In us having a therapeutic trust and a good rapport where	
244		we can actually explore those differences. So:: I use a lot again, the example of myself, the meaning of	
245		culture on myself, when inviting them to actually reflect on where their culture actually might be. As a	
246		significant emm concept and systems organising how this family interact with each other. And because I am	
247		for instance, an atheist therapist I was working with a family who are very very religious. And for them	religion is synonum to culture for this story
248		the meaning of emm cultural was a synonym to the community that they belong to, and parellel to that the	

249		religion that was organising every single interaction of them. Again it was something about being	
250		aware of my own stories and how those were getting a little bit in the way, in getting a better	reflexivity
251		understanding and being able to explore more. What was happening for that and I think honestly err	
252		and transparency we::re important element to just invite the family that conversation.	
253	R	How do they response to your transparency, honestly and inviting them?	
254	P 1	Nnh, I think they::, put them a position of ::: emm (P hissed) of of expert in their own experience. So I was having a	
255		one down position and really trying to be very very curious and open in finding ↑out, how their own	one down position
256		cultural community and religion was shaping who they ↑were as a family and:: just the fact that I handed	identity
257		over, actually these emm ehh story. Story handed over, story were theirs but I, I, I said very openly that I am not that familiar,	
258		help me understand this. I think it change the dynamics in the room and in the therapeutic course. That	
259		I was learning a lot from them.	
260	R	So you invite and they respond and they give you a lot of their (yes) their meanings.	
261	P 1	Yes.	
262	R	to whatever? in relation to eating disorder? or or symptoms? or or	
263	P 1	↑In relation to the eating disorders as well, because eh that mum was feeling very embarassed and	
264		their was an element of shame. Ehh, a lot more present compare to other family I have worked with.	
265		Because it was something about how the community is actually going to hear that. What is the meaning of eh	
266		failing as a parent. What is the meaning about our child having an illness like this were process?	
267		What does it mean for our God, so it was ( ) those eh concepts and themes needed to be address	meaning of illness
268		because mum was feeling actually, you could feel it in the bone there was a, the shame actually was	

269		getting in the way of her saying (.2) let's work with what needs to happen for instance. That she needed	
270		some validation and she needed to validate herself about what actually, arr how difficult the whole	
271		situation was for her, first of all. And after that the whole family and the kid and the community.	
272		But again, it was very very important to establish a therapeutic relationship with rapport before you	
273		are able, to further explore all of those themes.	
274	R	Nnh, so it sounds like this is quite connected with family therapy you know like a , family therapy way	
275		of working with race ethnicity and culture.	
276	P 1	It sounds very similar, sorry what did you say?	
277	R	it sounds very connected and similar to, to whatever the presenting symptoms issues, family bring.	
278	P 1	Nmm	
279	R	Emm, that will be similar in terms of how might we think about family.	
280	P 1	I would say so because for instance again with the same case. I feel that one of the function of the	
281		symptoms, one of the function of the eating disorder <u>was</u> to an extend that, was reflecting to an	function of ED
282		extend, on that shame that mum was feeling. She was trying to hide that problem eh emm away from	
283		anyone else from the community. And that thing from a eating disorder point of view it was	
284		eating disorder cognitions because the kid was moving away from getting their understanding, been	
285		listen to, and of course she was having an impact on acceptance of the situation. I say we needed to	
286		make sure on a superficial level no one would know. BUT then we are not really addressing what is	
287		the most important emotional impact that had for everyone, in the family. For example	shame from the community
288	R	Eh :: Sorry I interrupted, please carry on.	

289	P 1	No, no. ( ) but say that their mum had a thing was mirroring what was happening for everyone in the	
290		family. Because of regardless of whether they were in the same, come from the same culture. They	
291		had the same views on everything. Dad only attended once and the needs assessment with the	
292		consultant and never came back. So I guess it was what about mum was disappointing regarding	
293		the father is coming from the same culture and place, and just like that.	Parents' dynamics
294	R	So, I am just thinking about did any member of your team outside family therapy like your	
295		multidisciplinary team commented on this particular case. Are they, have they add any influence in	
296		the work you do with them?	
297	P 1	You mean for instance in err case discussion or team meetings?	
298	R	Yeah.	
299	P 1	Well, to be very honest with you. Usually was family therapy team who was bringing to the team	
300		meetings those hypothesis and thoughts and views. Because other teams, the nursing team, the	
301		dietitian, the consultants were managing actually other aspects of the illness. (haha) Usually the	
302		family therapy team was sharing ideas about the role of culture, gender, race, differences and withing	
303		the family and also between the families. And us as a team, clinical psychologys also were more focus	
304		on the individual needs, not necessarily from a systemic point of view because they were offering CBT	
305		for instance, individual session. And number of session only with the kids, so we were actually, the	
306		family therapy were the only one who would be consistently working with the whole family. And we	
307		would, that would have give us an opportunity to attend and address those themes	

308	R	When share your hypothesis with the team, what are the sort of like response that you would	
309		generate normally?	
310	P 1	Well, very much	
311	R	in this particular case, that we are talking about?	
312	P 1	very much depends on the team. So for example the previous team was a team coming from very long	
313		history of more psycho-dynamic emm approach when working with families. So systemic concepts	
314		wouldn't necessarily be something very familiar with. There would always emm get, they will always	
315		add that new perspective of thinking about the family but it wouldn't necessarily be part of their own	
316		curiosity or of their own language when they would present a case. In the contrary ::: in the team	
317		that I work with I feel like we do share more similar systemic language when we discuss a family and	
318		a case. And it will be part of the initial assessment that you will ask about cultural background,	
319		migration, first generation, second generation in order to help us with initial systemic formulation.	
320	R	Sorry, your meant your current team or your previous team?	
321	P 1	In my current team.	
322		Yeah, in the previous team were the longer history of psychodynamic way of working with (yeah)	
323		families. Always with, they will always actually hear those thoughts and hypothesis with respect and	
324		curiosity. But after we had raised them, with had actually shared those. It wouldn't be necessarily part	
325		of their own hypothesis and curiosity.	
326	R	Okay, I am just beginning to hear something like. I am trying is like that team, your previous team,	
327		context would be you will be expected to have a lot like therapeutic thinking as to risk management.	

328		But when you present your case to the team, people might how would you say that. They respond to	
329		it or they, they, when you say psycho dynamic. They are, what do you mean the psycho dynamic	
330		thinking, find it difficult to, to embrace their systemic formulation or or, help me to understand?	
331	P 1	Yes, I think it was a different approach so we focus of course as family therapist a lot on how all of the	
332		important systems and emm contexts the family located within. We try to understand how those	
333		system organise the family, how the family looks like. How the family is? And in contrary with emm	
334		with psycho dynamic approach is what I have experience of therapy that there is a different focus in	
335		the therapuetic work thinking about early developmental year and how those might have affected	
336		the emm the onset of the eating disorder. So the focus will be a lot ehh towards the INWARDS where	
337		we are also attending to the other and direction if that make sense (Yeah). I think the importance of	
338		the therapeutic relationship is the same. Of course, we will discuss the importance of culture when we	FT hold the role of discussing culture
339		work with the family with something that of course they would be, other professions and other	
340		members of the mdt would be emm there to hear, and adapt their perspective but it wouldn't be	
341		part of their role, emm focus of their work.	Culture is not share in MDT
342	R	Okay, so it sounds like the previous team is more clear about each other's role (yeah) whereas your	
343		current team are, are more mixing in, or doing mix skill, skill-mixed, everybody do risk, everybody do	
344		therapy, am I hearing something like that?	
345	P 1	Exactly, exactly. But we ::: in my current team they, their language is more similar among us.(Haha)	
346		Because eh, more, I think most of us have done at least first two years of the systemic training. So automatically	

347		there is a more shared and common way of working, so issues and themes around culture and diversity	
348		would be something that most clinician in this team will be working with rather than previous team	
349		that was only the family therapy team for instance.	
350	R	Thank you for helping me to understand it	
351	P 1	No, of course. Sorry it wasn't clear.	
352	R	No, no, no. its because eh like, I like to be clear rather than I interpret something differently. Although	
353		you have a chance to correct it because once I written up you will have a chance to "no that's not	
354		what I say, etc".	
355	R & P 1	(Both laugh)	
356	R	And so the next question I have is like err I have it down as like, can you tell me your experience in	
357		working in the field of eating , eating disorders field? And your practice as family therapist on REC	
358		issues? Do you think you can add more to, to :: this question?	
359	P 1	Just to make sure that I understood the question.	
360	R	Can you tell me your experience of working in the field of working, in the field of eating disorder? Did	
361		it eh, how it actually change your practice as a family therapist.	
362	P 1	Okay, so	
363	R	especially on the race, ethnicity culture issue.	
364	P 1	So I guess my personal experience of having migrated to different country where my English is not my	
365		mother tongue. Automaticly, err invites me to think how these, how important it is to attend to issues	
366		of diversity and cultural, or race. Because I automatically bring that element of working cross culturally.	

367		So as if there is an elephant in the room we don't really talk about it regardless of whether we	
368		live in a city, where it is <u>such</u> a multi-cultural denominator. So by the fact that you first of all acknowledge,	
369		acknowledge eh, ↑aware of who you are and what families from other culture might see you, might	
370		feel you in, in the room. I think regardless of the field whether I will be working emm in a self-harm	
371		specialist service to generic camhs, other population, or with eating disorders. This is there as a	
372		denominator. So what I have found and as I say, a little bit more. Yes, sometimes its thought	
373		provoking, it is not necessarily challenging but it is thought provoking. But it is the fact that I am very	
374		much organise by the risk and the medical, medical aspect and severity of the illness that are. I work very hard	
375		on finding out what can help this family and turn things around. With some families, ehh the truth is that	
376		they just want the kid actually to be safe so they would do whatever an English therapist compare to	
377		Greek therapist might say at that particular point. Ahh it can ( ) the transition to starting to working in	
378		a eating disorder service was a bit challenging. Because urr. Having finish my training, I was emm, I was	
379		basing so much on second order, positional of the therapist collaborative approaches and not knowing	
380		stands. And the fact that the, especially in these themes of first couple of days of treatment and phrases of	
381		treatment invite a lot of first order, use of self as a therapist been very direct. Using a lot of	
382		structural ideas, really working with parents in order to be able for <u>them</u> to feed the kid who is	
383		unwell. Sometimes I feel that this becomes the main way that I am using myself in the room and this	
384		is why I mention the fact that sometimes you are de::laying to address all of those systemic concepts	

385		or the hypothesis that you are having when you work with the family. So then, it is about yeah what	
386		organises and shapes the focus of the work early on in treatment. But I can, as I said this something	
387		is very present to be quite counterproductive in cultural difference for instance. You will address that	
388		or if you feel that something is getting in the way to the therapeutic relationship. May be because	
389		they were expecting to see and err old man, white hair, expert therapist and they see me. And have,	
390		what that look like, feels like for them. So I think you are always mindful of that, you just think when is	
391		the right time to start attending to those. But again you can always work in the context of creative	
392		practices. You can use structural ideas, first order ideas, from ehh, in a collaborative way. So the use of	
393		therapist self could be second order regardless of whether you are using first order approaches but just the	
394		fact that you need to tell, to those parents what they need to do. Sometimes can be quite challenging	
395	R	Nnh, yes. So I was just thinking about err you know when you mention first order, second order, matching the,	
396		matching the family and I was thinking about :: how would that look like to the family, like when in first	
397		order they are very worried and they are frightened. But eh that's my word, not your word you know.	
398		Emm, how do they respond to your first order approach.	
399	P 1	Quite positively, because they want certainty and they want clear answers and guidance. (P1 clear her	
400		throat) Excuse me and psycho-education (Nnh) it is this idea around the safe certainty that they want	
401		to feed early on in treatment, until they are more able to the position of the safe uncertainty. So early	

402		on, I think it is important for them to feel SAFE and more certain to the initial chaotic uncertainty and	
403		worry, and concerns .	
404	R	What are the things they tend to ask for certainty from you? from a family therapist?	
405		Eh whether, how the parent their kid with a eating disorder, is how IT SHOULD BE.	
406	R	Okay	
407	P 1	So there is something about parenting styles, something about err not knowing what the eating	
408		disorder actually is about very new. The world and the field of eating disorder but it is also something	
409		about communication and interactions. Some parents come with list of questions about when my kid	
410		said keep say one thing, is it okay for me to say something else or instead of something else, or	Description of safe certainty in
411		it is a lot of about interaction, relationship, communication err together with the unknown world of	
412		the eating disorder.	
413	R	Do they bring the sort of eating disorder related subject like food? Body image or err those kind of	
414		questions to your session?	
415	P 1	Emm, is it the parent or the kid or	
416	R	In the family therapy session?	
417	P 1	They do, they do because in our team. I am, we are assess one young person and then usually the	
418		assessor is the main therapist that who will be working with the family (yeah). So in therapy sessions,	
419		usually actually only with me for instance. Only if I get concern then I will ask one emm doctor to join	
420		me, or a dietitian to join me as a one off. Usually all the therapeutic conversation. For instance, me	
421		as family therapist will take place in the family therapy sessions.	
422	R	Okay, so eh, I am thinking about. I was going to ask my standard prepare question which is can you tell	
423		me what you bring to your eating disorders service as a family therapist on issues around race ethnicity	

424		and culture? So you mention about yourself your migration and your English. Do you want to add	
425		anything to this area?	
426	P 1	Emm, again when it feels the right time for therapeutic relationship point of view and when we don't	talk about race and racism
427		need to keep talking about food and calories and risk management all the time. It is important to talk	
428		about race, potential racism that family might have experienced of whether you feel that this is a	
429		conversation that would be helpful when a kid for instance share an incident at school whereby there	
430		was a severe bullying, not to themselves but to another kid, severe bullying coming from racist emm	
431		arr place. So just opening up a conversation about racism actually is something that em I find is very	
432		very important, to be, to have. Because those kids might have ended up developing emm an eating	
433		disorder but this is not going to last forever, start having those conversation as an agent about race and	
434		racism or important of cultural differences is something I can take with them forever. So this is how I	
435		see therapy with those emm young people and of course when it feels it's the right time something	
436		about sharing some of my own perspectives, about what I feel about race	
437	R	Can you give me an example of that, you know?	
438	P 1	That that, of course, the cultural example of emm my :: country for instance that I have share with	
439		emm some families and young people that I come from a country whereby a lot of racism. And now	
440		with the :: last few years with the influx of refugees coming actually to Greece. That actually has	
441		polarised even more, the people who are racist they have become even more racist. And the people	
442		who were anti-racist, they have become even more anti-racist. So again sharing personal examples	

443		and also coming from a political background, ideologic background that, that arr could give, that give	
444		could give an extra perspectives in thinking about the incident at school for instance. And of course	
445		therapy is not political arena but at the same time the context of having a lot of perspectives and	
446		voices and opinions is important as well.	
447	R	So did you share this in a family therapy session with the kid and the parents and	
448	P 1	and the parents.	
449	R	and the parents, so err what did they response, how do they response to that?	
450	P 1	It is interesting because I think I have already had emm a hypothesis that those parents and the family	hypothesis of parent & family
451		were more or less sharing similar views with mine. So the question actually emm yes. The the the, my	will share the same
452		answer is that the, they really engage well with this conversation because something resonate with	view
453		them either from a political or ideological point of view. And the kid was really not, eh was really	
454		against of that incidents that err, that was happen, whether it had impact them emotionally for	
455		instance. So, I think it, it felt safe to have this conversation with those parents. Because it was	
456		something about emm yeah, them what I was saying resonating with them. So:: other conversations	
457		that emm may be the key is more em ready to explore issue around racism. But it didn't feel I was at	
458		the time for instance was at the same place with that particular session. Then, we didn't really have	same place with the parent
459		the conversation if that make sense. It was something that we visited later.	
460	R	Did the parent share their experience then? You know when you share yours did they share theirs you	
461		know?	
462	P 1	They didn't come up actually with examples but they were more ( ), reflecting my story from a more	Safety for parent

463		philosophical, more humanistic point of view and then. It so, they didn't share personal experiences.	
464	R	I heard you mention the word safe, I was just thinking about is a topic that is around but it feels quite	
465		not , not easy to talk about.	
466	P 1	Nnh, now you are right, you are right.	
467	R	Oh, I am just wondering you know, because like err you were in the same room talking about things	
468		but talking philosophically like you say. Rather than like, I was wondering what might be your struggle	
469		about err, as a therapist and kind of what might be the family struggle, as a family hearing your	
470		invitation, but only able to err meet at the level of, slightly distance from themselves.	
471	P 1	Nnh, what might have got in the way for instance?	
472	R	Yeah, I wonder if you have any sense that, that any idea might be?	
473	P 1	May be was the fact that they were in that <u>many cultural differences</u>, may be something about	
474		everyone being on the same page of what we were discussing at that particular point (yes). So this is	
475		why I err mention the word safety that, it felt safe. As if we are, to an extent I wasn't really	
476		expecting these parents to really have very very different views on what I was sharing (nnh). But	
477		again that I gave the kid the opportunity to reflect on <u>why</u> racism for instance is not something that	racism is experienced different in generation
478		is acceptable. And I think for parents she is more reassurance, emotionally that they have done the right	
479		thing. So if er, it is interesting because if for example. The second example that I mention. If that parent	
480		whose kid who might have wanted to discuss racism but that parent just felt that it wasn't the right	
481		time for, for them (yes), may be <u>then</u> it would have been important. But again if I able to have been	

482		important probably to try and find the way that the Dad can tolerate this conversation. Because may be	
483		it was, it was triggering for him. But then, how much do you push because you think that this is actually	P1's reflexivity and
484		important conversation be having when the Dad actually is not. I mean across someone who	dilemma
485		would be keen on having this discussion. So whether there is a very fine line.	
486	R	Yes, okay. Thank you. If I move onto the next question you know. Can you tell me a time when you	
487		manage risk in your work and the implication on your reflexivity and race, ethnicity and culture? It's a	
488		long question, is when you manage risk what happen to reflexivity, to race, ethnicity and culture. Can	
489		you give me like a clinical example?	
490	P 1	When I manage risk?	
491	R	Yeah	
492	P 1	But that, sorry ( ).	
493	R	and the implication it has on reflexivity?	
494	P 1	(.2) I guess it is something about the power, that the therapist actually has interval (nnh), that it :: makes	
495		you, invite you as a therapist actually :: to visit your relationship to power, in making decision processes,	
496		to :: ethical dilemma that you might be having. For instance, if a young seventeen years old discloses err	Self-harm
497		self harm and they are asking you not to share that with, emm with the parents, and then it brings a lot	
498		of ethical dilemma, and then. It kind of triggers reflexivity because you think that the cause, causing the	
499		less harm might be good enough way forward. But then ::: when do you decide actually to share that	
500		with parents when the young person hasn't necessarily ↑given the consent. And how do you feel about the	
501		power that you have in this making decision processes. That, its something of course, that yeah, it it is	

502		present in every single difficult decision, and of course, of course supervision always so important for that.	
503		So culturally whether it is triggering anything, or there is an invitation to think about it. (.2) I :: I am a white	
504		therapist, I am suppose, supposingly consider one of the privilege actually population in this world.	
505		So ::: I am aware of that. (.2) It is when you manage risk and when I work, when I have work for	
506		instance with emm. Then again another family from Nigeria where the Dad everytime there was coming	
507		to the session. He wanted to bend a little bit as if he was, emm showing his appreciation by bending if	My English
508		that make sense. Sorry ( ) my English now. So again what definition had the risk management when	
509		his son was having ASD and also eating disorder, and this Dad was visiting a team where the therapist	
510		was emm white therapist (yes). So of course, its :: triggers a lot from self reflexive point of view. Who er	
511		have the year with Dad, I was white therapist but I was managing the risk for this kid. So of course, it	
512		gets a lot of self-reflexive thoughts about how I am perceived, where my difficulty might be coming	
513		from, how do I come across to that Dad without actually de-skilling him. Because clearly the Dad	
514		actually was saying, "just tell me please, how eating disorder, I know nothing". So it is lot of dynamics	
515		that he brings 100% (nnh) and whether that does answer your question.	
516	R	Yes, you do, because it is complicated situation, in a dilemma always and then and sometimes. Risk	
517		and reflexivity is a lot of balancing in the moment.	
518	P 1	Of course, of course.	
519	R	And and kind of like one’s own experience and narrative would be influencing all these things you know.	

520		And also, I just wondering what your service, you know the team that you working in, what might be, you	
521		mention supervisions and :: team, or team discourse about how these things should be managed, you	
522		know like, does it come into your risk reflexivity?	
523	P 1	Nnh, absolutely and I think this is something that emm I feel quite fortunate, in that team because we	
524		do have a very shared philosophy and ethos when it come, when it comes to those concepts and	
525		themes, and the importance for addressing those. So, from team meetings, risk management meetings,	
526		the case discussion, systemic eem group supervision, individual supervision. I think every team easily,	
527		including myself emm can bring that arr that aspect to the case discussion to the case. And everyone	
528		in the team will be already curious to find out more about arr race and culture. Emm making sure that	
529		we remain consistent with anti-discrimatory practices. So I guess the importance of language and	
530		philosophy that is quite share in this team, find it very	
531	R	=So if I, so if I may ask the last time you worried about a family and you took it home. Do you mind	
532		if I asked what happen to that case?	
533	P 1	Err, in relation to the, to the things.	
534	R	Yes, what was that case was about, you know how risk and err reflexivity you know and whether there	
535		is a race ethnicity culture component in it.	
536	P 1	Emm, so yes. It was quite tricky case because that kid had been assaulted by another boy emm in her	
537		school. So 15 year old girl been arr assualted disclosed that with me. And the school was following this	
538		up with the safeguarding team and towards the end. And err the nn the Metropolitan police contacted	

539		me because they wanted the every single medical notes, clinical records for that young person	
540		because she was going to attend the court (nnh). That boy got expell from school and he came to. Emm,	
541		they all, they all found out that he had been previously involved another assults. So there were preparing	
542		a collective trial from, if this is the right way of describing it. So nn, it was, it was tricky for me emotionally	
543		and therapeutically because I was trying to, yes trying to persuade the metropolitan police to give them a	
544		report rather than give you, assets to third party information where we had the mum talk, crying about	
545		the eating disorder, how this is going to be relevant. So it was something actually about the process	mum crying about ED
546		around consent, around confidentiality, safeguarding point of view and seeking support from my	
547		manager, my supervisor, double checking with the protection, all had been extremely helpful. But the	
548		emotional impact of that situation and experience might have had on the family is a different story	
549		because ehh, mum is English, Dad is Irish very religious, very ( ) to other idea as well. So I think	
550		it is important. Culture was an important actually element, in working with this family with regarding	religion
551		that particular incident. Because when the kid was communicating the emotional impact this assault	
552		was having ON them. Dad was coming up with emm cultural definition of what the 16 years old boy	
553		could be doing or are supposed to be doing, and was adding a religious element to it as well. When mum	
554		was quite emm, was focusing in a lot more on their, their child's emotional needs. And everything she	parents different
555		has gone through. And a part of me I was feeling that the, may be this is not the right time to talk	response to the

556		about the impact of context of that boy's behaviours. And lets focus on the emotional impact that	perpetrator
557		these has had on you. So I was feeling that I was allying a little bit more with the English mum which	
558		could be really relevant. Because there is no generalisation around her. But it was something about	
559		expectations, err from their, from them. What is the role of focusing on their systemic aspect when	
560		the emotional experience needs to be communicated.	
561	R	Nnh, expectation you mean from the family or from yourself or	
562	P 1	From the parents. I was feeling that I was having expectation from the parents regardless err of the	
563		fact that I am not emm a parent myself. About how much they are attending to the emotional	not parent myself
564		experience of the kid is communicating. Because I felt that, Dad was coming up again with a more	
565		generalise err description of why these things happen. Why the assault happen rather than staying with	
566		the emotion and really listen to the daughter.	
567	R	Nnh, so that kind of compromising, have to attend to the parent rather than the child.	
568	P 1	Exactly, exactly.	
569	R	So is, quite complicated, put the therapist in dilemma.	
570	P 1	Well, exactly exactly all of those dilemmas are part of the process. Other than, because that Dad can reflect	
571		how he was parented and what was supposed to be normal or expected for a 16 years old back in	
572		the day. And how this organise this quite, a little bit rigidity, how he was saying actually err what	
573		is common and not common about what boys could be doing. And that was moving him a little	
574		bit away from hearing what his daughter was communicating (nnh). But it was in the end helpful. Because	
575		the girl, the young person could see that Dad. Dad is coming from a completely different background	
576		in terms of er how, what is normality and what is expectation for him as a kid (nnh) compares to	

577		her experiences.	
578	R	Okay, I will move onto the next question if it is all right you know. I know my question is stirring quite	
579		a lot of your work you know.	
580	P 1	Of course.	
581	R	So emm, I am going to move onto thinking a little bit about nice guideline. Emm it is possible to tell me	
582		a situation where NICE guideline been helpful or constraining in your race ethnicity cultural practice?	
583		in your field.	
584	P 1	Emm, so I guess the fact that there is growing evidence based that shows that family therapy proving	
585		to be very effective in working with the variety and range of mental health related difficulties and	
586		can be even more effective than individual therapy. That itself actually quite emm, is opening up	
587		possibility for all of those discussions and the things to be addressed. So I guess its that, that times	
588		could have been very different couple decades ago when we were still trying to establish what we	
589		do or few decades ago. So :: I guess that keeps the family therapy err, keep family therapy the	
590		opportunity to explore err issues around diversity and race, and culture by the fact that it is	
591		considered to be for example first line treatment for a majority. For majority, for wide range of mental	
592		health difficulties. I haven't , as I said it goes back to the, the initiate point that the. I work in a manualised	
593		approach we, our family therapy with treatment model when working with anorexia is, considered to	
594		be one of the most effective ways. From a NICE guidelines point of view. First line treatment, in most	
595		cases so that again gives reassurance that there was a concept that can always be addressed. The	
596		limitation is around when you address them when you are working eating disorders. Because,	problem with manual

597		of course the manual is same, that is important for those to be explore but emm, and it is a	FT_AN
598		framework but it is very structural approach. So I guess that the agency context organises quite a lot	
599		our focus, of our initial stage, our initial sessions. So it is down to a clinician, an individual actually	
600		therapist when do they think that would be beneficial for this family to start having this conversation.	
601		But I wouldn't say that for us, in our team has been a limitation. It is a framework,	
602		you can use it actually in a way that fits for the family and your therapeutic styles.	
603	R	So it is a framework for you, for the team and for you as well.	
604	P 1	Exactly.	
605	R	Okay, Emm. Are there any kind of like :: small noises that it may be otherwise, have a different ideas	
606		from any other people from the team?	
607	P 1	Where there could be a little bit err limiting in terms of	
608	R	different from your, different from what you just describe?	
609	P 1	I am wondering whether, sorry	
610	R	= no no, I was trying to say you know this interview is privileging your view but just wondering if	
611		you are aware of there are other views around.	
612	P 1	Nnh, I am wondering whether it must er feeling a little bit err yes, limiting or constraining for other	
613		people who haven't really been trained in family therapy and those issues and themes and concepts	
614		around diversity is not something they are embedded, in their way of thinking, their way of working,	
615		with the families. So I guess it, it, it depends to an extend on the professional background. And also	
616		of course emm their own cultures. How comfortable they are to talk about culture when you come	
617		from certain cultures. Emm, and well this is not err prejudice but I am expecting different cultures	
618		to be emm, to be able to talk about culture in different ways. So I don't know how these might	

619		feel for, yeah, for other colleagues of mine. I can see that there is pressure from a NICE guidance	
620		point of view to be effective in a very short period of time. And make changes as possi, as quickly as	effective in short period of time.
621		possible because there is also the element of financial aspect embedded in that (nnh). So, that are	financial
622		might make some clinicians feel that they really need to make changes as soon as possible without	
623		really being able to explore, or to attend other emm, ehh concepts. For example, diversity or culture	
624		that might be having as a hypothesis, because we use the same framework but may be because we	
625		need to make changes within the first, let's say six months and then discharge. That might prevent them	
626		from being able to do it.	
627	R	Nnh, sounds NICE guideline a kind of embedding the manualised work quite well for you and your	
628		team.	
629	P 1	Exactly (P1 laugh).	
630	R	Okay, so I move onto the next question you know. Can you tell me the dominant discourse you know?	
631		We are on number six, so (R giggle) there is a lot of question bombarding on you. I apologise.	
632	P 1	No, that's okay.	
633	R	I apologise	
634	P 1	No, no no. Not at all.	
635	R	So, the number six question I have got here is like can you tell me the dominant discourses about race	
636		ethnicity and culture you hold professionally? And how these have develop in your practice?	
637	P 1	The say, emm dominant discourse around race culture	
638	R	Around race, culture and eating disorder.	
639	P 1	Eating Disorder. Emm so far (.2) how does that effect my practice?	
(1.15)640	R	Just think about the dominant discourse you hold as a practitioner, as a family therapist?	

641	P 1	Nnn, so ::: a part of me does feel that emm eating disorder are more known to the western world	
642		and that I feel that emm family outside of the western world. Err might be having actually different ideas	
643		on what an eating disorder might mean. Or generally or mental health emm might mean. Because that	
644		reflects quite well on, what we got available in the western world compared to what might be the	
645		reality of a, from a practical point of view, economically in small village in emm Africa for instance.	
646		So there is, dominant discourse around relationship between emm errr people in the western world	
647		and eating disorders, and I guess emm that changes, that has changed quite a lot, the last acutally	ED is different in culture
648		couple decades. Because there have open, we have open up that the conversation around the	economic
649		meaning of eating disorders and in other cultures. And we are moving away from the stereotypical	
650		white skin girl in front of the mirror. And even actually then, the way that er social media, to mass	
651		media have been using example of women who have eating disorder, all been unwell. Actually it	
652		changes which is very optimistic. There is an element of class, there is an element of gender when it	
653		comes again to the eating disorders in my experience. Because I have felt that err more privileges	
654		upper middle class have emm, have a different expectation from the therapist. Because may be	
655		that could be reflecting on the attitude to life. That they have certain ways of asking what they	
656		would like to, to get and that actually is mirroring a little bit their request and their expectation that	
657		they had from therapy↑. (nnh). So it was an element of class and there is an element of gender	
658		as well. What it means to be a boy in the err, particularly in the eating disorders? Err where it suppose	
659		to be girls actually struggling with that. So I guess that these, these also dominant discourse that I	

660		am :: yeah I think it has started to change and there is again, you read certain a lot of study around	ED with other MH difficulties
661		gender actually, dysphoria and eating disorder. So I think it is important that discourse changes	
662		around that.	
663	P 1	Nn, how do you think that incorporate into your practice then?	
664	R	In terms of how these discourses, changing discourse you know like you mention gender, class or the	
665		cultural meaning of eating disorder (nnh), In these aspects, in these elements you know, how do you	
666		think that, do you see that influencing your work?	
667	P 1	Of course	
668	R	How does this show?	
669	P 1	Yes, because you, when you first meet the family you come up with some initial hypothesis. You start	
670		developing your systemic formulation and then you start to sharing some of those, actually elements	
671		of systemic formulation and then the hypothesis. And if a discourse you have emm, it similar to	
672		hypothesis needs to be checked with the family. Because the fact that you have your own discourse	
673		doesn't mean that, that actually reflect on the family's reality. So I guess its been aware,	
674		acknowleging and sharing those with the family. In order to see what fits with them (nnh) because,	
(1.19)675		again it is quite a, it is, it is quite interesting for me. I am I work cross culturally so I can see that err	
676		I see cultural differences as being the dominant reality, the core denominator, well if I was working	
677		back in Greece. Uhh nnh majority of families would be Greek because it is emm country that before	self-reflexivity
678		the influx of refugees. Actually would like urr, 90% of the population are white Greek throughout	
679		the past few generations. So I guess it would be very different to see what discourses I might be able	

680		to bring back to Greece, if I ever decided to bring back there because it would help ME, help the	
681		families, give them a boarder perspective of how aids, how differently things could look like. While	
682		here, I feel as if there, everyone having different views and different culture, background shaping	
683		their families in a different ways. It is the norm (P1 giggle) because of the multi-culturalism about	check hypothesis
684		this place. So practically I checked those hypotheses and those formulations, of those sort with the	and formulation
685		family, see whether, what are their discourses about emm :: eating disorders, about adolescents,	
686		about how you parent your adolescent. Might be similar to the dominant discourses, similar to my	
687		discourses, so again is keep these therapeutic conversation alive and open always, always.	
688	R	I was just thinking on the note when you mention about if you return to Greece, and Greece and work	
689		with Greek populations you know (nnh). Do you see that as cross cultural work as well?	
690	P 1	I would say so because of the impact of UK contexts has had on me, the last six years I live here and	
691		another six probably before I go back, or even if I never go back. So it would have been a lot more	
692		different if I had never lived in the UK (nnh) but cross cultural experiences, we do have, we do shares	cross cultural work
693		similar cultural backgrounds but that doesn't mean that we share similar values, so prejudice about	
694		how this world should all, is looking like.	
695	R	Nnh, it is a very complicated field, isn't it. And and eating disorder, kind of in that field of discourse	
696		changes in, in, well I lose thread of that one (R laugh at herself). I just going back to the, the question	
697		about the dominant discourse about err race ethnicity and culture in your field, in eating disorder field.	
698		And it changes overtime. And how does it affect your practice. Do you have anything to add to that?	

699	P 1	I think it is very important to keep up to date, to how the discourse might be changing to reflect on how	
700		those might change your own discourses and check with the family whether that this with them.	
701		Because when I started working with emm err trans boy in the field of eating disorder, that beyond the	intersection between
702		cultural that change and help a lot ME, get the better understand of how differently the eating	culture and sexual orientation
703		disorder is actually could look like. And actually could emm, could be organise by, by other system, and	
704		other emm personality for example. Err characteristics or emotional needs (nhh), I guess is constantly	
705		checking.	
706	R	Yes, okay. Can I ask, tell me about your experience of this interview? I asked you a lot of question,	
707		can you tell me how you feel about the interview?	
708	P 1	Ahh, I feel positive because err, as I said not er always emm have the opportunity to talk (P1 smile) to	
709		talk about culture and diversity. The fact that I have a lived experience doesn't necessarily mean	lived experience
710		that I would always be bringing it in, in supervision. And it is important to keep this dialogue and this	
711		conversation and reflexivity alive because the fact that :: umm sometimes you feel as if emm you	
712		mention cultural difference, in order to support your formulation where is not, shouldn't be like this.	culture should be part of curiosity
713		Its always actually important to just, be curious about whether family is coming from. Especially when	
714		we have a three different generation sharing a household and two different cultures embedded in the	
715		same household. And then having another cultural adding up to these emm complexity and, regarding	

716		whether it is fascinating or not, it is very complicated (nnh). So :: I think it is a very self-reflexive process,	
717		this interview.	
718	R	When you mention you know, not always have the opportunity to talk about it. Emm :: that that	
719		sounds a bit, that get me quite interested. How come, what happen, why there is not enough opportunities	
720		to, to explore that?	
721	P 1	Because there isn't enough time when you manage a caseload of twenty people and you need to	
722		make sure you got a good safety plan for all of them at the weekend. Sometimes supervision could	
723		feel like a risk management type of supervision. That then, most of the time I feel that I have emm,	
724		I need to have a specific question and start with these questions, and with these case in order to be	
725		able to have more of an exploratory self-reflexive, actually superficial, for one particular family (nnh)	
726		because again risk becomes a priority and it takes all of the time. And then you feel it is quite a	
727		luxury to talk err eem, a little bit more or longer addresses all of those aspects of culture and ethnicity.	
728		Yes, so just thinking about you mention about you are white therapist and I am just thinking about	
729		what is your experience of talking with me as somebody who have a different race, ethnicity and	
730		culture from yourself, you know?	
731		Nnh, emm as a, as I said earlier this is :::, this is one of the most common themes, most common themes because the fact	
732		that we are both white doesn't mean that we are of the cultural background. Then go back to this	
733		great paper whether the shapes of whiteness are actually (yes) when we work together or cross-	
734		culturally. Ahh again, I feel that one of the over riding context is your background as well. So I feel	
735		that you have an understanding of where I might be coming from when I share, when I mentions	

736		certain things (yes) that becomes a wider system (P1 laughed).	
737	R	Okay, so we are getting there. So I have my last question in case you kind of thirsty or wanting to have	
738		a break you know (no). So can you tell me about this interview, how this, how this interview make you	
739		feel about your REC, call it race ethnicity and culture as REC. Emm how do feel about REC in your	
740		current practice?	
741	P 1	Sorry I miss the word?	
742	R	The race ethnicity and culture in your practice?	
743	P 1	Whether I address them or not?	
744	R	No, it is not about yes or no. It is about how this conversation (nnh), this interview we just did, make	
745		you feel about race ethnicity culture in your current practice in eating disorder?	
746	P 1	I feel that arr, I need to be exploring them more. And I need to be addressing them more. Both in	
747		supervision and in the team meetings, making time for this even though sometimes there is no time.	
748		And other things become priority and also with the families may be just expecting the right (.2) not	
749		expecting the right em em, waiting for the right time is one of the basic denominator, so when I work	
750		with family generally I am not going to impose any conversation. But it is really important to probably	
751		start seeding the plan and start opening up the conversation to see how:: willing err or ready the	
752		family might be, before:: before waiting for the next phrase of the treatment. I see the first couple of	
753		phrase of the treatment, we need to feed the young person and then we are able to do pure systemic	
754		psychotherapy. So there is, there is this kind of unspoken philosophy in the team. So may be starting	
755		actually having this conversation would be, could be with some families more beneficial because it	

756		also gives, gives them probably and hopefully a sense of (.2) a sense of being able to tell the story,	
757		not only the organise about, and this narrow down focus of managing the eating disorder. Tell, let	
758		them, invite them to say how they feel as a Greek mum who has a daughter developing an eating	
759		disorder. I mean my previous generation back in (P1's country), probably don't get what exactly I am doing	
760		because I don't really, they don't have the same views of mental health or an eating disorders. So again,	
761		it is something about inviting them to really share from the cultural point of view, what is the meaning	
762		of coming to see a (P1's ethnicity) therapist in a (name of the team) team, dealing with an eating disorder.	
763		So again, inviting the conversation around and meaning from a cultural point of view would be emm	
764		would be something I am taking away from the interview. And when it comes to of course regarding race, racism, again	
765		it is what the family brings and what you do with that? And how much you expand it, explore it, when	
766		that happens. Yeah.	
767	R	I am glad that there is something that you find it useful. And so what follows now. Er, (P1 name) is that	
768		I am going to do, transcribing and then do some analysis, you know then I will send it back to you and	
769		generate your thoughts about what stood out for you (nnh) from what I have written. And you have	
770		a chance to comment before I do my final analyse. Because there are couple of process, you know.	
771		So you have a chance to look, and read, and kind of comment what stood out for you. And then what	
772		you comment will be added to it.	
773	P1	Nnh.	
774	R	Is that okay?	
775	P1	Well, absolutely.	

776	R	I am going to do it slowly and not rushing, so where are we? We are in May, perhaps in July August.	
777		In couple of months time.	
778	P 1	Lovely	
779	R	I will do it slowly and not rushing. Is that okay? In the mean time, if anything after this conversation,	
780		this interview, you like to talk about and you have question. You know like, sometimes you know like,	
781		we don't know the effect of talking, just like in therapy (nnh). When we talk something is stirred up,	
782		if you like a follow up conversation, anything of that kind you are most welcome to contact me.	
783		Is that okay? Otherwise you won't hear from me (R giggle).	
784	P 1	THANK YOU so much for offering actually the opportunity.	
785	R	It is important, you may or may not feel like it or need for it. That's absolutely fine, you know.	
786		Otherwise you will still hear from me.	
787	P 1	Thank you so much. Thank you so much and then I can have a look and then send it back to you in July	
788		August.	
789	R	When I sent it to you, you get a chance to kind of comment because sometimes people don't, what	
790		I am trying to say is what stood out for you (nnh), you can almost a kind of almost like a dialogue.	
791	P 1	Lovely.	
792	R	Okay, I better let you have a rest now. Thank you very much.	
793	P 1	Thank you so much.	
794	R	Take care, bye bye,	
795	P 1	Bye bye, thank you.	
		Interview 2	
798	R	So all the button are buzzing (R laughs) it is better to make sure the, the technology are working.	
799		And eh, so shall we aim for about an hour (yeh). And today again is about your experience, your	

800		views, there is no right or wrong you know. And so I plan to do a spidergram but then I realise doing	
801		spidergram on the zoom is not easy on the whiteboard you know. So it highjack the time of talking,	
802		so I thought I just revert to conversation and then I do it afterward if that’s okay with you.	
803	P 1	Of course, of course.	
804(.55	R	So today is about, the main agenda is about food and eating and feeding. And eh, so arrh, shall we	
805		kick off. Do you want to ask any question before we start.	
906	P 1	And: not, just in terms of emm practicalities. Emm, I didn't need to sign the second, second	
807		document of consent, its part of the same interview (yes) from what I understand.	
808	R	Yes, that's why I didn't chase you with forms.	
809	P 1	Okay, okay, lovely (P1 laughs) Okay.	
810	R	Thank you. And, so it is a good question you know. Emm, I did, yeah. So the one is signed, is okay. It	
811		is part of the same research.	
812	P 1	Great, thank you.	
813	R	So arr, shall I start?	
814	P 1	Yes please.	
815 (1.50	R	Emm, as you are family therapist working with children with eating disorder. So I like to ask you arr	
816		whether you can tell me about your experience of food and feeding.	
817	P 1	Emm, my experience of food and feeding. I would assume at this current stage, throughout my	
818		life.	
819	R	Ehh, I don't mind you know. Its like whatever you, come to your mind (nhh) you can start	
820		somewhere. We can go and visit there, you know it is like (nhh), like I say its your experience you	
821		know.	
822	P 1	Nnn, emm ↑SO I, I think : migrating to the UK, to (a city in UK) from (a European country).	
823		That emm, its self ( ) affected to an extend. Ehh my :: ehh, the the rituals around eating I would say.	

824		Because coming from a family, a cultural, is like many others where food actually CORE in all of	
825		the significant life cycle eh stages in life from the time we give birth, we celebrate the baptism	
826		ehh weddings, emm, emm, up until funeral, core element of how you interact with people is	life cycle
827		through food. SO it has always been a way : just bring families together, bring emm emm peer	
828		group and friends together. And the, it has been from a celebration to :: has been a celebration	interact
829		to actually to the main tool that interact with each other and the, given the fact that I don't have the family, OR extended	bring people
830		family in the UK. That has, has been replicated a little bit in the context of friends, but it hasn't.	together
831		It doesn't really have a this particular stage, the same, I think it doesn't have the same meaning that	
832		the, you would be meeting on every Sunday, with a family or with the extended family, and	
833		it would be a very long ↑feast. That people would eat and drink for the whole day for ↑instance.	
834		SO, emm yeah, I think that's that's the main, the main difference I would, I would say, having live	
835		in (city in UK) for seven years. Having grown up, live in (country origin) for most of my life that	
836		emm. Yeah, the ritual around food is slightly different at this stage.	
837	R	Nnh, I just wonder about the, the feeding aspect about, when you mention about family gather	
838		together, who is doing the cooking, who is doing the eating, you know like that relational bit,	
839		how does it work?	
840	P 1	Right, well, the, traditionally there is expectation about the, the gender stereotype. So mum would,	
841		my mother would do, all of the cooking or my my auntie will do the cooking when we would go to	cooking
842		to their place, to, for the extended family, to be altogether. Ehh, my grand, my grandmother	
843		as well used to help a lot, before she became a lot older. So, eh, the traditionally and typically	
844		emm, where women would be in the kitchen organising, preparing, serving and looking after, emm	looking others
845		looking after others. Both the, mainly in the extended family, in the family but also the kids. There	

846		will be emm, there will, there will be an atmosphere that there, especially auntie, or grand, my	
847		grandmother will keep or arrrh, make, will, will want to make sure that we eat a lot. And and	
848		regardless of how much we eat, it is never enough. That there was, this aspect of yeah, caring	caring
849		and looking after, with, I think because we have been having this conversation with the families	looking after
850		as well. I think its something about they, the impact of the second world war, whereby two	WW2
851		generations ago they didn't HAVE enough food. So they want to make sure the food they provide	
852		actually do, the next generation is always there because it became a luxury. So : yes, and combine	
853		with emm with wine as well. Home made wine, so will be a culture around that, everyone	
854		would share. Emm, yes, usually mum, usually the females in the family will be playing that	female feed
855		role around feeding, and making sure actually that you eat. That would be, it would be slightly	
856		rude to leave the table, for instance if you haven't share the food, and if you haven't really eaten	
857		what is on your plate because other people had made it for you.	
858	R	Right, okay. There is a lot of sharing, caring and the children, the receiver know what to do (nhh) in	
859		respect to the food being cook and served and	
860	P 1	Exactly.	
861 (7.2	R	I am just wondering what is the significance for you as a person then. What is the significance of	
862		food and feeding for you as a person now?	
863	P 1	Emm: the significance. Well, I (P1 clear her throat) just wondering is it about emm, first of all my	
864		relationship to be feed, my relationship to eating regularly, my relationship to looking after myself	
865		and also looking after others. It is in the context of again, in the context of sharing the experience	
866		with other people, with my housemate, my partner, my friends, my social network. Emm, yes, I	
867		think on a personal level is something about making sure that the, the physical health and	

868		emotional health is going to be : emm yeah, at the maximal through, through regular eating,	
869		through making sure that err nutritionally that I get everything that I need.	
870	R	Nnh, right. I am just thinking about how, how do you think about that experience, kind of like, how	
871		does that make you think about your professional work in eating disorder	
872	P 1	Nnn, emm well depending on the stage of the treatment that the, patient and the, again the	
873		patient can actually eat, is basically at the later stage whereby the, the risk eh associated with	
874		restricting eating has been managed to an extend. And we could afford the luxury of more	exploring is
875		exploratory work. I will bring in my own experience culturally sharing what is the meaning, the	luxury
876		cultural meaning of food and eating, and sharing food actually. Emm with others, err you know the	
877		the try and invite them to reflect on what is the meaning of food for ↑them. Err separately from	
878		the eating disorder. And it is so so an invitation to think how ritualisticly and how the family sees	
879		food especially when the work with: emm: when we work cross culturally, when is actually more	
880		than one cultural, and raising in the family that you work with. So trying to bring my own	
881		experience trying to share and: how, what is the meaning of food for meal culturally going back	
882		to the Greek denominator and yeah, try to invite the family to bring in actually their own	
883		significance or meaning, or part of their rituals generationally around food. In order for them to	
884		reconnect a little bit especially for the kid to reconnect a little bit, with the meaning of food has	
885		been separate from this, eh distorted perception of what would this, and what would food might	
886		do to them.	
887	R	I will come back to the stage thing later but I was just thinking about how does working with families.	
888		and about, how does that experience of working with them, talking about culture, and you know	
889		like the stage, and how does that impact your own life you know? Because when you working	
890		with families and talking about that, how does it, does it have a impact on your own life.	

891	P 1	Your relationship with food (yeah), well admittedly I would, I become more aware and my, actually	
892		notice a little bit more of my own patterns, and my :: close people's patterns. Emm and I think	
893		I have adapted of, the past few years I work with eating disorders a new lens. Not necessarily	
894		looking for, being suspicious, looking for something that is not going well but just ensure that	
895		things are going well. So, after, I have through psycho-education or through experience in emm	
896		getting a better understanding of the dietetic aspect, of the medical aspect, of the important	
897		physical and mental health. I think I, I am, I make sure a lot more emm that I am eating regularly or	
898		that my emm surrounders that I care about actually do the same. Ah :: it, it always, its been, its been	caring style
899		the case, but emm at the young age where families were a lot closer, I think there were more	
900		to learn for, but at this stage ehh yes definitely em understanding, better understanding of food	
901		and how eating works, the meaning of it for each person and each family. It is something that has	
902		made me reflect on what is happening on a daily basis here.	reflecting on
903	R	For yourself	herself
904	P 1	For myself and the people that I : close to.	
905		Okay, so, are you responsible for feeding your family or, or making sure that err, so like being	
906		look after?	
907		In the context of my work?	
908	R	Yeh, in your own personal life if I, if you, just wonder how it affect your life and the people you are	
909		with? You know	
910	P 1	Nnh, yeah, well I share a house with a friend. So : I got a house maid here, usually we take turns.	
911		So :: whoever cooks will cook for the other person as well, depend of course on : them, there teams	
912		and working demands. But, most of the days emm one, one of us will cook for both. And it will be	
913		sometime that we will especially at the weekend that we will share the process if we want to try	

914		an, quite a demanding recipe that might be time consuming. I don't feel responsible for feeding	
915		especially because I have lived in three houses already in the UK. And the first one, I wasn't	
916		necessarily feeling that close with my housemate at the time. So we had a very separate, emm	pattern
917		yeah, daily patterns of routine. So that time I was only feeling responsible for myself to be honest.	routine
918		There was something about the closeness in relationship as well that organise that a little bit. Yeah,	
919		it will be my tendency or my willingness to care for other and share that with others.	relationship
920	R	Yeah, yeah I suppose its not like a family situation where, where the relationship is different.	closeness
921	P 1	Exactly, exactly.	willing to
922	R	So your family is in (country), is that, what I understand?	share
923	P 1	Yeah, everyone is in (country). However, my brother travels and visits quite a lot. Because I also live	
924		here and his partner, his girlfriend lives here. So my brother is interesting because every time that	
925		he comes over, ehh he will cook for me. Because he knows that this is something I would appreciate	
926		and because daily life is very demanding. Ehh workwise, emm he would like to make sure that	
927		he cooks a couple of different, actually ↑dishes and one of them could sometimes can go	
928		into the freezer for instance. So I can have it the following week. So: I think my brother has	
929		changed a little bit, the typical expectation around the part, usually women cook in the family.	
930	R	Yes, it sounds like cooking for your family is very important aspect of showing closeness, that's	
931		my interpretation, I don't know.	
932	P 1	Exactly, exactly, absolutely.	
933	R	So I just thinking about emm, so that is the (country) culture or particular to your family culture or,	
934		or how would you	
935	P 1	Yeah, the majority	

936	R	Yeah, okay. So I am, I am just thinking about emm are there anything specific to your own culture	
937		that bring to food and feeding	
938	P 1	How do you mean, so that I understand the question?	
939	R	I just thinking are there, because you described you know your experience of food and feeding,	
940		and your families you know, and the (country) relationship with food you know. And I just wondering	
941		are there anything that are specific about your culture, that you haven't touch on and	
942	P 1	Nnh, emm, depending on the family of course, and depending on emm ehh whats the relationship	
943		with, parents relationship with families of origin. Emm, I can use the example of my mother, were,	
944		she has, her brother who lives in the mainland in a village. So my uncle from that village has his	
945		own farm and they, makes his own ehh honey and cheese and olive oil. And the, and wine. So they	
946		will be sending us, he will be sending us on a monthly basis actually. Homemade food, so they, will	
947		be saying to my family, now that I don't have this luxury anymore. Emm, so it is something about	
948		them, the definition around the nature food chain. So that part of the family, that side of the family	
949		have never been vegetarian for instance. Because part of the natural food chain, we have our own	
950		farm and it will be part of the actually what it is expected to have, and we will said that with for	
951		instance his sister who actually moved out of the village and move to the city in (city name). So	
952		and then, how I relate, I relate to that part of the family even now that I haven't seen them in years.	
953		The first question that my uncle asked my mother, in terms of how I am doing in (city in UK), is	
954		whether I got enough olive oil. Because they do send me on a yearly basis, whether I got enough	
955		emm honey. So yeah, it how you communicate that you care about the other person actually	showing care
956		making sure that emm yeah, they be look after by you through sharing that good quality of food.	ensure

957	R	Yeah	enough
958	P 1	Relationally as well	food
959	R	Yeah, food has a, in a sharing, is showing care by the sound of it	
960	P 1	Yes, exactly and the majority of the families are like this, not just necessarily my family but because	
961		the close connection, with the family, with colleague who still lives in the village.	
962	R	Nnn, I am just thinking about the emm, early on you mention about the stage of treatment and	
963		I am just thinking about when they are sort of like, the :: risk area when they are low weight.	
964		what happen to those thinking about food, caring and all the things that you need to do. I just	
965		wondering how that process looks like and what might be your thinking and feeling when you are	
966		doing the stage 1 if you like?	
967(19.4 8	P 1	Yeah of course, of course, that's a good question because you always try, from, from initial	assessment
968		assessment, you always try to reframe a little bit emm the meaning of food for someone who	
969		might be cognitively impaired or effected by an eating disorder. So when the kid might be complaining	
970		the fact that my parent are trying to make me fat because they are trying to feed me. You, you	
971		challenge that you reframe that by saying of course, because they care for you and they want to	
972		make sure you are, that you are going be okay. And you are going to be safe. So : you are, from	
973		early on in treatment you try to normalise it and depathologising the meaning of food. But when it	
974		comes to conversation around more cultural meaning of food and how it used to be for the family.	cultural
975		At the beginning young people don't really, find it very difficult to tolerate these conversation (nnh)	meaning
976		Its something about the clients readiness, it said something about the cognitive state of this kid is.	of food
977		And even for the family that emm, sometimes they come with their own agenda, thinking that	YP's role in
978		we need to manage the risk, we need to make him meet, would make her eat and then getting,	stopping
979		before we get to the point that we can step back and reflect and have a different type of	exploration

980		conversation around yeah, meaning culturally or significance or yes, how it use to be, how it is	
981		for them. And how they would like to be. So emm, you keep, you keep checking in, you keep, you,	
982		I always bring it, then in the context of its not control, its care, its not punishment, its safety.	
983		You reframe a lot, you normalise it but ehh you need to keep assessing all the time. And you need to	
984		keep checking that it is the right time to have those explorations.	
985	R	Nnn, so I was just thinking about because of your own experience of food and feeding in your own	
986		life experience, you know when family present that at the very beginning, and err they err,	
987		the young person have a different view, like you just describe you know (nn). Do you think about	
988		your own eating when you are talking with them, I am just thinking, your own eating, feeding, you	
989		know when you are with them.	
990	P 1	I am, I would think about my eating : in my adolescence. So I would try a little bit to reconnect the,	share own
991		with how were, eating use to feel like for me. And this is something that I could share that from	adolescence
992		early on in treatment, that I would say, well I can recall how my, how I used to be at the age of	experience
993		fourteen and how my MUM would react if I wasn't eating. How does that fit for your family, so I	
994		will try, I would use those examples emm more in the context of engaging with the young person.	
995		And also for the parents to feel that err, will also be with adolescence because I work in a	
996		camhs service. So the reason, expectation they call to be opposing to work, do your boundary that	
997		you are setting. Not necessarily in the context of eating disorder but just in the context of	
998		monitoring and support. That there is a typical teenager aspect to it that whatever the parent	
999		who actually will go against it, regardless of what that actually is. So, emm how food ehh,	
1000		influence translated in these dynamic. Yes, usually I would use example actually from my own	
1001		adolescence you know therefore, the kid to have a, the young person to have another perspective	

1002		of how these could have been for the therapist or someone actually push, or already now might	
1003		have had actually emm, has also, has also be a teenager.	
1004	R	Can you give me an example how might adolescence responds when you say to them about	
1005		your own experience of, of as an adolescent eating?	
1006	P 1	Nnn, I think I think nn they, first of all, they get quite surprise by the fact that I share (ahh). Because	
1007		it goes back to the expectation probably. About how much a therapist should be sharing about	
1008		their own life (nnh). I think they get a little ehh surprise, some of them have been curious. In the	
1009		context of emm, ehh in the context of emm err food in, in (therapist's country of origin) and	
1010		culturally what, what that means actually. Emm, and of course its so much, so much depending on	
1011		the case that I think in the context of engagement, usually helps, just bringing a part, an aspect of	engagement
1012		yourself in therapy regardless of whether the kid is struggling or not at this stage. I think they	through
1013		appreciate the fact that you are trying to connect through personal examples. Yes, and the parent	Personal
1014		do too. You can actually notice from, yes from their nod, or facial expressions that yeah. They also	examples
1015		witness these, they also witness these attempts, then willingness to connect.	
1016	R	So, so I suspect, I just wonder when you say you share a bit of your adolescence experience and	
1017		do you engage the parents as well you know. How do you, because parents in the role of feeding	
1018		the children and do you think that your experience of being fed also engaged them or, do you think	
1019		about your experience of being fed by your family?	
1020	P 1	Yes, absolutely because of emm, you can always use personal example, personal experience	
1021		of feeding or sharing food, and eating in order :: for those parents to remember they were able	

1022		actually to feed their kids, and up until the onset of the eating disorder. The fact that now that the kid	
1023		has been affected doesn't mean that wasn't the case actually prior to the onset of eating disorder.	
1024		So similarly because of conversation, for instance I would be having with the kid around my own	
1025		experience from adolescence, the parent has gone to be there and I could easily turn, and I have	
1026		them to the mum and say that, this is how, for example, the role of mum used to be in meal	
1027		preparation and we weren't allow to be there. Because we are going to mess up with the kitchen.	
1028		So trying to be pathologising a little bit, emm in terms of we weren't in there because we have,	
1029		we have cognitions but it was culturally and traditionally that mum was going to be in the kitchen.	
1030		And has that been in the case for you. Is that something actually, that always been for you and	
1031		your family, and now that the daughter for instance has a, develop eating disorder, she started	
1032		wanting to be involve in meal preparation. So tries to see what the patterns around eating used	
1033		to be for that family actually, before emm the difficulties, actually the eating difficulties keeping.	
1034		And some of them realise no, the kids were never interested in getting involve in meal preparation	
1035		or in the kitchen. So this is the impact of eating disorder in how they present, and how, what yeah,	
1036		how they want to be present actually in the kitchen (yeah, carry on) and ↑also, regarding emm,	
1037		the the all of, both parents, or when, I will bring the, them as well. That err how, what's the word?	
1038		what's the meaning of definition and expectation about how much dad would be caring the	
1039		young person to eat at the table ehh when dad might have step back or might have stop eating.	
1040		And I would invite the, the dad just to say, just to think if the mum, for instance is not in the table.	
1041		If she wasn't in the table, would you be encouraging actually emm, your, your kid to eat. Is this	

1042		something you traditionally or typicly do, at a family. Just to bring into different voice around how,	
1043		yeah, meal support looks like in that family. Not all in the context of eating disorder.	
1044	R	Nnn, so you brought in lots of their relationship, outside.	
1045	P 1	Yes, absolutely.	
1046	R	So I am just wondering if its possible to talk to them about their enjoyment of like, eating	
1047		together as a family before eating disorder.	
1048	P 1	Of course.	
1049	R	Yeah,	
1050(28. 5	P 1	Absolutely, absolutely, because, yeah definitely because this is something that they bring to us	
1051		before we ask them. That is usually the parents ehh, the parents loss, to a temporary lose, that	
1052		we used to enjoy going out. Actually to restaurant together, we used to eating altogether, and	
1053		laughing and sharing that experience. And now, just become miserable. So most of the time, my	
1054		experience is that, this is what the family, what the parent brings first. That they would like to go	
1055		back to that stage.	
1056	R	Nnn, what about the impact of this conversation on your own thoughts and feelings, when you	
1057		kind of like, your own experience and what they present, what might that creates in you, when	
1058		working with them?	
1059	P 1	Emm, (.2) well in my, it, it yeah, it is, it brings back recollection first of all. Of emm, how: yeah, how	
1060		I was positioning myself in the family or I am position myself in my family of origin, especially	
1061		when I go back. And then it gives me : yeah I think it gives me emm, curiosity around regularly	
1062		thinking how : how I use actually food in the current context, noting the context of family, of course	
1063		I don't have the family here, but yeah in the context, in the context of replicating of those	
1064		experiences with my social network because it has always been important to me. So yeah, it	
1065		will bring back recollection I think. And that, yeah, I think so.	
1066	R	Bring back recollection and you know like more mindful of your own context, your own personal	

1067		context and I am just wondering what about in the room with them you know, with the family who	
1068		come with their difficulties and err I am just thinking what family might evokes in you? Thoughts	
1069		and feelings in you?	
1070	P 1	Nnn, I think they would emm, they would usually yeah, affect me in the context of wanting to	care
1071		help even more. So, they all think of caring, or being cared, that I have been, yeah very much, its	
1072		been very much carry down to me from previous generation, and yeah my family of origin. Emm,	
1073		organise a little bit of my, my, my willingness or my tendency to just sometimes just messing with	solutions
1074		solutions, and make sure that we care, I care for that family. Those parents are care, you know	
1075		that they care for the young person. So YES, some, sometimes I think this is yeah, this is what emm	
1076		emm the main trigger that we need to care, right now. Because we are talking about food which	
1077		is the most fundamental basic primary needs. So yeah, I, I try sometimes share that, that this is	FACILITATE
1078		the most important element that we are talking about right now, how the kid is going to give	NEGOTIATE
1079		permission to those parents to care for them through feeding, feeding them, making sure that they	between kid
1080		are eating. Because otherwise they might get admitted to the hospital, so that organises a little	& parent
1081		bit of my thoughts and emotions, that we need to find the way actually to get to that point. Because	
1082		of my personal meaning and experience of feeding and food is caring.	
1083	R	So this is alongside with, sort of like what the stage one meant to be doing. I am hearing much	
1084		more richer	
1085	P 1	Yeah. Yes, its, then again. As, as you say in stage one, I will be mindful of those thoughts and	
1086		emotions. I won't be self-reflexive, but again you need to really think through about when is the	
1087		time to bring it in the session and in what way. The reframing actually happens from, of course	
1088		the initial stage, from the initial assessment. But again, keep, keep checking the dynamics and	checking
1089		the readiness, I think it is very, very key, it is very important. So that you can have a meaningful	dynamic is

1090		conversation and that doesn't mean that the young person or someone would disengage because	part of
1091		you are leading the conversation somewhere without necessarily that fit in what the family wants	reflexive??
1092		to bring or wants to cover in that particular session.	
1093	R	Am I hearing something is not necessarily stage driven but err at your own reflexivity, that when	
1094		you feel the right, sort of like, appropriate, you will do your reframe, you will do something like your	
1095		sharing of your own story, culture stories about food, caring, when it is appropriate rather than	
1096		just its is stage one we do this, stage two we do that, kind of thing?	
1097	P 1	Nnn, well that is a good example	
1098	R	Is it allow to say that?	
1099	P 1	Yes, of course. That's a good point because, for me it depends on the family. The manulised	FT-AN
1100		approach, the stage approach actually is a framework. So if you feel that these family is ready or	framework
1101		can really explore the things of phase one, two and three at the same time. Then, we, there might	
1102		be a dance between the three different stages. Given the fourth one is the ending, so I think it does	
1103		depend on the family and you always remain self-reflexive throughout the treatment regardless	
1104		of the fact that sometimes at the beginning you need to be more direct, and a bit more firmer	
1105		around boundaries to manage the risk. But that doesn't mean that you stop being aware of	
1006		triggers or self-reflexive aspect of this process. How much you share is of course, depends on	
1107		the family, when you do it what is your rationale, yeah.	
1108	R	Can I just go back to when we started, you ehh, I asked you about your experience of food and	
1109		feeding. You mention about your family and gathering you know. I just wondering what about on a	
1110		day to day basis, everyday life you know, what is your experience of food and feeding in your own	
1111		family unit.	

1112	P 1	At this stage?	
1113	R	Then and now	
1114	P 1	Okay, okay, well, where should I start. So all of the my school years, lets say, up until university	
1115		that I :: so up until university that I was living in my family home. Emm typicly mum would have	
1116		prepare emm, ehh the food for us, first thing in the morning. And then, we would go to school and	
1117		emm mum will go the work. And then work, depending on who would come back first, there we	
1118		would know actually the food would be ready for us in the kitchen to serve ourselves. And work,	
1119		around work, working patterns and daily routine. It wasn't always the case that all four of us,	
1120		because I have a mum and a dad, and all four of us will be sharing. Err will be having dinner on	
1121		a daily basis, will all depend on working patterns. I will always have it with my brother and most	
1122		of the time with my mum as well. Sometimes dad will join too but on a Sunday, ehh and most	
1123		Saturdays the whole family will be serving both lunch and dinner. And depending on the weekend,	
1124		we will have extended families as well. So that emm change in, when I moved out of my	
1125		family home, when move into actually my own flat with my own friends when I was studying	
1126		psychology as my ba. And then again, we would either be bringing at the beginning pack lunch	
1127		or cook food from the family home to our own apartment or we would be cooking on together. Or	
1128		we will, has lots of people together, so depending who is around, you would try a little bit to, yeah	
1129		you would try little bit to do it. But we were very young at the same time, so the eating wasn't that	
1130		regular, as it used to be before our family homes. So YES, it would be more about yeah, going out	
1131		and have a big meal altogether and then come back home, you know keep on nibbling, snacking or	
1132		have another snack. There will be a lot more irregular in the context of university (nnh). And then	
1133		that actually changed again when I move to the UK. Because it was a lot more structured when	

1134		I was doing my MSc here, and the family therapy training, it's a lot more structured so I knew	
1135		exactly my timetable and what I was going to be doing emm on a daily basis. I was making sure	
1136		that emm, yeah I had actually meal, homemade meals with me. So rarely ever have I bought from	
1137		outside, I would do it every Friday with my colleagues and from the training. We would be having	
1138		for instance on Friday, ehh fish and chips because it was the treat. But other than that, the thing,	
1139		the fact that I always had homemade home. This has organised how I cook for myself and	
1140		usually on a daily basis at least. Not that we can enjoy going out the restaurant. Emm, on a daily	
1141		basis I will have my own yeah, homemade food ready with me.	
1142	R	So the values of homemade food is quite important to you, that from beginning (throughout) to	
1143		your, yeah.	
1144	P 1	Yes	
1145	R	So, I am thinking about this experience. I think you mention you share with young people about	HOME
1146		your experience you know. Whats' their response? I mean you said that they are quite curious about	MADE
1147		how it is? How do they relate to their own? I am just wondering.	food
1148	P 1	Err, if I can use the example of emm homemade home for instance. It is interesting because	
1149		young people I think with, to be fair emm, to have pack lunch with them made by the parents	
1150		compare to buy from school. They are even more unaware of around how these has been made.	
1151(40.4		So there are two different aspects in that. I am wondering whether there is an element of some	
1152		cognitions err during that process. Emm, and I think something about safety, I think they feel a	
1153		little bit safer, having actually homemade food. Emm, but again it depends on the case where	
1154		that sense of safety comes from. So, I would, I would share with them that err I used to have	
1155		pack lunch with me because this is, this is better quality of food from my point of view. And its	
1156		you know how you make it and emm. I think, I think they would that would resonate with them,	

1157		in comparison actually to buying food from somewhere outside or, or, or school. So this is	
1158		something that they, they would be a little bit reduce but emm you realise you always have another	
1159		conversation about the fact that parents need to do the food, and preparation of them at a	
1160		later stage again of the treatment. They can have the responsibility, and we can have the	
1161		responsibility, hand the responsibility back for them to start making their own food and show that	
1162		they can also look after themselves. Similarly to how the family or the parent have look after them.	
1163	R	Nnn, it sounds a very useful intervention, what you described.	
1164	P 1	I hope so (P1 laughs)	
1165	R	Yes, it does sounds like it. So I, I am hearing the stage one when they are at the sort of high	
1166		risk area. So rather than just like negotiate food, psycho-education. That actually there is lots of	
1167		reflexivity and interventions, very useful you know, yeah. (nnh) And yes so. Thank you for sharing	
1168		that you know. Emm, I think this conversation is mainly about emm, wondering what might	
1169		be going through your head when you are working with families about food, like stage one when	
1170		they are high risk, or when they are further on the stage is that right (yeah). So it is like further on,	
1171		you can be more, you cover that in your, our last interview when you can be more, whats the word	
1172		you got, you can have more conversation, is that what I am hearing?	
1173	P 1	I think so, because the family they, mainly the young people are more ready to have a more	
1174		exploratory or reflective conversation with you. At the beginning, they don't even know whether	
1175		we are the enemies or whether we are working with them. Again the eating disorder. So, unless	
1176(43. 4		these therapeutic trust is established. Adolescents would find it difficult to explore anything else	
1177		or meanings, with you. This is emm, and this is quite typical part of the field, how it should be. So	

1178		in terms of there is a position, that these developmental stage. Emm, but err it is very much	
1179		dependent on the case of course. That depending on, how cognitively affected they are. Some	
1180		might actually engage in that conversation or in those conversation a lot quicker than others.	
1181	R	I just wondering physical risk is something across eating disorder because of the low weight. I	
1182		just wondering how low weight comes into your self-reflexivity.	
1183	P 1	Say that again, how low weight?	
1184	R	You know like the physical risk, managing physical risk as a family therapist (nnh) how does it	
1185		kind of influencing your reflexivity whatever stage you might be?	
1186	P 1	Yeah, well admittedly err, one of my initial response, don't necessarily share it in this ways. Just	JUST FEED
1187		feed the kid (P1 laughs) we are talking about the kid of refusing to eat. We are not going to step	the KID
1188		back and just witnessing them actually deteriorating. Lets go back to the initial developmental	
1189		stages of them, initial, initial developmental stages that they were toddlers, they were refusing	
1190		to eat, what would you have done back then? This is probably the stage we need to go back to.	
1191		We are not going to led the two years old, wondering around themselves and not eating, and	
1192		then sitting back and said it is okay. So my initial response is something about having the	expectation
1193		expectation that parents will be able to it. And have the capacity to do it. And yes, yes my. I think	on parent
1194		that's always mainly my response. Lets try to feed the kid and lets do it. Just do it. Because you	
1195		have done it, you have been doing it over the last actually, I don't know fifteen years before. Before	
1196		the diffculties. You won't stop doing it now. So yeah, sometimes I just becoming a little bit impatient	impatient

1197		around that. I don't communicate that, that doesn't come across. And respect the fact that these	
1198		parenting style has been affected so significantly. But part of the working we do is actually make	
1199		them feel that they got the capacity to do it. And find again the skill, and the expertise as parents.	
1200		Because again my personal experience has been, especially growing up that yeah there is no way	
1201		that you could just leave the table having eaten two grapes, and that be considered actually as meal.	
1202		That's what I am trying to say.	
1203(46.3	R	You sound very clear that parent have done it and they have got the capacity. How does the parent	
1204		response to that.	
1205	P1	(.1) I think they hear where we are coming from and they hear the fact that we believe they have	
1206		the expertise. And we share it, I share it in a way that we might be the expert in eating disorders but	
1207		you are the experts in your family and you have been caring for your kids for so long. So they	
1208		reconnect, I think with those skills and with that capacity. But you also validate their knowledge,	
1209		the fact that at this particular stage. Emm, they feel stuck, and they feel deskilled. So they are	
1210		unable to support them, so: you work a lot with them around how would, about their relationship	relationship
1211		with boundary setting. Not only in relation to food but their relationship to any other behavioural	
1212		that would be concerning or unacceptable for them. So (.2) of course, first of all we validate the	
1213		difficulties in the house, how hard things are for them. But you also work with them, in order for	
1214		them to feel that they can do it.	
1215	R	And courage them to create the behavioural change?	
1216	P1	Exactly, exactly, with boundary and also through validation. So, what you are doing with the	
1217		parent is actually what the parent should, hopefully eventually do with the kid, the kid. You, you,	
1218		you help them. And you support them, in order to be supportive, and support their kid.	
1219	R	You mention two things, one is like sometimes therapist might feel a bit impatience. Do you think	

1220		the family notice that, or, or like actually, how does it play out you know?	
1221	P 1	Nnn, well it depends on how, how much you want to mobilise the family's anxiety and resources.	
1222		Because its been the case that the parent undermine the severity of the illness or one of the parent	
1223		undermine the severity of the illness. Or other families that they are already highly anxious, you	
1224		will contain them. You wouldn't necessarily, give them more anxiety. But yeah, it is something	
1225		about the family dynamics. It always feed actually the parental anxiety. So what is, yeah what is	
1226		the rationale around mobilising the family. Not only anxiety but also resources as well, in order	
1227		for them to step back involvement and realise that change needs to happen as soon as possible.	
1228		Otherwise we are facing, all kinds of run at A & E presentation which again goes back to their	
1229		relationship with the meaning of eating disorders, mental health or mental illness. So there is	meaning
1230		a lot, then depending on the family you might be able to have this conversation altogether or you	
1231		might need the parents on their own to say. Lets really : have a thing together about what the	parental
1232		eating disorder can do for you kids to make sure they are on the same page.	talk; clear
1233	R	Somewhere helping the parent to reclaim their parental capacity to feed the child.	about
1234	P 1	Exactly	expectation
1235	R	This is really really helpful and thank you for sharing your experience and how it interplay with	
1236		the family as well. Emm, I just wonder if you have any comment or reflection before we finish, we	
1237		finish today.	
1238	P 1	Emm, no its been. Yes, it’s been a really nice discussion, thank you. And thank you too. Its emm what	
1239		I will keep on thinking is emm yes, whats, how, my own expectation that these parents can do it.	
1240		How this is communicated? And how, how the parent actually might read it, might feel about it,	
1241		my senses in the room. And I think it is always support them to check in. Emm just be very	
1242		transparent. This is what I am expecting, not only as, from my role as a therapist in eating disorder	transparency

1243		but also because that's my own experience have been. How they fit in your own family, your own	
1244		parenting styles with how the kid sees how you are supporting them? So just is awareness actually	
1245		needs to be. Their awareness is there but needs, needs to be share, needs to be yeah. Always	P1's take
1246		remind, I need to remind myself of that. Why I do it, what is the rationale and what would be the	on R's Qs
1247		impact, what will be the benefits. Yeah.	REFLEXIVITY
1248	R	So, I mean you mention remind. I am getting an image of like something might be shadowing it you	
1249		know. What might be the dominant thing when you are in the room with the family, you know at	
1250		different stages. I mean the first stage is feeding I hear that	
1251	P 1	The first stage is feeling?	
1252	R	The first stage is refeeding, empower the family, enable the family (yes) to regain (yes). So that	Looks stage
1253		would be the main task and later on, more exploratory of different things.	driven but
1254	P 1	Yes, typically but different family at the stage that they can do both at the same time (yes) then	actually
1255		nothing stops us and ehh you know as I been saying that throughout the treatment you never stop	reflexive focus
1256		becoming emm, you never stop actually being self reflexive. But just emm, yeah the, the reminder	
1257		that around expectations and how our own expectations of treatment of all of those parents	
1258		might affect that, those particular parents. Not all of them but because it is a very case by case situation.	case by
1259			case
1260	R	That's arr really useful. Thank you so much (P1).	
1261	P 1	Pleasure, thank you so much.	
1262	R	As usual if you have anything that after the conversation, like to catch up do let me know.	
1263		In the mean time perhaps I turn off the machine.	

Appendix 1b: Transcript for participant 2- Beverley

1		
2		R: Researcher
3		P2: Participants 2- Beverley

4		
5	R	And also I have a standby iPad to record it as well. Sometimes, always have a contingency plan.
6	P 2	Yeah
7	R	That's get all of them ready. Okay, so this is running and this is running. Yeah, recording you can see the
8		dot is glowing. Okay, I am going to start by, eh, I have about eight questions, so it is a lot. So it is not
9		like job interview or whatever. No right or wrong, its completely your experience. So em the first
10		question I like to ask is about Can you talk about how you feel about this research title. When you
11		see the title race, ethnicity and culture in family therapy with children with eating disorders. How do
12		you feel about it?
13	R 2	Em ::: I think I feel as though emm hhh because of the supposed demographic of children who gets eating
14		disorders. Emm, and I feel sometimes that there is not been enough focus on difference emm in the population.
15		.hhh and then I am sort of balance that against my own experience where I feel emm, I certainly not seen emm,
16		patients err, that sort of represent the general community emm where we, you know the the community
17		that we would treat generally in CAMHS. Emm but that we have seen a lot of em black and minority ethnic
18		patients. Emm but not in the number you seen in the normal population or in the normal camhs
19		population. So when, when I think about it I sort of feel as though may be I have to rely on other areas
20		of experience. May be previous to becoming a social, eh eh a family therapist as a social worker in the
21		past to draw on, the experience I had as a social worker with a very very different em demographic on
22		my caseload. Emm but always holding err that sort of social work training and the discourses we had
23		as social worker around race, culture, power. Emm in the work of eating disorders. But feeling as
24		though the further I get away from that social work experience, the more … (lose internet connection)
25	R	Sorry I lost you, you know err I think you know like perhaps the wifi is not very reliable (Yeah) It might
26		be one of those morning, I think so far I haven't been in trouble so every interview is something to
27		learn. (Laugh)
28	P 2	Sorry, so I think em I just had a teams meeting with about ten people. It was a little bit glitchy for everyone

29		but em (right) but sorry I was rambling anyway.
30	R	No, no not at all. You are, its part of the process to to tell your story, you know. So em we were on.
31		when did I lose you? You were talking about you drawing on your social work experience.
32	P 2	Okay, so yeah I was saying that broadly speaking I don't think there has been enough focus on it in the
33		field of emm eating disorders, certainly in child and adolescent eating disorders. Emm and so what I draw on
34		emm in my own practice and thinking is the previous experience is more than anything about bearing in
35		mind, race, culture emm, and power differences, emm and ::: I think you know on a national training Liz Dodge
36		emm was presenting on race and culture, and because it is still a sort of minority area of research. I think
37		even that the the, because there is so little research, sometimes it feels as though there is a bit of
38		stereotyping happens because of the small number of people that are being looked at in that respect.
39		So, thinking back to the question what does it bring up for me in the title. It brings up emm (.2) .hhh. It brings up
40		lots of things, it brings up emm ur concern that there are too many competing issues for that issues necessarily to
41		emm be prioritised very often. Emm and. But that, also that emm, because of the model, systemic model that we use.
42		I feel that at the root, in the core of systemic therapy is a emm urr a real interest in beliefs and focus on
43		difference and that brought the fore in the practice we have anyway even though we use a manualise
44		model. The systemic underpinning of that model pays attention to difference. It pays attention to
45		different family culture of each different family. But also more broadly em looking at the culture that
46		that family come from. So YEAH, a whole mixture of thoughts that come up, that’s an interesting area.
47	R	So, can I just go back when you say there are competing issues, err with race, ethnicity, culture, what
48		might you, you be thinking of?
49	P 2	Emm competing issues, I think ::: because so little is known about emm eating disorders in childhood anyway
50		emm that aside from the the more broader research that is done into the area of eating disorders in
51		children and adolescents. There, there are even less in relation to how race culture ethnicity fit into that. So
52		that become emm side lined against a really dangerous illness, and the illness where you know, there is
53		always an attempt to see how can we treat it early, more successfully, more quickly so it doesn't

54		damage life for too long. Emm so then, that I think that, that was what I mean. That was what the
55		competition is in my mind, in terms of understanding eating disorders and child and adolescents. That
56		race and culture err is you know comes low down, may be on people's priorities (Em) and and ↑then
57		I think well actually realisticly we are talking about tiny numbers of people statistically who develop
58		eating disorders in childhood and adolescents, at least with anorexia. And so the numbers of young
59		people from emm black and minority ethnic groups who develop it are even tinier. So yeah, those
60		competing em research focuses mean that it is, that is the competition I think.
61	R	Nnn, so err you mention earlier on that your demographic in your service is, have high proportion of
62		minority family, is it?
63	P2	No, no, no. NO, it I am saying it is low.
64	R	It is low.
65	P2	If you look at the population that we are serving (yeah) emm and :: I think it is increasing, and with
66		different groups its increasing. Emm and the split between the different diagnosis, seems to also go
67		with different groups of young people which you know, so for Black Afro Caribbean patients is quite
68		unusual to get patients referred for anorexia in those groups. Whereas they are more represented
69		with bulimia. And I think an understanding of that would be very helpful (Nnn) emm and then <> you
70		know, am I stereotyping that I always struggle with the idea that we are not :: emm that those patients
71		aren't being referred or we are not seeing them? Because I imagine there would be a lot of parable
72		deaths in the community through starvation that those groups of people emm and I don't think that's
73		happening, so I don't you know, I think that is so much more we should know about this. Emm (nn) to
74		understand it better and may be, certainly we did a project in the service raising awareness of Bulimia
75		and that show a little bit of spike in referrals coming for both males but also em black em
76		Afro-Caribbean young people as well. So you know there is something in that we could potentially be
77		missing patient who need our services emm because, yeah, there is a reluctance to come forward.
78		Because in that community may be or within their own beliefs they don't feel it should be something

79		that they emm are trying to manage.
80	R	Nnn, and you also mention about early on about your social work background. The race, ethnicity and
81		culture eh is kind of relying on your previous training experience (yeah) and how do think you have
82		grow since you enter eating disorder field?
83	P 2	.hhh I think when I train as a social worker in the 1980's it was on the back of a real political change.
84		in em ::: you know things like. I can't remember when the McPherson report was, but when :: almost
85		people discover racism for the first time (smile) you know. As if it haven't been there before but there
86		there was a real em recognition of power difference. And the social work course that I was on was ::;
87		that was a sort of really really big part of the teaching was around how to practice in a way that isn't
88		mirroring those power difference in the community. And making sure that you are em as a white
89		person, aware of difference between yourself and someone who was em in a different power
90		situation. So and I think because it was a really formative experience as a sort of mid 20 year old emm
91		I never lost that it really, it was really part of the culture being a social worker at that time. Emm so
92		you don't lose that. Em
93	R	And you took, took it into your family therapist identity as well?
94	P 2	(.2) I hope so em :: Yeah I mean it was certainly the the, the teaching around difference was very
95		different (giggle) when I did my social work training, then the 2000s. Em but I think it meant I, I, I had
96		different questions about it then as a family therapy trainee, having you know, come to the family training with that social work
97		background, and with that experience emm :: Yeah.
98	R	Can you remember what they are? You know when you change from one area to family therapy?
99		Difference in managing?
100	P 2	(clear the throat), I think it was more the difference from, going from err from one setting to another,
101		so going from a social work setting to an NHS, clinical setting (Nnn) that was the bigger difference.
102		Emm in that the way : race and culture was talked about in the NHS was very different the way it was
103		talk about and thought about and prioritise in a social work setting. So I think that surprise me. I think
104		emm I felt that the NHS were reluctant when I first join the NHS, to acknowledge that those power

105		difference were everywhere in every system, in every group of people. Em so certainly that's still
106		hold true today. I know that there are certain, people who I work with who denied that there is a
107		power difference for example between a consultant and myself. (Nnn) where as patently not true.
108		And in the same way they are a bit blind to any difference to any power difference between white
109		patients and patients whose background is different, em their heritage is different.
110	R	Nn, how can you have conversation of this kind with your team, let say err?
111	P 2	Emm, so those conversation do happen and they, in the family therapist is a very live conversation
112		because as I said, you know I think we come from a position of valuing difference as a way of
113		learning more about people (Yeah). I think it may be between professions that becomes a more trickier
114		conversation. Because it involves different professional beliefs but also status and other complicated
115		relationships coming into that conversation in the wider team. And I worked in a very very big team
116		and so you have those conversations may be to your profession group or your closer colleagues. Emm
117		so it is still there. Emm but may be that is part of the, the worry is that, is there is a bit of lip service may
118		be to race and cultural difference, it generally.
119	R	Err ::: I was just wondering if there any, can you give me any example that kind of like you remember
120		about where race, ethnicity and culture in your field which is eating disorders, children eating disorders
121		that happen between the team, that arr either quite helpful or not that helpful?
122	P 2	Emm (.2) a specific example. Emm (.2) I THINK the main example is where in a large group, a MDT
123		conversation emm :: it will quite often not be consider part of the conversation in terms of whats
124		going on with the family (Ha) unless a particular person brings it up. Or emm or prioritise that as
125		part of the conversation. Emm whereas you know that, I suppose it might that we save certain
126		conversation for certain meetings and contexts and it is quite likely that conversation has taken part
127		, taking place in a em sort of private supervision group or supervision between clinician and their
128		supervisor. But in the wider group I think sometimes it doesn't get address so that’s not being, may be
129		that's not specific enough for you Charlotte (laugh). Err

130	R	(laugh) or the experience of telling something within the
131		bigger group, in the MDT group you know, does it feel heard the group acknowledging?
(13.2)132	P 2	Emm :: I think it is acknowledged, I think it is acknowledged but I still think it is sort of considered, may
133		be slightly as a sort of niche conversation that come below the sort of treatment models or the
134		individual you know the the :: (P2 hissed) so we have em models of treatment, we have our manuals
135		but you know, it is not totally manualised, we are not robots. But em, the emphasis for example on
136		early err weight gain and making sure that people are physically not at risk. That overrides all of those
137		conversations. Now the way you get to how you support a family to feed that child, if culturally
138		there is emm, a real big difference in understanding or a real difference in that family experience in
139		relation to health, emm accepting health treatment or being emm recipients of you know, a service
140		where there has been you know mental health services. That sort of conversation might not take
141		place. The conversation about oh well you know, we got to make sure we are not imposing emm
142		(hiss) err our, off the peck meal plan for a family whose food is going to be very different
143		culturally you know. THAT THAT sort of acceptable but it is that political bit that isn't discussed. Emm ( )
144	R	Can you think of, can you say a bit more the political bit?
145	P 2	↑Well, AH I think in you know in XXX (an area name), there will be generations who er, who would certainly
146		black and Afro-Caribbean families whose experience of mental health treatment would have been
147		pretty awful, going back em a generation or two. Em and then they are presenting themselves to
148		XXX (hospital name) again with their child and that would be loaded with the, you know the
149		experiences that had come down through their generations of what it meant (yeah). SO you know
150		that bit (smile) would NE::VER get discuss in the team meeting. It might get discuss, as I say in smaller
151		group. (Yeah) Emm, BUT I don't think necessarily that psychiatrist in the team or some psychiatrists
152		would acknowledge the actually there is is you know for our family in XXX (Area name) for example.
153		You know there would have been a real emm narrative about what it means to present yourselves to
154		the XXX (hospital name) for treatment. (right) And I think that's relevant. I do think that is relevant emm and

155		that might come later in treatment as well that. THAT that conversation when we get to the point
156		where the patient is less at risk physically. Then, you know in terms of beliefs and trust and developing
157		the, well you know developing the therapeutic relationship. It might be important to have that discussion with the family.
158		But I don't know that would be seen. I DON'T THINK it would be dismiss as irrelevant by anyone but
159		you don't, I don't get the impression that everyone would have that conversation.
160	R	Right, so does it sound? I am just testing it out my :: Does it feel like be belongs to the family therapy's?
161		or the psychological therapies err to think about these things?
162	P2	Err, I think, nnn, it would be really interesting if I were a psychologist or one of the psychiatrist or a nurse in the team.
163		Emm : it DOES feel a bit like that. I think our tradition is far more LIKELY, that our tradition and our focus means we are
164		far more likely that we would want to have a conversation about those things if it felt right for the
165		family and right from a therapeutic point of view.
166	R	Nnh, so you hold the sort of like, whats the word? The the VOICE for for kind of examining the race,
167		ethnicity, culture for, for the family.
168	P2	May be> IT seems emm :: it might be really unfair but it may be, I think that might be the case. It might
169		be the case >
170	R	So going back to these sorts, like situation, scenario, example, case example of family come to your
171		service em, kind of like is is discussed in a certain way in the team. When you mentioned in a smaller
172		group, you know like or in supervision or in group peer discussions. How are they being discussed?
173	P2	Emm ::
174	R	Or if you pin it in an example that you have discussed together that might, might be really helpful.
175		If you can think of an example?
176	P2	Emm, let me think of an example. (.2) I can think of a family where em em Yeah (.2) Afro-Caribbean
177		family where there was generational mental health problems and certainly in smaller supervision
178		group and in supervision. Absolutely was discussed as part of the picture, part of the mother's em
179		reluctance to engage her response to us. I mean it was a very complicated situation but even in the
180		young person there was discussion about emm, the impact of em both treatment in the family with other

181		members of the family and for her. And what that meant for her and then being an inpatient as a
182		black child in a predominantly white inpatient unit actually at that time, down in (Area). So yeah, I don't
183		know if I heard the question right but that that was certainly thought about and talk about. Emm but
184		that would not have happened you know in the meeting where sometimes there may be thirty people
185		in the meeting. So I think it is not just that issue that doesn't get discussed in the bigger team meeting
186		and and actually we divided out the team that that the case discussion part of that meeting out now.
187		Because amongst other issues, people found it harder to talk in a wider group. Emm about case
188		management. Emm so it is a much smaller group now. In recognition of that fact, so race and culture
189		is easier to talk about it now in a smaller group (Nnh) because you can test out more easily what,
190		about people's responses going to be and whether it is going to be a helpful conversation or not.
191	R	So does this conversation? How does it show in your practice? When you are doing therapy, family therapy
192		with your families you know?
193	P 2	Emm :: .hhh I think like other things, at the beginning of treatment emm. It may it is reflected may be
194		in a, in practical conversations about arrangement in the family for eating and food and emm, the
195		meaning of food. Emm and how we are going to get the practical tasks of the child eating more or
196		And I am thinking about anorexia obviously. Emm but likewise with bulimia, understanding the family
197		culture around eating and food. So that, that would immediately bring it into the room. And
198		acknowledging the difference and I think as a therapist taking a stance of wanting to understand.
199		You know and learning about that amongst a whole load of other things about family. So you are
200		asking so many intimate questions anyway. You almost emm, it is part of that conversation to
201		understand how to help a child and the family help the child. Emm, and then like other things. It may
202		be that it doesn't necessarily need to be return to. Emm unless there is a sort of a real clear sign from
203		the family or from your gut feeling as a therapist that there is something about race and culture for
204		example. Emm, that is, is having an impact on the treatment process or the relationship or the
205		engagement. Emm and then I think that's when you may talk about it, a bit more and check in with the

206		family more about what their understanding or their, their beliefs about therapy and you know. Em
207		their experience of therapy, their experience of you know family members having, may be have mental
208		health treatment. Emm so it is translated in that way but only in as much as any other potential
209		problem. (P2 laughed), I wouldn't want to call it a problem, any other potential difference might
210		impact on the process of therapy and treatments. So
211	R	Such as when you say those potential difference, what are you referring to?
212	P 2	Emm, separated parents, or things that might interrupt the therapeutic engagement, so lack of trust and in
213		what you are saying as a therapist? Emm, ah financial situation of the family, you know when you are
214		suggesting things that may be suddenly you realise, actually this jar with this family. I have
215		misunderstood something about where they are at financially. Or .hhh something about their beliefs
216		emm (P2 hissed) parenting you know. SO general beliefs on a, on a belief level maybe we make assumptions about
217		that. And unless you asked every family, but that certain things you are not going to be understanding
218		and therefore you won't appear, you know to be trustworthy I think. (Nnh) Err, sorry I am rambling, I am
219		getting.
220	R	Er, I am just thinking if it is helpful if you give me an example that you give me an example, perhaps a
221		piece of work you did yesterday or last week? And that where you think race, ethnicity and culture
222		might be relevant in that process?
223	P 2	Emm, that is really interesting because at the moment emm I have, I only have one black family on
224		my caseload. I have a small caseload because I am one of the manager in the team. And err that
225		has not been a massive focus of treatment because the patient has done really well. And they, I am
226		about to discharge them and there hasn't been a need to really to specificly focus on that. There is a patient
227		whose mother is em Greek Cypriot, and I beginning to form a question in my mind about her beliefs
228		about family and parenting and up. And I want to explore that but actually, very particular to this
229		situation, it feels harder because I am doing the therapy on video and > I think (P2 hissed) I, get my head
230		round how ::: how good is the engagement to begin that conversation. When I already feel like she

231		feels a little bit criticised unintentionally because I think she is doing a really good job. Emm but her, I am just
232		not sure about how the engagement is, so if that were in the, face to face in the room. I think I feel
233		far more able to say to her. I really think it would be helpful if I understood something about, about your
234		family experience and how it was a child at your daughter's age when you were being brought up. So I
235		can understand a bit more about what sort of mum you want to be and the sort of mum you are.
236		(Nnh) Em, I find that really difficult on video (P2 giggled) at the moment, with that particular person.
237	R	Yeah, it is important to acknowledge, you know like the movement from face to face to online work
238		you know. I think very often we refer to, if a therapist feels safe, the family will feel safe (smile). If we
239	P 2	Yeah, yeah.
240	R	So I was thinking about em the er I was just rambling, I am rambling as well. (laugh) you know
241		just looking at the questions (both laugh) that I had prepared you know, is like. I have this one is like
242		Can you tell me a story from your practice where race, ethnicity and culture were central, so it can be
243		not just last week but kind of like any any from your memory that stick out for you?
244	P 2	Where it was central? (Nnn) you see this is where that, this is where the specialism sort of interferes
245		with that because it depends, you know you have to choose a point in time in treatment because :::
246		you know am I believe in the model that we use because you know it works. But for a child who is
247		really unwell I wouldn't say it could ever be absolutely central at the beginning, other than on a practical
248		level and acknowledging difference, acknowledging a practical difference. Potentially in the family's
249		practices around eating and food. But thinking about :: taking that forward to treatment, was it ever
250		central emm? I am struggling to think of a time when it was central. (Nnn) Because there was so many
251		layers and may be that is a family therapy copt out. But you know, you always looking at
252	R	Or is always there, you know is it always there?
253	P 2	It is always there and it comes to the forth in a flow. Em or not you know. Its ::: er em, I can't remember, I am trying to rack my
254		brain and think, is it ever central? Emm (.4) Ah (.4) ah. Yeah, I mean :: Other than when (.2)
255		other than when communication been really difficult because you have to use interpreter for example.

256		(Nnh, Nnh) but you know that’s central in a totally different way. Emm (.2) and the, and the actually
257		the thing that springs to mind that in that incidence is a mum whose, who was from Korsakov. And
258		came with her older daughter and the younger daughter who was the patient. The older daughter was
259		this really tall healthy looking young woman, patient was tiny looks like she was failing to thrive. Emm
260		we had interpreter but then mum prefer to use the older daughter who was over eighteen, as the
261		person to interpret for her. And actually what emerged was that this mother had gone from one
262		paediatrician to another. And you only had to look at the older sister to see that something very
263		wrong was going on for this child (nnh) Emm, and the mum was being ridden off as anxious and
264		traumatised because of her experience in the war. And so the other professionals had totally focus
265		on the mum. Almost a mum blaming way, on the one hand they were saying oh mum been through
266		so much. She is over anxious about her child. Emm, but in another way you know, oh she should just
267		feeding this child more. You know there was so criticism there I felt. So several paediatricians she
268		had seen and then she came to our service and◦ We assessed the child, we didn't think there is eating
269		disorder but we did some tests. And it turn out that this child had a brain tumour ,hhh and I remember
270		feeling incensed that this child had managed to go through the hands of several paediatricians (Nnh)
271		Em :: and you just had to look at her to see there was something very different and they're just home
272		in on the mum's deficits or supposed deficits. And hadn't looked at what that child needed. And I
273		felt really upset and angry for the mum who, who :: by the time she came to us she just had lost trust
274		in her own judgement as a mother. She felt that she was doing something really wrong and this poor
275		kid just couldn't eat. You know there was something badly going on physically should have been found.
276		And because other people held this view in their in their mind. So that, that is not race necessarily but
277		that is difference. People making assumptions about someone (nn) both emm good and bad but
278		mainly bad and the result was potentially deadly (sure).
279	R	And it took the child, the family arriving your service before her health, tumour being identified through
280		the intervention of your team?

281	P 2	Yeah. Luckily we have the paediatrician on the team and he, you know he did, we do blood tests. And
282		you know he pick up from the blood, something going on. And you think how did that get miss. You
283		know this kid had been, had a ^rafts and ^rafts of tests and that. It wasn't as if that tumour had just
284		pop up you know. It was there. (Nnn) But the tests that had been done previously were more focus on
285		:: er I don't know why, I don't know what. But they didn't discover that, they didn't realise because I
286		think they, she was dismissed a lot of the time.
287	R	Wow, and what happened to the family then? Do they get discharged from your service because?
288	P 2	She had surgery and she then thrived. Because the problem was gone. I can't remember what type of
289		tumour it was but she had surgery over the road at (hospital name). And you know the mum was just
290		incredibly relieved that she, you know it wasn't that she was starving her child or doing something
291		wrong. AND she had a ( ) , you know in fact the family were very :: emm. OH, that is, that is my
292		delivery. I will I will
293	R	Go, go, go, I will pause this (P2 received a delivery and return to the interview)
294	P 2	Oh here, family you know they didn't need anything else. There was no more need for our service.
295		Emm
296	R	Thinking about the, race ethnicity and cultural issue, you know emm. How do you put it in terms of
297		family therapy?
298	P 2	In that case?
299	R	Yeah
300	P 2	Emm (hiss) well I suppose actually it may be that was a stupid case to choose because from the point
301		where we realise there is a physiological problem, it was sort of taken out of our hands anyway. So
302		there was a lot of support. Emm afterwards, in the aftercare. Not a lot actually, a bit but I wouldn't
303		say I was doing family therapy with them from that point actually. Emm. And whether or not I am trying
304		to think about any other family were central. Because that was the question, wasn't it? was it central?
305	R	Or relevant if you can't think of something central.
306		I think it is always relevant. (laugh) if that makes sense or another. Emm its whether or not it remains

307		relevant all the way through to lesser or greater extend. And I can't remember a case of work where
308		it remain the main focus.
309	R	Or was in focus or whatever reason you know, for a period of time?
310	P 2	Emm (.4) Actually, strangely enough. [I am sure there are and its actually the one that comes to mind
311	R	[I am sure you are
312	P 2	more is that, not in this service but when I was training. Emm if that is relevant. [But it is not, no that
313	R	[Yeah, yeah, yeah.
314	P 2	wasn't eating disorder though.
315	R	All right, okay yeah.
316	P 2	Err, so you want eating disorders where emm, er er (.4) you know I am finding this situation emm
317		the lockdown thing. I am getting far less creative with my thinking.
318	R	Yeah, because we lost the stimulation (laugh)
19	P 2	Yeah, yeah (laugh) and so it is you know racking my brain. It is almost painful thinking back, because
320		life has changed too much. But I am, let me think◦ Emm (breath in heavily) maybe we will come back
321		to it. I have to
322	R	Yeah, yeah, maybe we will go to another question rather than focusing on this one.
323	P 2	Yeah (laugh)
324	R	So if I just turn the focus to ask question about risk, you know like a emm Can you tell me a time when
325		you manage risk in your work and any implication may have on your reflexivity or any kind of race,
326		ethnicity culture issue?
327	P 2	(.2) so risk associated with the work,
328	R	with eating disorder field, in your field.
329	P 2	Emm, and whether race, ethnicity had a feature in the management of that risk
330	R	Or how it impact on your reflexivity?
331	P 2	Emm okay, (P2 hissed) I think going back to the patient whose mum was emm (P2 hissed) also a patient in the adult service.
332		Emm, and was becoming really unwell in the community and was also meant to looking after my
333		patient who had been unwell for long time and both began deteriorating at the same time.
334	R	Do you mean Kosovo family?

335	P 2	No, no no.
336	R	Not that one.
337	P 2	This is the black African Afro-Caribbean family where they had been generations of emm
338	R	Yeah, yeah you mentioned.
339	P 2	Family emm in treatment. Emm and I think the trouble with that in terms of the therapy. I had to
340		manage the risk because the child was becoming unwell.
341	R	How old is the child?
342	P 2	At the time, the child was sixteen
343	R	Sixteen hnn.
344	P 2	living at home with her mum. Parent has separated a long time before and she spent a lot of time
345		with her father. But was actually living with her mother and the mother was very very. The separation
346		had been incredibly acrimonious. So it was really difficult for the dad to (R coughed) overly influence
347		what was happening with the girl. I mean he did, he stood up massively and took her to her
348		grandmother in the end. Em at one point, but race and culture in that was, it was around as a thought
349		because actually the mother, her sort of history was that there was lots of disengagement with
350		services, with the adult services. Emm she had horrible experiences in hospital when she was a younger
351		person. Emm and so, in trying to negotiate with her how we can carry on treating her daughter whilst
352		she becoming unwell. Emm, (P2 sighed) it was, it was in my mind but the mum was so unwell at that point
353		that it didn't feel as though there is much of a helpful conversation that could happen about that. She
354		was incredibly paranoid and a bit manic. Well very manic, so ::: that raised additional problems, is that
355		you know, you you were aware that there was a whole layer of history in terms of her treatment as
356		a mum. And then seeing her daughter potentially having to go into hospital. But because she was so
357		unwell. You couldn't really quite get to that conversation and also that tension between you know
358		whose the patient and actually in managing the risk of the girl deteriorating. The focus had to be
359		on maintaining her safety whilst trying to get the adult team to do what they should be doing to
360		monitor and support her mum. And so I feel like, you want me to talk about some fabulous family

361		therapy that I had done and I hadn't, you know. [What I doing it was (laugh) was fire fighting. It's a
362	R	[No, no
363	P 2	care coordinator and therapist, and someone who had :: I hope trusting relationship with the girl, less so
364		with her mum. Emm, just trying to, actually more like a social work job to be honest.
365	R	I suppose my interview is aim for reality, so whatever comes to your mind. You know
366	P 2	Yeah, Yeah. < But you know what, I think that raises another thing may be going back to the specifics
367		of emm family therapy in eating disorders is that sometimes. I feel like family therapist in eating
368		disorders has gone a bit vogue (P2 laughed) Em where, you know in later phrase of treatment, we hopefully
369		sometimes do some really good explorative work with families if that is indicated and helpful at that
370		point. But we are doing so much more adjusting our focus from em, being quite directive and not
371		explorative in early stage and so sometimes I think there is a bit of guilt, that actually we are not doing
372		family therapy. (hiss) WE ARE doing family therapy, I think we are doing a really complicated job of
373		family therapy in eating disorders but sometimes you struggle to think well actually, didn't sit down and
374		have a lovely narrative conversation with that family or, landscape of :: em change or whatever you
375		know. Its its :: yeah. So that is where my thinking has gone with that, its that it was much more like a
376		social work practical tasks I was doing. But base on a therapeutic relationship (em) and in a trusting
377		relationship.
378	R	Am I hearing the work of like the traditional family therapy ehh have to wait until you get the right
379		phrase and whereas before that it will be like mainly aiming for relationship, helping the family, helping
380		the child to get to a safe weight?
381	P 2	Yeah, it depending on the level of risk I guess. If the level of risk is high and you can achieve emm quick
382		turn around in terms of restoring physical health to the point of the risk is not at risk anymore. Then,
383		yeah I think you are being much more directive but I would still argue that, that is skilful family therapy
384		because you have to build engagement very quickly. You have to build trust very quickly emm. Strategic
385		family therapy might have emm a bad name. But you are being strategic in what you are doing and

386		because you know where you are going with, you know where you are going next. You know where
387		the family needs to go next. So I think you, you are still using all, loads of skills. Em ::: and also you are
388		always focusing on the future as well. So whatever you do in the early stages, you need to know
389		you are going to have to adjust your position so you can be more explorative and emm use other
390		therapeutic skill later on down the line. So you know I think its, we are doing tons of family therapy
391		It just doesn't look like, what even in my head it’s a bit of stereotype what family therapy might be
392		imagine to be. Does that make sense?
393	R	Yeah, yeah it does make sense.
394	P2	You, you do it yourself. So you know.
395	R	Yeah, you have to be different things at different time.
396	P2	Yes, totally.
397	R	Yeah, and :: can I just ask you err when was the last time or if you can remember, the last time you took
398		a kid home? You know in your mind. You know like worry, worry about them in terms of risks and
399	P2	In terms of risk?
400	R	Or something got to you
401	P2	(.2) Ah :: It is funny because I think that is changed a little bit again under these circumstances because
402		there is a risk meeting every morning. And so I am bearing in mind my own patients who touch wood
403		(P2 knocked) are all stable. But I am thinking about other patients in, the around in the team which aren't urr,
404		at the moment, there is a sense of foreboding is one of the manager's you know whats going to happen.
405		Are we going to be, are we emm practising safely enough? Err I think we are. Hopefully. Emm, when did
406		I take someone home with me on my mind? I think that has happened over the years lots of times a
407		little bit. Emm, so in terms of risk, I think more so early on when I was less experienced as a specialist
408		in specialist service. But I think the culture in my team is a bit, and I am stereotyping. But urrh I think
409		that an inpatient admission is a failure, emm not I am a bad therapist or we are a bad service. Or the
410		family failed or its just :: you know we do all we can to keep people out of hospital knowing that the
411		best outcome is, if they don't go into hospital. And sometimes it happens. Emm and I think the one

412		you take home, the one I have taken home with me have been the one where, just I work, I felt I work really
413		hard to keep the child out of hospital or to sort of help the parents' help the child to sort of bring it
414		back to you know a safe place, in terms of their eating or just to get a bit of weight on. So that I can
415		start thinking a bit differently. And sometimes you, those are the one you take home. You think what
416		else could we have done. What else could I have done? What's, what could I have done
417		differently. Em why, why that family would had a- early on as, in specialist eating disorders. Er I have this
418		really strong moral dilemma, ethical dilemma in my mind. Thinking oh my god if, if someone more
419		experience in the team had been managing this case may be this wouldn't have happened. And then I
420		a sort of .hhh occasionally think oh, you know is that ethical, is that ethical, how do you learnt as a
421		therapist (laugh) unless you kind of, you know have some families where things don't go so well. And
422		of course, that was fairly irrational because you, you know had brilliant supervision as well, so it wasn't
423		just me. Em but I think those earlier on were the one I take home with me more. That horrible doubt
424		that may be arrh someone else in the team could have done a better job. (Nnh) Em ::: ah but more
245		recently, did you want something recent?
426	R	Well, whatever come to your mind, is a kind I am a :: an audience to your, to your reality, what you
427		remember you know.
428	P 2	Yeah, (.2) I think sometimes emm the one I take home with me are maybe where I done an assessment
429		and I feel like I could done a ^better job. Emm◦
430	R	Would any of the race ethnicity culture come into mind, you know like its like ahh?
431	P 2	Err, I, I remember (.2) I remember a family emm ::: Vietnamese family ::: err where I felt. It's quite a
432		while ago actually. The girl was really mature :: thoughtful. I think she was > about sixteen. Emm ::: and
433		her Dad wasn't around, that she lives with her mother and her older sister. And her mother ab - well
434		the story was that her mother wouldn't accept that she was, she had an eating disorder. Emm and
435		I worked, I hope I was trying ( ) very hard in the <u>right</u> way to negotiate with the girl to let me meet her
436		mum. Emm and I think I took that one home. Oh, hang on something happen (click the computer)

437		EMM I think I took that one home because I never quite felt that I done justice to it with the mum.
438		Emm, the girl got better but it was more under her own steam. You know, ( ) it was that judgement
439		about was it, should I be listening to the child and you know absolutely taking for granted what she
440		was saying about her mum inability to see it from anyone else's point of view and, and not to accept
441		they're you know that this eating disorder is something she could ^help with. That's what I was trying
442		to get the girl to (Nnn) work with me, to think about. Could her mum be helpful in an acceptable way.
443		And also overcome, may be some you know I, I, if I could make er some sort of relationship with the
444		mum. Could I you know, be helpful in helping her to understand her daughter's dilemma and
445		difficulties. And I just never never got through to any point where I felt that I done that justice. (Nnn)
446		and might be that particular mum was very you know, stuck in her the way of thinking^. Or it might
447		be the girl was, also may be sabotaging it. And didn't want the mum talking to me. I don't know. But
448		anyway, she got better. Emm but I, I remember a time feeling
449	R	How old is this child? You know (sorry) how old is this Vietnamese child is?
450	P2	How old is the child? (Yeah) She was about sixteen.
451	R	Sixteen, yeah.
452	P2	Sixteen and emm, she did get better. She recovered emm and we had lots of conversations about
453		what she imagine what her mum would think of her. What was the beliefs she thought her mum had
454		about what she was struggling with. Emm, I don't feel I really manage to understand it. Because mum
455		wouldn't engage and the girl was guessing a lot. I don't think she has a particular good relationship
456		with her mum. Emm, just trying to, actually more like a social work job to be honest.
457	R	Okay, did did the mum ever come then?
458	P2	Emm, she (.2) came once.
459	R	Okay.
460	P2	She came once and it felt as though she was checking me out (all right). And then, she didn't stop the
461		girl from coming. Its just, I couldn't convince her that there was something may be helpful. She could
462		be doing or if you know, we could work out what else she could do to help her daughter or she might

463		have questions, and and so a ( ). I think in my mind I was thinking what's your belief about professional
464		help as well. Is it, you know and and, try to have those conversation with the girl, and the girl was
465		quite clear that yeah, her mum just ^wouldn't understand (laugh). That seems so unfair on a mum
466		bother to come once, and (yeah) I felt a bit as though I hadn't really manage to engage her in a
467		meaningful way. In ::: any shape or form. But it would have been really helpful, em to understand
468		a little bit. If I could asked her a little bit more about race and culture. I don't feel I even got to that
469		point where its an acceptable thing to ask because mum was just ::: yeah, I, whatever I did it wasn't
470		helpful for the mum.
471	R	So this girl is in your so call the later phrase of like therapy zone.
472	P 2	She ::: didn't stay in therapy for very long. She resolve things pretty quickly and she wanted to move
473		on as soon as she was better. (Yeah) And as soon as she was weight restored, she wanted to move on.
474		And this was sometime ago, emm (.2) so yeah. She would have been, I would have seen her early on.
475		She came to the assessment on her own, which is unusual for our service. And so that right from the
476		outset there were conversations about that. And about why her mum wasn't there, whether her mum
477		would be able to be more helpful in understanding if she were part of the process. So it took quite
478		some time to get the mum in. Even that one time
479	R	So who does the meal plan and feeding for this girl?
480	P 2	Well, she did it for herself.
481	R	She did all for herself, whereas the model would say empowering the parents? Is that right?
482	P 2	Well, we don't, we don't call it that at the (service name)
483	R	All right, okay. (laugh)
484	P 2	Well, we don't ( ) we we been, it is a different conversation. But for few years, we have been thinking
485		about not using that language anymore (right). About referring emm (.2). Certainly yeah, we would
486		want (.2) ordinarily for the parent to be in a position where they could support their child to eat.
487	R	Right, okay.
488	P 2	Emm, but you know there is also a real belief in our team that you, you know if that isn't going to

489		work. If that is not, going to fit for that child or that family then you have to find another way. You
490		don't give up trying .hhh because you want, you know you want to explore why mum isn't there (nnh)
491		and why the child doesn't feel that they can depend on that parent. And we think a lot about
492		attachment and trust and all of those things. But in that case, I think there was also considerable of
493		what cultural beliefs are there, that you know, may be emm ::: in the mum's mind about you know,
494		you go to a doctor, the doctor makes you better. Emm and you know, I wanted to sort of explore
495		that. Because I might have been making a massive assumption about that. Emm :: yeah, sorry I am
496		rambling again (P2 giggled).
497	R	No, no, no. It's its its er it’s the, it is fascinating you know when family present themselves in all sort
498		of (yeah) situations you know.
499	P 2	^YEAH and also I think there is er ( ) I ab absolutely believe that emm you know, part of your judgement
500		with that, with that child for example she was incredibly motivated. She was bright, she got herself
501		on track. She wants to go to university. Emm that was what her focus was. She wants to do it her way
502		and it absolutely fixed for her. You know she gone down a rabbit hole with weight loss and she
503		manage to get herself out of it. And it felt as though :: that was a massive strength of her. And that,
504		that's what she, the way she wants to do it. And the way she, the only way she believes she can do it
505		was on her own. And that, you know having met the mum I think. I could sort of understand why^.
506		You know that was the way, you know people in that family operated. They were self- sufficient and emm
507		so yeah you go with each different situation. You don't put a template on people and expect them
508		to form that shape you know. You have to work out what each family needs which was again, get
509		going back to what I am saying about race culture ethnicity and eating disorder treatment, is that
510		because that's you know you are absolutely doing it with each family and learning about them.
511		And (nnh) ::: valuing their views and beliefs, and seeing how that fits the model, rather the model,
512		having to be a template. Does it make sense?
(55.0 4)513	R	Yes, yes, yes. So.hhh if I just check, move, ask another question about something about NICE guideline?

514		So, can you tell me a situation where NICE guideline been helpful or restrain constraining? Err in
515		race, ethnicity cultural practice?
516	P 2	NICE guidelines (yeah) Err hhh. ( ) to be honest, I never put the two and two (P2 laughed) things together.
517	R	Haha.
518	P 2	Em, that is really, that is a lateral question for me (P2 laughed). It shouldn't be, may be Urr, only. I mean this is really
519		(.2) sort of fringe thing. BUT you know I thi::nk NICE guidelines were recommended, you know (.2)
520		doctor using Marzipan. We use Marzipan to, sort of work out risk. Emm and I think sometimes
521		assuming that sort of percentage weight for heights are not variable, across different ethnicities.
522		Emm that is really fringe (P2 laughed). I mean I don't know. I don't know
523	R	and if You move away from eh risk, generally like the NICE guidelines have got certain, or
524		recommendations that they, it made. You know, have they been useful or helpful in race ethnicity and
525		culture in the field.
526	P 2	Well, only in as much as for child and adolescent eating disorders FT-AN is recommended, for example,
527		for anorexia and FT-AN model absolutely pay attention to emm understanding the each individual
528		family and their beliefs and their strengths and their resources. So in a way, that's that's helpful (Nhh)
529		depends on how people interpret what they read in the manual. Or what they think FT-AN is. I mean
530		I think there is a real discourse about emm, certainly in our service about the differences between
531		FT-AN as a practice by family therapists and FBT as practice by other people may be in the States.
532		Emm in different context. Emm who haven't got systemic background or systemic supervision or
533		systemic ethos in the team. Emm because that can be used if people are interpreting the NICE
534		guideline as FBT, then I am not so sure that is much attention is pay to those things if they are following
534		that manual to the letter.
536	R	Nnh (clear throat) so you think it is quite helpful because it invite the attention to race ethnicity culture?
357	P 2	Well, I don't think it is doing that overtly. I think that would be overstating it. I think in as much as
538		there is a emm (.2) a real understanding (R coughed) we need to understand people's beliefs
539		we need to understand each individual family, we need to understand their strength and resources.

540		And their emm, yeah.
541	R	So the FT-AN model when you work you know, emm are they only systemic therapists, family therapists
542		doing it? Or likely to (ah) is a multidisciplinary?
543	P 2	Yeah, its multidisciplinary team but there would be err systemic supervision of that and they would be
544		systemic groups, plus supervision emm, ↑OR THOSE ACTUALLY it is not true, some psychologists have,
545		they would have their psychology supervision but its talk about in case discussion you know. They
546		would have been trained in FT-AN. They will be surrounded by other, you know family therapists in the
547		team. So yeah, its mdt approach, anyone in the team in the outpatients service would be delivering it.
548	R	I am hearing your description and I am just wondering would that be any kind of different description
549		in your team that you think might be around? Or none (laugh)?
550	P 2	Description on that in particular.
551	R	On the NICE guideline you know.
552	P 2	(.4) emm, I don't think. ^I don't know :::. I (.2) I am feeling I am, I feel like I fail this question Charlotte.
553		(laugh). I know you want
554	R	No, no, no. Not at all, there is no fail. I was just [thinking, you are describing your experience. I was
555	P 2	[I know, I know
556	R	just, one of these other questions do you think there might be other people have a different experience.
557	P 2	Its might be people who read the letter of NICE guidelines and remember something that I am
558		forgetting (both laugh). It was part of the problem. Emm I think I ::: yeah I can't imagine what other
559		response people would give.
560	R	That's okay. You know when I ask it doesn't mean there is something there you know.
561	P 2	Yeah, yeah, yeah.
562	R	So, I think when we first started I was asking you, can you describe a case that you worked with, that
563		kind of where race, ethnicity and culture were central? I wonder you know like if anything pop at the
564		back of your mind, as we were talking?
565	P 2	.hhh Well it depends what central mean you know the the patient I talked about the Kosovo girl or
566		the mother who was from Kosovo. That was central because the whole way that, that mother was

567		viewed was, because of assumptions that (sure) ◦made about her (hnn). And the patient who had to
568		be admitted to hospital emm, was it race that was to the fore, actually no. It was mental illness that was the
569		fore in that situation with you know that the possibility had I managed to. You know had, had the
570		patient remain in treatment in our service and the mum had become well, and the girl become well.
571		I, no doubt it would had been something we might have talked about. But we didn't because she you
572		know, she had to go under a psychosis service and so we didn't see her from then on. Emm, so nothing
573		have come back to mind. Apart from the Vietnamese girl em (Hnn).
574	R	That's okay.
575	P2	Beat myself when we finish this conversation.
576	R	I know that’s how it feels like, and that's okay. I would say a bit more, you know like if anything you
577		know, you come up in your mind you can just let me know. Its okay.
578	P2	Okay.
579	R	And emm, if I just ask what might be the dominant discourse that, about race ethnicity and culture
580		that you hold professionally.
581	P2	That I hold professionally?
582	R	Yeah, yeah. The dominant discourse about REC in your, eating disorder field? About race ethnicity
583		and culture?
584	P2	Emm, I don't know if I understand the question right. Tell me if I am, if I got the wrong ::: end of the
585		stick. When I meet a family for the first time, I am assuming they are making assumption about me
586		and they are assuming that I am making assumption about them. (hnn) Emm, and that sort of assume
587		differently is, you know doesn't make that happens because we all do that and matter who who
588		the persons we are meeting for the first time. But if my culture is different from that family, then I
589		think you have to keep it in your mind that something that may be important to think about with the
590		family but that you are going to sort of store it somewhere as a therapist. Emm, and think about
591		when is it going to be appropriate or necessary to prioritise that. Emm as a focus or ahh a topic of
592		conversation. Now, you could argue that whose to say its your decision of therapist whether it is a

593		topic of conversation but you know we making those judgements all the time as therapist. With
594		, we can't deny that you know, less or greater degree with, we are dictating the, the conversation. We
595		are in a position of power. They come to us, WE conduct things and you try and adjust
596		that. You try and get to a position where the family conducting things that make sense to them. They
597		conduct in the session at a certain point. .hhh Emm ::: so I think in my mind, it, my belief is that its
598		something you have to think about you can't pretend that I understand you or you understand me
599		unless we have a conversation about it. If we don't have a conversation about it you may be missing
600		something really really important. You might label under misapprehension, you might get something
601		really wrong. And you might miss strength as well as fragilities and diffculties.
602	R	Nnh, Do you think this idea has changed since you join the eating disorder field? (.2) Or did that
603		develop since?
604	P2	For me.
605	R	Yeah.
606	P2	(.4) Not in that respect, no. I don't think its changed. Emm, I suppose I have to be honest, things has
607		become err less to the fore because in team. Its ::: is not prioritise as a topic of conversation but
608		certainly personally, professionally is something I try, and to bear in mind. And I will certainly talk about it
609		in supervision. Emm, so and also because, yeah, ten twenty years ago it would have been far more
610		to the fore because I wasn't an eating disorders service. I would have been, it would have been more
611		of a topic of conversation because my caseload would have been far more, emm that would have been
612		far more people who would different, different you know in terms of their cultural, ethnic background
613		to me. Emm, now I don't know, probably anyone time, there will be may be ten percent of the people
614		we see who would. Emm, but then you know (P2 laughed) I would say everyone is different you know. But race and
615		culture yes. I think its important absolutely, to acknowledge a difference in your mind and overtly
616		sometimes and certainly in supervision emm it comes up (Nnn) for the family◦
617	R	So, I was just thinking about how would that conversation (.2) with a family in your initial phrase where

618		they come in to restore weight, how might race, ethnicity, cultural attention to these families might
619		look like?
620	P 2	I think right from the beginning there may be acknowledgement of difference in terms of you know
621		weight, and discussion about family members and you know sort of, emm (P2 hissed) that would be more
622		from a physiological point of view with one of the doctors but then in terms of food and eating fairly
623		early on as a therapist. I might be saying you know what the routine with your family? Do you all eat
624		together, do you tend to cook food from scratch, you know tell me, tell me whats like, what is going
625		to be like trying to support so and so to do this. Emm, I need to understand what is like in your family
626		so that we can work out whats going to be most helpful. Emm so, now if that's, if a family then saids Oh
627		you know, we cook from scratch, and I cook food that you know, our family has always eaten and
528		family food that I eat as a child. Emm, I want to make it absolutely clear that, that's great (P2 laughed).
529		And that's what we want to support because you know we are giving far fewer meal plans now. So the
630		sort of message we want to give is you know, you know how to feed your child but we have got a
631		meal plan, is this meal plan going to fit for your family or is it too different. If it is too different, would
632		you like some help from the dietitian to think about the things you generally want to feed the child. And
633		we will see if emm, we can help you work out what they need more or less of. Emm, so from the
634		beginning there would be practical conversation around it.
635	R	So it is about working out differences than help?
636	P 2	And ::: NNN ^no, it is more about working out, emm how things work in that family. And what do they
637		do. What are the practices in each family? Its not just if there is a difference, is that each family you
638		want to know. Because you are looking at the real practical tasks of eating and food and how that
639		happens in any family.
640	R	Kind of strengthening them.
641	P 2	Absolutely, and making sure that we are not imposing something just will never fit or make sense,
642		or work for that family. So it has to be, you have to have that conversation. Now, I guess I might make
643		more assumptions unconsciously about a white middle class family which would be totally, that would

644		be foolish. But that's why I say you know, generally speaking you are having that conversation early
645		on with every family. Em (Nnh) because every family has (P2 laugh) their own way of doing things.
646		AND YES it would be about looking to see where the strength are but also where it can fit with a child
647		being fed enough. And in a supportive way. Emm it wasn't too different. Emm to what they know,
648		what the family used to. What the norm is for that family.
649	R	Nnh, that's very useful to hear that. And so just thinking about the experience of being interviewed?
650		you know, can you tell me what, how it feels like to you?
651	P 2	Emm, so it feels nice to be asked questions (P2 laughed) and to have to think about something like this
652		because I feel like I haven't thought about myself as a family therapist. And the way I think for a little
653		while. Apart from in supervision. Emm it makes me think I need some more about it. Emm, it makes me
654		think I want to talk (name of supervisor) who is my supervisor and think with her a bit more about it.
655		Emm.
656	R	What might be the first question you would like to talk to her about? If I may ask?
657	P 2	Well you see this is interesting, so she is Black African woman. Emm, and thinking, this is not her
658		responsibility to be thinking about these things as a team. But I am genuinely intrigued to see what she
659		thinks about the general discourse in the team about race and culture (emm). I th::k, YEAH I can't
660		predict what she would say about that.
661	R	It is okay, I was just thinking about spontaneous, after we just have this conversation and what,
662		how you feel? Yeah. I was thinking about, sorry
663	P 2	I was just going to say I think again I can't get away from this extraordinary situation that the whole
664		world is it. And thinking what are the, are the wins and the losses? I think one of the loses potentially
665		is, if we are not careful. Some of the emm, some of the things were not, we may be fallen into a pattern
666		of not paying attention to it enough. That, that would get worse. (nnh) Because it is difficult having
667		new ones to conversations, emm over video with a large team, emm so there is potential for
668		something to become even more subjugated.
669	R	Nnh, now the online become err demanding attention
670	P 2	Yeah.

671	R	And then, am I understood what you are saying?
672	P2	YEAH, its partly that but its partly about HOW does conversation happen and this is not a natural way for
673		a conversation happen. IT WORKS, it could work between two people. I feel like it has sort of work as
674		a conversation between the two of us. But, throwing fifteen other people, twenty other people and
675		you know its that free flow doesn't happen in the same way on Zoom. There is going to be losses.
676		We just have to be more creative and work out.
677	R	And acknowledging yeah.
678	P2	Yeah
679	R	So the other question I was trying to ask is your experience of interview by me who is someone with
680		a different race, ethnicity and culture from yourself. (Emm) I wonder how it feels?
681	P2	(.2) I think, I am probably doing the same thing I do whenever any work are talking about me personally if I
682		with someone where I assume there is a difference race or culture. Emm there is a bit of me that
683		thinking urr. How did I, did I phrase in ar appropriate way. Emm, (.2) but that's only right at the start and
684		then that become less > in my mind. And of course you are doing research, and you are a sort of a peer,
685		Emm, so I also thinking what judgement you are making. So you know
686	R	I hope that my overall context is not judging. You know.
687	P2	No, no absolutely. It was nothing you were doing, that was coming from me Charlotte (both R & P2 laughed)
688	R	So, yeah, I am just thinking about these conversations we have. Can you tell me how
689		this interview make you feel about race, ethnicity culture in your current practice?
690	P2	Emm, I think it was helpful to bring it to the fore to think about and to acknowledge it is always in
691		my thinking to a lesser or greater extend but maybe it deserves more attention, and may be (.2) I need
692		to look at more of the research. And think about it again. And talk about it more, and talk about it a bit
693		more. Emm, so yeah that is what it brought up for me. It's a good reminder, it’s em, its important ahh.
694		So the interview has sort of reignited em sort of curiosity about all of the things we talked about.
695	R	Nn Nn,
696	P2	But particularly in eating disorders.

697	R	Do you think that there is something about eating disorder and race ethnicity culture because I am
698		particularly looking at this intersect (nn) you know where they cross over. Err kind of like what might
699		be the biggest challenge for that?
700	P 2	Well is it a copt out to say, you know going back to what I was saying earlier because that it is, is it?
701		This sound terrible, I was going to say is it a niche interest, you know, it is a tiny proportion of young
702		children and adolescents will get an eating disorder and even tiny proportion will be from emm black
703		ethnic minority groups. Should you, your interest em related to numbers? Because the impact is the same
704		on each individual young person. Emm but it is made me think about that tension you know between
705		research, knowledge, interest. Is it because you know the vast majority of professionals working in
706		eating disorders were the one whose doing the research? You know white middle class professionals
707		(P2 phone ring) Sorry I need to just decline it, sorry. Emm (.2) sorry I lost my chain of thoughts. Em.
708	R	The interest of the researcher, I think you mention.
709	P 2	.hhh. Yes, I forgotten the question (P2 laugh) sorry.
710	R	(.2) I was just thinking the biggest challenge between eating disorder and race ethnicity culture practice.
711	P 2	Oh yeah. So yeah em .hhh there is the small number and the fact that you know. There is just not enough
712		known emm about anything to do with eating disorders, let alone the impact on young people from emm
713		(race ethnicity and culture) Yeah.
714	R	Would you consider two white people talking they have different cultures?
715	P 2	Yeah, yeah (so) <u>BUT BUT</u> I don't know that the other people would agree. I mean I :: each family have a
716		different culture. Each individual has a different culture. I mean everyone has a different culture. So
717		I don't (.2) yeah, yeah BUT two white people talking about culture, unless there are you know, other differences
718		in term of power, they will not be a miss match in terms of what attention is pay to
719		their experience of an eating disorder as suppose to err a white family and a black family talking about
720		it. We are still living in a culture which, where some members of our society are not attend to in the
721		same way. And that does have an impact then on their beliefs about (P2's phone dinged) what they emm

722		yeet, what ::: whether they receive mental health treatment, feel that their community suffers from
723		those problem as well as white community because they are not represented in the white people
724		talk about it.
725	R	Err, the whole historical context behind is very different. Yeah
726		Thank you very much for giving me the time and letting me asking you all sorts of questions.
727	P2	Pleasure Charlotte. Em how many people have you interviewed now?
728		
729		Interview 2
730	R	Okay, again this is emm, emm it is about your experience you know, so your view, there is no right or wrong.
631		Everything you say will be confidential and anonymised you know, just to mention that before we start. Emm, do
732		you have any question before we start.
733	P2	No, emm, willing to see where it takes (P2 laughs).
734	R	Go with the flow (R laughs). Okay, today emm my main focus is to ask you about err your personal experience of
735		food, eating and feeding as someone working with eating disorder service you know. So err if I kick off, just ask you,
736		you know, can you tell me your experience, what is your experience of food, eating and feeding.
737		Emm, I guess I err, I grew up in a family where :: there was very much emm a second world war attitude to food. So
738		my parents were bought up as children in the second world war when there is scarcity. And: there was an
739		attitude that you ate everything on your plate. Emm, and : the most part that was fine. Emm, I do remember
740		sitting in front of a plate of smoke haddock for several hours because I hate fish. And my grandfather sneaking into
741		the room and eating it for me. Emm, because he could see I was, you know I just hated the taste. But there was
742		no emm. Yeah, my parents were, when I was well, I didn't always live with both parents. But while I was
743		little. I live with both parents and that was very much the attitude that you don't waste food and you eat whatever
744		you were given. And we had a good range of foods. But I just hated fish, but there was no sort of allowance for
745		that. Emm, we don't have fish often but emm, and then that I think my father was very influence by my,
746		and arr emm, and emphasis on good food cooking. Emm, so I always had food cook food. And it was a bit
747		disrupted by :: arr :: yeah, parental separation and divorce. So I remember period of time when my grandmother live

748		with this because we stay with my father. And that was lovely because of, I love my grandmother's food emm.
749		And then we had a housekeeper for a while and I hated her food. So the meaning of food was, for me as a child
750		was very much about familiarity and belonging, and emm not having food I like seem to sort of emm, ehh,
751		intensify a sort of loss around my mum not being err at home anymore. So it is, yeah strong emotion
752		food (nnh) and I took some of my beliefs to my parenting, with my own children. Sometimes I regret a little bit.
753		But I certainly wasn't a mum who is going to prepare different meals for different children. I wanted to tailor it
754		so that everyone would eat the food. And I try to avoid preparing, I knew my children wouldn't want to eat. But
755		they, they ate well and so, I think it was only later when they were older teens that they were able to say they didn't
756		like the fact that they had to eat everything on their plate. They sometimes felt that they were given too much.
757		That of course made me feel a bit guilty. Emm, but : yeah, emm (.2) but in terms of eating. Did you ask about
758		eating disorders as well, so.
759	R	We will come to that, but at the moment I am just kind of interested in your personal experience about food,
760		eating and feeding you know. (nhh) and I was just thinking about when you talk, say about familiarity and belonging
761		emm, can you say a bit more about that? You know.
762	P2	Yeah : I think there may been a bit snobbery around that certain thing had to be made in a certain way. And,
763		not snobbery but no, its familiarity, so I, as a family I always felt you have to had THICK gravy and that thin gravy
764		was somehow wrong (P2 Laugh). And emm Yorkshire pudding had to be separate and my grandmother, my
765		adore grandmother used to make separate Yorkshire pudding and my less like grandmother used to make one
766		big one. And I just remember real likes and dislikes, and feeling that there are certain ways of doing things.
767		Emm, so my grandmother cook on an aga, she lives in the west country. I love that country cooking and my other
768		grandmother was : just not a very cook at all. And so it, there was emm (P2 hissed) its, it, I think for me growing
769		up, food was just really important in having a sense of belonging and feeling comfortable. Emm, feeling out of
770		my comfort zone if emm, I was being cook for my another sort of parental or grandparent figure. And it wasn't
771		quite right. Emm, I wasn't fussy, emm I eat anything except fish. Emm, but, its I suppose family meals were also
772		sometimes (.2) quite hard emm, sort of there was tension around in family meals, sometimes. Emm, so real

773		mixture of comfort but also a bit of distress, sometimes about the emotional atmosphere at meal time. Emm,
774		because we are big family. Emm, yeah things got play out I think around the meal table. We always sat down to eat,
775		emm you weren't allow to ate on our laps. Emm,
776	R	You mean your own family origin or your own family?
777	P 2	Both (both) both actually. Yeah my family of origin and my children when they were growing up. We would
778		always eat together. .hhh and now I think : that yeah quite often we will still meet. My children are growing up now
779		so they are adults. But going out to eat or having them come home to, for a meal. Emm, it's a nice occasion, emm
780		mostly. So I think I kept that sort of sense of eating together being an important time to come together as well (nnh).
781		And food is very much part of the way we would celebrate things as a family (nnh). Yeah (.4)
782	R	Are there any aspects that might be sort of culture specific, I haven't heard your mention culture in your food then.
783		Did I miss that or?
784	P 2	NO, I don't think you missed it. I, I, I sometimes struggle where the cultural compass is on my family's attitude
785		to food. But I think there, going back err err going back couple of generations it would be, would have been err
786		<u>rural</u> <u>English</u> <u>farming</u> emm culture where, you know you eat what you grow and you eat what the animals you
787		rear. Emm, that would certainly be on my father side of the family. Emm, a very sort of, an, an in fact on
788		my mother side of the family as well. They rear their own chicken and geese, and grow their own vegetables but
789		they lives on the outskirts of emm (county). Emm, so its, and they were very working class. And my parents were
790		sort of, they became very middle class. So middle class, English attitude to eating. My mum was a really good cook,
791		she still is actually. Emm, so there was a very middle class attitude to .hhh cooking you know. French cuisine
792		and things like that. She really enjoys cooking. Although, we will come onto eating disorders but emm there was
793		a bit emphasis on it when my mum cook for us. But I didn't live with my mum from about the age of five (nnh)
794		when my parent separated. So my dad <u>like</u> cooking, he would cook for us at the weekend when he was not working.
795		Emm, and then there were remarriages, so there were emm different mother figure then who came in and cook
796		their way. And I really <u>hated</u> the way my stepmother (P2 laughs) cook. Emm, so there is a lot of emm (p2 hissed)
797		longing bounded in food. You know that, you, having to get used to someone else's way of doing things (nnh).

798		Emm, it is hard. And it really exemplify for me that, that loss. Emm, not having familiar food that my mum would
799		have cooked or my grandmother (nnh) later on.
800	R	And feed by stepmother who has a very different style of doing it.
801	P 2	YEAH, and, and then would, when my half-brother came along she would buy special food for him that we weren't
802		allow to eat. So that was really hard, so he would have these treats that, that the four of us who weren't her
803		k
804		was for him, we couldn't have ribena, we couldn't have his peanut butter. It was very strange, emm quite hurtful.
805	R	Yeah, there is a lot of emotion, hurtful and (yeah). How do you make sense of it now as an adult? I just wonder.
806	P 2	Emm, (.2) I guess my stepmother I think you know, she came into a family of four children who were missing
807		their mother (nnh) and she try to do her best but she became probably a bit of resentful I think. And then her
808		own child came along and that was the apple, he was the apple of her eye. I mean he is a lovely lovely person
809		(P2 laughs) he is just you know. I love him dearly but he was the favour child. And she didn't manage that very well
810		at all. She didn't, I think she was probably unhappy as well in her marriage to my dad. So, you know it probably
811		spilled out in her attitude towards us as children. And we were, we were probably angry frustrated sad children
812		who weren't very rewarding for her. It wasn't sound of music, that’s for sure (P2 laughs) you know. We were emm
813		yeah, we been through a lot.
814	R	Nnh, and one thing play out is the Ribena that allow to one kid but not the other.
815	P 2	Nnh, yeah, I mean I er just, we accepted it. We were angry about it, and we couldn't make sense of it (nnh) why
816		someone would do that. We, we you know, we knew inherently that was unfair and I suppose I was very angry
817		with my dad. Because he knew and he didn't seem to challenge it as far as I know. I wasn't aware of him
818		challenging it. Emm, I think he, looking back I think he chose a partner who would look after his children. So he
819		could carry on with his career. Emm, yeh and she did her best, bit it weren't very good (P2 laughs).
820		Sounds like, it is sort of like .hhh, how, how do you feel talking about it now P2?
821	P 2	Emm, sad, churn up
822	R	Yeah, the, the food conversation, sounds like food connect with a lot of memories and emotions.
823	P 2	YEAH. Definitely and I think the, may be the strongest one my grandmother, my father's mother was just such

824		a loving woman. And yeah, I, I wanted to go and live with her when my parent separated but that wasn't, you know
825		he, my father, he didn't want to split the children up (nnh). Sometimes I wonder you know what, what it would had
826		been like if I had stayed in, you know with my grandparents. But that was not about food, but the food is in there
827		definitely. I mean I love go an visit them and, and err (.2) you know my grandma only had a small range of things that
828		she would cook but they were all delicious to me (P2 laughs) you know. They really felt comforting and emm it
829 (12.1		was her expression of love to people cooking for them (nnh). Yeah, so it is very emotional (P2 cries) much more than
830		I would.
831	R	Yes, Yes (.2)
832	P2	I am okay (P2 tries to stop crying)
833	R	Take your time, I think we will go with your emotion you know, not just because I wanted to do a research.
834		Sometimes we don't know what, what we hit when we ask a question. So
835	P2	Yeah, yeah, I am okay (.2) I am happy to go on.
14.47	R	I am just thinking about the significance of your experience, err with food, feeding and eating, what is the
837		significance of food for you then, just thinking about food and feeding.
838	P2	The significance, there are so many layers of significance. The significance in them working in an eating disorders
839		service where you are constantly talking about food. And seeing distress young people and distress parents (nnh)
840		So, that's that layer and then…
841		Line 840-842 deleted at P2 request
842		…And I, I, a sibling who
843		develop anorexia as a child, as an older adolescent as well (nnh). I didn't seek out working in the eating disorders,
844		it <u>sought</u> me out (P2 laughs). I sort of avoided it really. Emm, but now you know, apart from this year, I :: is the
845		best job I had, but emm so its, its complicated. Emm
846	R	Nnn, I guess what I was about to say what it means to you, and also the next question I was going to ask is like
847		how does it show in your work in eating disorder, you know having a big experience of like your personal growing up,
848		and then your, you mention your father and your sister's experience you know. Family experience, I was just
849		thinking about how, how does it? Perhaps, first of all, the significance of it on you. How do you feel, feel about that?
850	P2	I think when I first started working in eating disorders, that I think I reflected a lot on you know, what it meant

851		for my sister to have an eating disorder (nnh) and actually finding resolution and recovery without treatment.
852		And just being amazed how, how she got herself out of it. And wondering how that happen you know. When you are
853		working in eating disorder, you have patients with anorexia, you, you don't know about the one who have it and get
854		better without treatment (nnh). So I often wonder about that, what you know, there are many people like that.
855		Emm, who manage to bring it back from a really bad place. And and (.2) what else, in some ways, as time gone on.
856		And that's nine years ago that I started working in eating disorders. NOW I barely think about it, you know my sister
857		has been well for many years, has four children, you know she got over it. Emm, I think it was just when I first started,
858		it make me more about that, make me think about what emm (P2 hissed) what my dad had made of it. Because by
859		the time she got better, she had gone, she left home. She was a medical student, emm she had been unwell for
860		a short while at home. Before she left home, so I wonder about that. But I don't, it doesn't preoccupy me NOW.
861		I think the significance of my experience with food in family, and with work is. I think I, I, it, it, I don't know if that
862		has that much influence. I think I, I sort of rely so heavily on, the model of treatment that guide me to help people, to
863		you know overcome it. But in some ways, you know every family is different. And my experience is, doesn't have
864		much bearing on it. You know, I have to understand each individual family experience of food and eating, and how it is
865		done in their family. I suppose sometimes I might feel a little bit emm curious or frustrated when I come across family
866		with really emm you know with very different attitude towards it. Emm, but I honestly think I, I see each family and
867		try and work out what it means to them, in order to understand them and make you know. Put together some sort of
868		collaborative plan, that make sense to them and their beliefs (nnh) and or, try and be curious about their beliefs and
869		talk about their beliefs so that we bring those to the fore. So that you know, emm I am not assuming that people
870		have the same attitude towards food as I do. Emm, or you know everyone is different and every family is different.
871		(nnh) Emm, but may be influence me more earlier on when I was learning how the model works. And how I was
872		going to be as a therapist. I am just trying to remember back and think, did that influence me? I suppose I might have
873		had more of an attitude you know, you should sit down together but I don't think necessarily I did. I didn't think
874		that was necessarily how meals had to be in every family. Because it just doesn't work like that for some families emm

875		I think I probably identify, sorry (no, no, no carry on) I just going to say I think I identify quite a lot with the emm
876		the intense emotions for mums who is, and dad whose children refuse their food. I can't imagine that must be like,
877		I try and imagine what that must be like. Its such a rejection .hhh emm, and the terror it causes. Your child starving
878		and (nnh) and not have experience of that. Emm, yeah.
879	R	You mean you don't have the experience of mum and dad watching over you eating.
880	P 2	(.1) I do have experience of that I suppose but not in the same way. Yeah, the expectation that I am going to
881		finish as a child. I have to finish what was on my plate (nhh) for my own, most part I just accept that, that was
882		what you did. You didn't waste food, so you ate it. When it is fish (P2 laughs)
883	R	Or someone watching over your sister to make sure that she finishes her plate
884	P 2	Well, no. I don't, I don't remember what happen. I don't remember what happen. I think when she was unwell.
885		I think it was, it must have been so close to the time she was leaving home that, it. That wasn't, my memory of,
886		I have no memory of my dad trying to get her to eat. Emm, I think she must have left home actually by the time
887		she was really unwell or she was becoming unwell. Emm, actually I remember something else I remember one summer
888		when I was about fifteen or sixteen, my dad went to a conference in (foreign country) and was gone because he was
889		going make it into a holiday as well. He just left us at home which, we were quite please about emm, and I stop
890		eating (P2 laughs) I just I don't, I don't think. I think I miss a bullet I think I doge a bullet. I think I just didn't quite know
891		how to look after myself properly (nhh). So I think I, it was classic I forgot to eat because I was having too much fun.
892		Because I was having my friend round to the house, having parties (P2 laughs) emm having a great time. And I just
893		didn't bother factoring in food. And then I remember a friend just say, you got to eat and, and a friend making
894		me eat. Emm, by that time I think it has gone on for quite a while. And I remember I lost weight and I remember
895		find it really difficult to eat again (nnh). Only take dry toast and gradually build up emm, I honestly believe that
896		either, I mean (.1) I don't think it was to do with developing an eating disorder but it could have done.
897		I think I got the genetic predisposition, I think my mum was probably anorexic as a child as well. Emm, so yeah,
898		I forgotten about that.
899	R	So I am just wondering your decision to come in and work for eating disorder. Was it a big decision or how

900		would you describe that (did) how did that happen?
901	P 2	I resisted it for a long time. I, I, so I been working. I was a, a social worker in (area). I was doing child safeguarding
902		and I was finding it. I done it for about ten years, really growing to hate it. It was very, I was unsupported and it was
903		just scary work. It was horrible. Emm, and then there was secondment to do therapeutic work for (area) social services.
904		So I apply for the secondment, so it was a team that work systemicly. Emm, they were looking for someone who
905		is interested in systemic work and have a child safeguarding background. So I got that job and then, sorry, this is a long
906		explanation but I feel like it is relevant. The, as soon as I join, the, there was a decision that, the work
907		they were doing was too similar to work that was being done in CAMHS. And so they should join together. So
908		then I found that I wasn't working for social services. I was still employ by them but I was working in (area) camhs.
909		And then in (area) camhs, I decided I wanted to train as a family therapist. So I started my training, and then
910		towards the end of my training, (name) wanted me to apply to do a research job. Emm around (mental health) so I
911		got to know him. He was supervising me when I was doing the (mental health) trial. And then, job came up and I was
912		encouraged to apply for it. Emm, yeah, so I apply for it and having seen jobs advertise in Eating Disorder service and
913		thinking no, no way I want to work there. It sounds awful, I don't think I can do it. It sounds too scary you know,
914		kids starving themselves (P2 laughs) I don't want that. Emm, I had some good friends working there, they said well
915		you would like it…
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917		
918		
919		Line 915 to 923 deleted at P2 request
920		
921		
922		
923		…So it is (carry on) very complicated. It is complicated (P2 laughs)
924	R	It is many layer, different layers of relationship I hear you know. And I am just thinking about what, what, sort of
925		I was asking you about the significance of food and feeding means to you as a person. And yeah, the next question
926		I was thinking is about how do you think that comes into your work you know. And I am hearing you say,
927		put yourself aside and you focusing on what the family presents to you. Is that what I hear?

928	P 2	Yeah, yeah and I suppose that's yeah. The only time I felt I had a different take on it, is when I, I, I put on a lot of
929		weight when I had my children (nnh) and when I went to Eating Disorder I put on more weight (P2 laughs). You just
930		talking about food all of the time, .hhh and then I realise about six years ago that I needed to lose some weight
931		and :: it was then when I lost weight I got a glimpse of what it was like to lose weight and to feel, like you are really
932		achieving something. Emm, so that, that was interesting. I felt like I could then see where some, some of the feelings
933		were coming from some of the young people that, you know you are, you are really achieving something
934		and then someone comes along and tells you, they are going to take it away from you. That, you know that really
935		gave me sort of a bit more insight I think (nnh) into what it was like, not only to feel that sense of achievement
936		everytime you stood on the scale and saw it go down (nnh). Emm, but also some of the psychological
937		effect you know, feeling a little bit out of it sometimes when you are hungry. And you are not eating emm, may be not
938		eating sufficiently. Emm, that was really interesting (nnh). Emm, so, yeah it of course you, personal influences your
939		work. But I, I still maintain that in terms of my personal experience of food in eating growing up, its not, its not
940		terribly helpful in informing me about any other family or any other individuals experience of eating disorders.
941		or trying to get better from an eating disorder but only in, I suppose occasional things that happen and you think,
942		that actually, yeah that like losing weight, that gives me a bit of insight into some aspects of what it is like to lose
943		weight.
944	R	So I was thinking about that connections about your losing weight experience and kind of understand how the young
945		person might have experience. I was just thinking about by working with the young people, how does that
946		affect your personal life you know. Just thinking how that, if there is any
947	P 2	I think it is a really hard question to answer at the moment. Because this year has been so difficult to separate
948		work from my private life. I am in my bedroom, emm, working and working more than fifty hours a week. And so it is
949		spilling over into absolutely all of, and I am exhausted emm, I am, every couple of weeks I think I can't go on doing this
950		for much longer (R cough), so emm, then I see a family and the kids doing well and that’s fantastic and its like
951		makes sense to carry on doing it. But I am also trying to manage a team and everyone on their knees. So
952		(P2 laughs) its really difficult you know. If you asked me two years ago, I might have had a different answer.

953		But it is just overwhelming and spilling out to absolutely my whole life (nnh)
954	R	Yes, at the moment is a very tough time, but like to you if I asked you two years ago, you might have a
955		different answer. What might be your answer then, just thinking.
956	P 2	My answer two years ago probably would have been, actually take it back three years before I started being the
957		manager as well (P2 laughs) trying to be a clinician at the same time (Yeah). Three years ago, I would have said it is
958		one of the most rewarding job that I ever done in my life because people get better. Most patient get better and
959		food is magic (P2 laughs) it works you know. You eat and the model works, and the therapy works. And you are literally
960		helping the young person and their family get their life back. So there was nothing more rewarding than that
961		Emm, yes you have cases, patients who struggle and I, you know it's a dangerous illness and some people don't
962		get better. But for the vast majority of your patients they are you know transformed.
963	R	So, I think different role have different experience by the sound of it, from, when you just a clinician to become
964		a manager and now with the context of covid. Its kind of like another layer onto your normal job, normal role.
965	P 2	Absolutely, but my job, my role was always going to be a manager and clinician. And now I am trying to
966		be a full time clinician and a full time manager, and it is impossible, and you know we have over five hundred and sixty
967		referrals in one year, when normally we would have two hundred and fifty. So you know I had to make really
968		difficult decision about who gets treatment and who doesn't. And that's terrible because that was the other
969		thing you know. Three years ago we would accept 98% of our referrals, so we are doing preventative work. We
970		were doing early intervention. We were you know, giving such a good service and we were doing right up until
971		the pandemic. Our resources were a bit low, emm going into the pandemic we didn't have enough staff. Emm, so
972		yeah. Its, its not, I mean hopefully in about six months time it will improve when we recruit more people. We are
973		recruiting people now. So, so now, don't feel, I don't feel resentful, I am delighted that I can still manage
974		just about and treat people and they are getting better still, even people I never met even through virtual working.
975		Emm, I am sort of falling out of love with it at the moment, I have to say at the moment.
976	R	Nnn, just going back to the model. We were talking about food and eating, and when you working with, the significance
977		of it when you working with families in eating disorder. And I am beginning to think about when you talk with family

978		you know when you like, whether it is virtual world or face to face world in the past, what is going on your mind,
979		what, what : are your thoughts and feelings when you talking with families about food and feeding?
980	P 2	I think going back to the model and understand the, the sort of, the core (.1) focus is you know that, without emm
981		without restoring weight no one is going to get better (nnh) you know you have to restore weight first and then
982		you have to make sure that you understand how that is not, how is not going to happen again in the future and
983		obviously that is a simplification. BUT, it means that : a lot of the conversation as far as I am concern is that food
984		is a, it has to be a really functional medicine (P2 laughs) you know. You have to eat in order to live, you have to
985		eat enough to regain weight in order to get better. Emm, so I think (.2) its its (.1) for me it is talking about it in a
986		really functional way (nnh). Because young people coming through anorexia, I am talking mainly about anorexia.
987		They are not going to enjoy food, its not about getting them to enjoy food in the first place. It is about getting
988		them to refed. In the hope that they will get better and they will start enjoying food in the future. And they will
989		develop an appetite again. And they you know, they will recognise hunger .hhh emm, so I think some of the
990		conversation are quite often about that functional aspect of it. And also challenging people's language around it. So,
991		so many parents talk about well, I give them really healthy food. And you say what you mean, whats healthy, because
992		grapes and lettuce you know, they are not healthy (P2 laughs) on their own. Emm, so yeah, I think I have a very
993		functional attitude towards it, with my patients and trying to demystify. Its not about getting exactly the
994		right balance. Its about getting calories initially (nnh). It has to be.
995	R	I mean, on the odd occasion. I am just thinking about will there be family, sort of like finding difficult to take on
996		board about you know, the functional approach or, of like emm (emm) you know some family might say ehh I can't
997		feed him, I can't feed my child because she refuse you know. I can't make her.
998	P 2	Yeah, all of them (P2 laughs) all of them say that. Absolutely, but that's why I was saying go back to the model
999		because it, it work you know. I will, you are setting up all the way from the beginning of the first assessment when
1000		you first meet someone, you are weaving in psycho-education. And letting the family know that you understand.
1001		But also letting the family know you have to take an expert position and letting the family know that you know that
1002		this child needs to eat. And yes every family feel its impossible but it is possible and I am here to help you MAKE it

1003		possible. Emm, so we are even, I have done you know testing out virtually, getting them to go to the kitchen, by
1004		get a glass of milk and a biscuit and bring it in front of the camera, and the child has to consume it. And it is
1005		amazing you can do it virtually (nhh). And show a parent that their child can eat, and they can help their child eat.
1006		And its not me making them do it, its their presence and their encouragement and their insistence and their love
1007		and concern, that get them through it.
1008	R	I am hearing determination, err you know like because they come to you as a, we can't do it you know. She, kind of,
1009		the child don't want it. The parent say we can't but your, you mention model, your model and I am beginning to
1010		hear your determination, this will work, try it. Is that what I am hearing?
1011	P 2	Its absolutely, but its only built up with experience, and, and feeling comfortable with being an expert. And saying you
1012		just have to do this. But containing people and being really reliable. So you know, when I got a, a team sessions
1013		with a family I am therefore waiting for them at the time that they expect me to. I am also responding
1014		a lot more to emails actually. Emm, just containing people because no parent thinks it is possible. Most of them
1015		think its impossible. So you just have to exude confidence, be determined, keep pushing. Emm, and as I say for the
1016		most part it works (nnh) and that's extraordinary (nhh) that's brilliant, you know its great. Its emm, I mean its
1017		frustrating when you, when you feel like you were a stuck record. But you know that even if you sounding
1018		like a stuck record, that’s worth it as well because eventually it get unstuck. And parent can do it and the
1019		child can do it.
1020	R	Yeah, what about your own thoughts and feelings. I am hearing your determination, your experience and you know
1021		your approach to it and it work. But would that be a time you might have thoughts about you know like some of your
1022		own feeling coming through. Or your thoughts about outside of, of this.
1023	P 2	You mean in the actual, my thinking processes?
1024	R	Yeah, you know when you sometimes this generates this feeling. That feeling generate that feelings? I was just thinking
1025		about whether there are some families generate, touching on your own personal experiences you know?
1026	P 2	Emm (.4) I suppose what touches, yeah occasionally where there are separated parents and the child might be
1027		going from one household to another, and they seem to be losing sight of whose needs are paramount. Is it
1028		their, the parental right to have half and half (P2 laughs) of their child (nnh). Was that the child needs or does the

1029		child needs something else. And sometimes I think there is a frustration in me if I feel like the parents are doing it
1030		because that's what they want and the child has become a sort of emm, symbol of ownership rather than their,
1031		you know what's best for their child. I think that sometimes might trigger something in my own experience
1032		of having separated parents and then you know hearing one parent does it one way with food in one household.
1033		And the other way in the other household, may be that sort of brings up feelings for me. Emm, from my own
1034		experience possibly. You know as a therapist you, you have to be on the lookout for that, don't you in yourself? (nhh)
1035		Emm, I don't know that I ever always manage that well without it becoming, may be is I don't know. I hope it doesn't
1036		come across as frustration, I hope I don't ever come across as frustrated to my patients or their parents. Emm
1037		I am certainly feeling it sometimes inside (nhh). Yeah, emm, in terms of other experiences, maybe I am determine.
1038		because (.2) because of my own experience I don't know, maybe I am determine to do a good job to proof
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1040		Line 1039- 1053 deleted at P6 request
1041	R	
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1054	R	when you say you first started, pressure of proofing yourself, finding your ground and the experience of kid
1055		coming and say I don't want to eat, the parent say I can't feed you know like, and juggling all these things and your
1056		own feelings and thoughts, and
1057	P2	Yeah, yeah, I remember very early on you know. I share an, a different office with different colleagues but you know

1058		there err, there was some really experienced brilliant therapist who is still there, and I see them come out
1059		come out of a session with bunches of flowers and boxes of chocolate and, you know it seem like they just had
1060		all the answers :: I feel like to begin with well, I don't know what I am doing. This is awful, everyone else knows
1061		what they are doing, so it felt really pressured. And I very, very deliberately talk to new people in the team about
1062		that and about what that feels like. Because it is so destroying if you let it be, if you go down that sort of route.
1063		I am useless and everyone else knows what they are doing. And so many people in the team when they join the
1064		team expressed those worries. And I remember it so clearly, I absolutely determine to tell people that the people
1065		who look like they are brilliant, emm they have their off days. And they all felt terrible to begin with because you have
1066		to fake it at the beginning. And it is a difficult feeling as a therapist (nnh) trying to be authentic when you actually
1067		you don't feel like you know (P2 laughs) much at all. It is very hard.
1068	R	I mean, that's the the interface with colleagues with the institution, with the service you know. I am just thinking
1069		about when you mention the word emm authentic you know. I am thinking about being authentic with a family.
1070		How does it look like, when you have to talk about feeding and knowing that they struggle. I am just thinking about that?
1071	P2	I think it gets easier and easier to be authentic when you been through it hundreds of time with hundreds of
1072		other families, and so now I feel so much more comfortable saying look, I don't think I ever come across parents
1073		who hasn't felt frightened about this or hasn't felt that they can't do it, and for all those families that have said
1074		that in the past. There is equal numbers who managed it. So you know, we will find a way but I need to work out
1075		with you what a way that's going to work for you. So being authentic gets easier and easier. The more you come
1076		across every sort of scenario that you could imagine in your caseload. And that is, I did struggle with that at first (nnh)
1077		because I watch other people work and they would say quite often, and the model ask you to say, well you know other
1078		family have done this. Well, I don't know any other family yet (P2 laughs) how can I say that? But you know, you have
1079		to, you have to contain parents. You can't say to them, well I don't know. I don't know how people kept at (P2 laughs)
1080		so you have to find .hhh a way of saying things that aren't out lies. But they are saying look, this can work, we will
1081		find a way. This is how some families do it, lets see if that works for your family or (P2 laughs) and hoping it come
1082		across in an authentic way until you get your back catalogue of families that you actually been through the process

1083		with. That's really hard.
50.32	R	Am I right to hear that something you know, as I am talking to you P2, I am feeling that you put yourself aside
1085		you know but focusing on the family, focusing on the model when you working with your families?
1086	P 2	Emm, in some ways yeah. What I notice, I mean I, not entirely I use a lot of my own personal humours with families
1087		and young people (yeh) and that's me. Emm, maybe I am being strategic in using that (P2 laughs) but I am sure
1088		there is something strategic about it, but emm, but its not entirely putting yourself to one side as a therapist, is it?
1089		I mean you are using, I, you can't completely put yourself to one side. I don't think that was possible. Emm, you
1090		do find there is its own, you have to get into when you are working with a family say, a family who you find
1091		may be frustrating because you are repeating yourself all the time. And they don't seem to be giving much
1092		back. They are not giving a sense that they are working as hard as me, may be (P2 laughs) they need to, to get things
1093		moving. Emm, you have to put yourself aside them. Then if you come across as frustrated or angry, that's not
1094		going to be helpful for them if they feel anymore guilty than they already feeling, because they feel that they
1095		are being blamed by their therapist that would be terrible (yeah). Err, so its not entirely putting yourself to one side
Dec-02		and I suppose its <u>easier</u>, its easier to be authentic if, if you know, nhh I am losing my chain of thought now. Emm (.2)
1097		the more experience you get the more :: you can really say things in an authentic way. And it feels more comfortable
1098	R	That comes from your experience.
1099	P 2	Yeah, yeah.
1100	R	I think early on the bit that you were, it is not entirely putting yourself aside, you mention you don’t want to show
1101		frustration to make them more guilty than they already feel. And early on you mention about ehh some families
1102		might trigger memories of your own parents separation and when you see a child that might be yeah, I
1103		was just thinking those feelings of like when your own, when yourself being stirred up you know, a kind of
1104		how do you deal with it?
1105	P 2	Nnn (.2) I don't know I do something, I put myself to one side but being in a different sort of zone where the
1106		connection is with that family and what they need (nnh). Emm, and I am trying to think of that lovely article
1107		from training. But that sort of having someone on your shoulder coaching through it. And say hang on a minute,

1108		you could start getting cross here, don't get cross because they are feeling worse. Don't make them feel worse
1109		(P2 laughs) try an understand, be curious or its that sort of emm things that whispering in your ear as a therapist.
1110		Emm. Telling you
1111	R	The internalise other or something?
1112	P2	Oh, I can't remember, I am trying to think who the guys was. It was sort of describes it really well. That sort of internal
1113		dialogue, its not necessarily internalise others, but it is more internalise, sort of a dialogue that coaches you
1114		in the moment when you are finding yourself lost or thinking you are going to be showing frustration or
1115		annoyance. Emm, it wheels you back so that you can still be authentic and connected with the family (nhh)
1116		but not expressing your feelings (nnh).
1117	R	It's a very complicated process, I have no doubt you are very connected with the family you know. And I
1118		was just thinking about going back to ehh when you are with the family, what about family that might have some
1119		culture, because early on I was asking you about your own culture and you say you are not quite sure. I am just thinking
1120		about emm, when family of culture that comes in, emm how how does that show, plays out in the, how you connect
1121		what happen perhaps the question?
1122	P2	I think using the skills that I used with other families but with a lot more curiosity, not a lot more, curiosity enough to
1123		understand what make sense as a family coming from a particular culture. Interesting that I have just err taken on
1124		a, a girl whose parent only speak mandarin. So obviously using an interpreter to begin with until the dad who brings
1125		her in that he actually understanding a lot more and can communicate better than maybe he thought he would
1126		be able to. So I have been using an interpreter and I think I do a lot more explaining about where I am coming from,
1127		may be psycho-education, may be in the wrong belief that is going to be a sort of gulf of understanding why that
1128		might be? Maybe I am sort of, sort of outing myself here, may be assuming that there is a wider gulf, share
1129		belief about the childs needs in terms of eating and food. Emm, but being much more curious and asking a lot
1130		more question about the sort of practical, practical way of food is eaten in the family and err, with that particular
1131		family they run chinese restaurant. So, one way of making sure emm I was understanding you know what, what they :
1132		you know what what their family tradition were around eating was to make sure that emm, she was going to
1133		the resturant in the evening, in the afternoon after school with her dad while he was setting up for the trade in

1134		the evening. .hhh and she was eating the food that the chinese restaurant provided. And so, so it made absolute sense
1135		that he gave me the restaurant menu and we put together a meal plan that using the resturant menu. The things that
1136		she was used to eat, from the menu so got the dietitian to do that. And the dad was really, really you know please
1137		with that emm because it made it easier for him. But she would eat in the restaurant and that's the way they
1138		did things and she is doing a bit better now. Emm, I have not managed yet to understand why, where mum is, in all
1139		it (nhh) I only met her once. And I been firefighting a little bit because of the, the girl is so low weight. Emm, unwell.
1140		I am just trying to get the, that bit done and then try an understand a bit more about the family (nnh). Emm, the
1141		culture is really important to understand, sorry hang on a minute (P2 types). Sorry I lost my screen, it would have
1142		been crazy to just assume that, they would be fitting the sort of white middle class template for you know, how food
1143		is done in their family.
1144	R	What about those ehh you know like, you mention quite a lot like your own connections about emm food is
1145		about emotional connections early on? And I am just thinking, would emotional connection come into conversation
1146		with this family or
1147	P2	Not yet, it might be relevant later on. But I am sorry that's why I be, I am sort of saying I am saying it's a
1148		very functional thing to begin with for me (nnh) you know. And in a way you can get lost in trying to explore those
1149		things. But the child starving to death, you can't have those conversation until it is safe. And so sometimes you
1150		never have those conversation because by the time the child eating better and its well. It's a non-subject, its not
1151		relevant anymore, the child is well and, there is no sense that you are going to understand why they became
1152		unwell, you could carry on looking for years and never find out (nhh). But if, you start getting a sense from
1153		the family that there is something important about the meaning of food, eating together and their relationship, their
1154		relationship to food and eating together, then of course, once the child is you know, out of the, sort of the risky place
1155		that they often in. Then you can have those conversations (nnh) But I, I really wouldn't be down that road early on.
1156	R	No, not. I remember you say :: the stage model you know.
1157	P2	Yeah.
1158	R	So, I think that more or less what I would like to ask you know. Emm, I am just wondering err if you have any thoughts
1159		and reflection from our conversation.

1160	P2	(.1) emm, I suppose how quickly emotion can be there, talking about your own experience of eating and food, emm
1161		as a child. And I wonder you know is that, I imagine that probably true for most people. There is some
1162		memory that either or good memory or poignant memory relating to food and eating. But then again equally you
1163		could ask someone about their first house they lived in and that might bring up very similar emotions (nnh).
1164		So I don't, maybe I am just emm reluctance to think about any mystique around food, food you know I love food.
1165		I love celebrating with food, but I don't, I sort of resist any idea of mystique around it. Its (nhh) yet it can
1166		evoke emotions, thinking about it that food is food.
1167	R	Yeah, food is in every aspects of our life you know, from sort of like you say the mystique to the really joyful
1168		celebratory.
1169	P2	Yeah, so: yeah, so I am surprise that how yeah, how I felt about talking about some of it. It touches on so many
1170		other things doesn't it? I mean may not be for everyone but certainly it felt that way for me and it is making me
1171		think how long do I want to do this job really (P2 laughs). Just want the pandemic be over so I can start enjoying
1172		it again.
1173	R	Indeed, you know, we all looking forward to the pandemic to be over.
1174	P2	Yeah.
1175	R	On that note, I am going to stop the recording.
1176	P2	Okay.

Deleted lines: 840- 842; 915-923; 1039-1053 at P2 request

Appendix 1c: Transcript for participant 3- Caroline

1		
2		R: Researcher
3		P3: Participant 3 - Caroline
4		
5	R	Check all the buttons are on properly ^. Emm (.4) okay. So emm before ::: we start. I think I cover most
6		of the things about consent, taping and time and emm it is about your view, your narrative and your
7		story about working in the field yeah.
8	P3	Yeah.
9	R	If I start with asking you, can you talk about how you feel about this research title. The title is race
10		ethnicity and culture in family therapy with children with eating disorder.
11	P3	(.2) Err, I think its, its very (.) inter::esting and I think when I first read it out, like nnh that's interesting err
12		point from which you can look at. Because I think and also err what attract me to participating in
13		research or express my interest to participate is, was that it actually looks at the:: family therapist
14		rather than clients or families. (nn) so the reason, one of the reason why was because we often
15		concentrate a lot on eh how family feels, how the young people feel, how parents feel err rather and
16		forget there is a therapist as well in the room, and you know from point of view, there is err a lot was a therapist
17		bring and and you know that from family therapy training and theory and all that. But, you know err
18		how we position ourselves, what story we bring and all those kind of things but how they influence
19		what happen in the therapy rooms. So (nn) Yeah, it it very much how I felt about it and I was excited.
20		Ohh that was an interesting piece of research that's definitely.
21	R	Good to hear that you find it interesting, so I just wonder how, how do you it connect with you personally
22		or professionally?
23	P3	Err the title or so?
24	R	Or you can give an example if you want to.
25	P3	I think it, it so, I was thinking, I was thinking obviously (.) reading about the research have err taking to think and reflect
26		on my own. What do I bring to a therapy room and what sort of .hhh, things might influence my work

27		with eating disorders because eh eh to be honest, I never thought about that in particular from the eating
28		disorder point of view. I think I thought about it in the family therapy but not in a eating disorders
29		work. So don't, don't I think ::: reflecting anything about it take me back to my childhood, to the country
30		of origin and what sort of narratives and em err stories I had as a child, as a young teenager, as a young
31		woman about food, and about err image and how you look and, and those kinds of thing. Yeah, yeah
32		I think it took me on a very personal journey. (Nn, Nnh) to reflect.
33	R	And race ethnicity and culture?
34	P3	Sorry?
35	R	race ethnicity and culture?
36	P3	Yeah (nnh) what do you mean by that?
37	R	I mean you know like the title is race, ethnicity and culture in family therapy with children with eating
38		disorder, so family therapy, family therapist you mention are very personal experience. I am thinking
39		about race ethnicity and culture as well
40	P3	And that, that kind of goes back to me thinking about, of what sort of err stories in my culture, there are
41		what eating disorder, about eating, about, you know body image and all those kind of things. So (nhh)
42		yeah, definitely brought lots of different thinking about that.
43	R	Nnh, and professionally when you working with the kids.
44	P3	Professionally, I guess being aware of those stories, how (nh) about my own thinking and about
45		especially ::: evokes and beliefs about being thin and how you know in my society, in my culture seen as
46		a very good ↑thing. (nnh) As a you know, if you are thin you are slim, you are beautiful and will
47		achieve a lot in your life. So I think (.) I often professionally, need to be aware of those narratives which
48		kind of comes from my childhood to ensure that I don't err congratulates where :: you know, wish
49		to be thin, to lose weight and to, which will keep the eating disorder. So yeah, just being aware of
50		those.
51	R	Nnh, is it possible to give your personal experience, like or or professional experience that are, you
52		come across this sort of things you just describe.
53	P3	Errh, do you mean what was it like personally or do you mean, what do you mean?
54	R	Both, you know like, you mention your your childhood, where your race, ethnicity culture influence

55		that story about being thin and you know err the things you described. (yeah) and I just thinking about
56		does, does anything that come to your mind as an example that you can talk about?
57	P 3	So I guess its so, in (name of country) if you are thin and, or if you slim. You are like I said, you
58		are count as beautiful and woman are encouraged to stay slim. You know after having a baby, or ( )
59		baby should feel the need to kind of go back to being slim. Woman are encouraged to eat less as ↑well.
60		So you :: shouldn't be having a same portion as a man because you know, you are woman
61		you should be petite, you should be this slim tiny thing and what she often, so when I was growing up eh,
62		the thing what was celebrated and eh in my kind of generation was eh young women getting married to
63		rich man and for that you had to be. You have to look certain way (nhh) so you know slim beautiful
64		and all that kind of stuff. So hence that, growing up it was always you know well you can not be
65		overweight, you need to be, you know slim and to be, you need to make sure you active, you know
66		train and you know eat : little which you know a kind of, very much (.2) what somebody
67		with eating disorders would do.
68	R	Right
69	P 3	So ::: yeah and I guess going back to a professional's side where you know if the young people, young girl would say
70		well I want to be slim, I want to be pretty, I want to be beautiful. That, that very much aligns with
71		what I grew up thinking and you know. No I don't have eating disorder but you know it is thinking style
72		much alike. (Nn) I think.
73	R	Similar
74	P 3	Yeah, similar. So yeah. (.4)
75	R	If I may ask you. Can you talk about a case emm you work with and the :: specific eating disorder issue
76		being discussed?
77	P 3	What do you mean, specific case of eating issues?
78	R	Yes, so like eating disorders issues like sometimes people might say food, weight, look and other things
79		that eating disorders or control, you know those kind of very generalise. I am just giving you example
80		because I am not meant to say these are the issues you know (R laugh) what I mean.
81	P 3	Okay.

82	R	I am just thinking about from your experience errh can you talk about a case you have worked with or
83		you know of and emm ::: what are the specific issues has been raised and discussed.
84	P 3	So do you mean just random any any case?
85	R	I suppose you work in the eating disorder field or or, all your clinical work will involve eating disorder.
86	P 3	Okay, so for example I currently with a :: young girl with anorexia nervosa who is restrict ( ), and
87		striving to be as thin as possible. (Nnn) and yeah
88	R	Nn and how old is this girl you talking about?
89	P 3	How old?
90	R	Yeah, how old?
91	P 3	Fourteen.
92	R	Fourteen year old, emm I am trying to gather a richer description of her and your work with her. If you,
93		that's why I might be asking a lot of thing.
94	P 3	Okay.
95	R	Yeah, yeah. So she is fourteen years old. Is it inpatient or outpatient? Or
96	P 3	Outpatient community.
97	R	Yeah, and a, and, do you want to say about the context or the issues that you work with her.
98	P 3	Eh, so we have been working and ::: adhering to SFT Model for anorexia nervosa, the Maudsley Model.
99		And err working on refeeding and arrh, currently we are looking at providing more independent for the
100		young person so moving onto, kind of ehh getting parents .hhh LESS involved in, in a, in a treatment but
101		also we have been exploring a lot of family dynamics. So even though at the beginning was more
102		about refeeding and talking more about food and, and how to get this young person into health. At
103		the moment is ab::out family dynamics so previously we. Prior to eating disorder this young person's
104		sister had a err physical illness which meant the parent have more into care for her, which meant that
105		the young person I am working with err was felt neglected by her family left kind of behind. So the
106		eating disorder gave that :: role. Or gave that er, gave that opportunity to get the parental care (.2)
107		from parents. And so we have been working and exploring <u>how</u> that kind of evolve and what is happening
108		at the moment within the family.

109	R	Nn, so this is a context of like parents and two daughters.
110	P 3	Yeah.
111	R	One is physically, one has physical problem, the younger one fourteen has got anorexia nervosa.
112	P 3	Yeah.
113	R	So, err I mean you mention about arrh family dynamic, you know. So what do you think the main
114		issue was you know.
115	P 3	Within the family do you mean?
116	R	Yeah.
117	P 3	So we are exploring that at the moment. I think uhh we did, we did recently a sculpt where it seem
118		like ehh, both sister's help very much neglected by parents. Ehh when they were, you know when one
119		was ill, the other was neglected and I am interested to find out more how parent deal with, with
120		her illness and or any kind of treatment, what that feels like? They move from (P3 took a deep breathe) keeping
121		concentrating on one thing and putting hundred percent, and move into another thing. So yeah, I just
122		exploring that.
123	R	So mum and dad both come, is it?
124	P 3	Yeah, yeah. All of them to be honest, four of them.
125	R	Yeah, how long did that take, was you mention the Maudsley model you know. In terms of refeeding
126		was she sort of stabilise or took a long time to come out or still in the middle of it.
127	P 3	Yeah, to be honest she is now healthy weight. (nnh) and I think she took about three months (nnh), two
128		months and were just about to, to get her weight stable (nnh). And we are in the phrase now between
129		two and three, kind of, to be giving her control but also exploring family dynamics and whats happening
130		within the family.
131	R	So when she was in the initial refeeding phrase, what would, might be the things that you, you and
132		your family were discussing and talking about?
133	P 3	So that was ↑mainly about what will need to happen at home and look after, supporting this young
134		person to eat more (nnh). And supporting parents who I did quite a bit of work in regards to err having
135		conversation with parents (nnh) on now on. We help the young person because it was felt like some
136		of the symptoms she was describing, so she was describing a lot of physical, being physically

137		uncomfortable and it felts like some of them were caused by ↑anxiety by eating disorder rather than
138		actual being physically unwell (nnh). So yeah, we spent, I spent quite a bit of time talking about you know
139		what will need to happen from food perspective but also from emm intra-gastro, parental guilt and
140		em em how parent will need to support each other. Arr (nnh) through this time and how they need
141		to be united to ensure that they address this eating disorder (hnn)
142	R	So I was just thinking about how do, what about race, ethnicity and culture in this process you know?
143		How they are being considered?
144	P 3	(.2) So this family is white British (nhh). We haven't raised ethnicity and culture in, ↑in there. And is, it
145		didn't. It never came up to be honest. It was never discussed, kind of never. But, I think for me I ::: I really
146		like this family, may::be because err the mother in the family is very strong figure. And very kind of
147		strong. Yeah, she, she just very strong as a woman, as a mother. You know which a kind of reminds
148		me of mothers and women in my culture (nnh) which you know help I think to engage this family.
149		And ::: to <u>want</u> to help ↑them. (nnh) So, yeah.
150	R	So you feel quite similar with this mum, in terms of how strong and
151	P 3	I think made me more, I could see some of the qualities, from that of my mum was when I was growing up (ha)
152		So yeah, the good qualities were being strong, that kind of doing everything she can for the child and
153		kind of putting everything else on hold, and just concentrating on her daughter, and helping her
154		daughter.
155	R	What about the father then?
156	P 3	Father is :: more relax, more there, is always <u>there</u> to support the mother. But yeah but is less involve
157		in the whole process. More like follower rather than (nnh) leader.
158	R	And the elder sister, does she come into the session as well?
159	P 3	Yeah, yeah she comes in, she is quite vocal and sometimes the sister will say that oh we have really good
160		relationship, close relationships. Another times ehh they will kind of compete between. oh you have
161		more attention when you were ill and I, I was neglected. And the other will say yeah but you were
162		preparing for exams and you know I was ill. So that make sense for you to stay in your home and
163		then vice versa. But its interesting, how the younger sister seem to have mirrored (.2) whats the older
164		sister has gone through the physical health issues.
165	R	Do we know what happen to her, is it something long term or just short term? Or

166	P 3	No, it was unexplained seizures (ah) so she had a ^one, I think or two seizures and then nobody could
167		explain why what happen. And parents had been, were quite, lived in quite raised anxiety for some
168		time. So you are worry that this can repeat ↑itself .
169	R	Sorry, pardon me, you say quite a raise society,
170	P 3	Yeah, raise anxiety.
171	R	Oh, raise anxiety.
172	P 3	Yeah, so worrying that you know the seizure could repeat and what will happen then and ::: how you know,
173		whether it could affect the older sister even more (nhh) so↓.
174	R	So, I am curious about when you say this mum reminds you of your mum, woman of your own
175		culture, was strong. Does it :: make, just thinking about this connection, do you want to develop that
176		a little bit, say a bit more?
177	P 3	Emm (.2) I don't, I don't know if there is anything more to say to be honest. (nhh). It just, it just that how it
178		I, I think I connected with this woman because of how she dealt with eating disorder and how unface.
179		she was by anything where eating disorder will throw at her. So you know, the young person, at times
180		the young person was very abusive towards her (nhh) and saying really horrible things and this woman
181		I could see it was really hard for her but she just stays the same (R coughed). And you know was able to
182		externalise eating disorder pretty quickly and was able to separate the daughter from eating disorder
183		and to me that was you know, that was, I think what help in getting the weight up, pretty quickly (nhh)
184		at the beginning so you know, there are no messing or playing around yeah. It just, yeah, I was so, I was
185		very much. I, I admire what this woman had managed to do, in a short term (nnh) in a short term. Even though
186		you know I say this woman, she was supported by her husband. So they both, to be honest were always there
187		for the sessions and always, you know, willing to try things, and was never you know, say No No. We
188		surely, we can not increase anymore food you know, and all that. Even though the young person was
189		saying she was experiencing excruciating pain. We were still prepare to do stuff and, and yeah, to get
190		the eating disorder (nnh) so. > Sort of refeeding signs sort of so (.2) yeah.
191	R	The family got, had a very tough time by the sound of it.
192	P 3	Yeah, they did. But they, you know, they took it really well and they kind of. It was a lot of, we can do

193		attitude (nnh). I really admire, we weren't paralyse by a eating disorder. We were you know, able to,
194		sure we have lots of tough time but they were able to use the support, they were able to use the
195		sessions and ask for help as well. (nnh) so
196	R	And then she came through two months refeeding, stabilise and then,
197		you continue to help them to, emm, you were talking about dynamics, exploring the dynamics.
198		(Yeah) how are they responding to that?
199	P 3	They are engaging really well and you know and using the sessions, so and is sometimes even now
200		we will start talking about some emotions, or whats happened in between the sessions and eating
201		disorder will come in and try to take over sessions. Even I sometimes get a morning, like OH, no, again?
202		like we were talking something interesting and more important than like eating, and I say we will
203		come back, with I don't know, another conversation while dinner or something like that. But parents
204		should stay with it, and know, able to, to, or attempts to address what's happening in the room. And
205		to help the young person to soothe and, and get back on track on work where we had been talking,
206		So really nice to see from that side. (nn nn)
207	R	How do you think will happen to them next?
208	P 3	Eh, I think we are in the area of discharge, to be honest (nnh). I think they are very close to that. I think
209		its about stabilising the weight, because we reach the healthy weight and it has been kind of going
210		up and down a little bit, so just find that normal, whats normal for their family, exploring exploring dynamics
211		in the family and I think emm. There is quite a bit of eh tip toeing still, walking on the eggshells you
212		know. Oh lets not upset the young person in case we lose, the project comes back so. The most
213		recent discussion we were talking about boundary, and you know hierarchies, how, how where the
214		parents side, where the children are, how you know where eating disorder has stopped in the past
215		parents from influencing boundaries. So you know example of where the young person or ^eating
216		disorder say rude stuff about their food, mum brings. And so we talk about how, in any other
217		circumstances that would not be appropriate or acceptable in the family (P3 stretched herself). But how
218		eating disorder may have trick them, or you know, kind of paralyse parent in, in allowing that actions

219		(nnh). What kind of, how do you find your, your ::: your, your role as parents back. So yeah.
220	R	And your role in supporting the parents, how do feel about that role?
221	P3	(.2) ↑Yeah, I think. I think it, it really bring immediately me, more at the beginning. (Nnh) There was a lot of;
222		crying and does not know how to structure, ho:w eating disorder might be presenting in what sort of
223		thing needing, so might be making the young person doing all those kinds of stuff whereas now they
224		definitely need less of that (nnh). And it was interesting that you know I suggested that recently to,
225		we communicate by emails and I suggested well, you know we, we should choose eh something
226		representing them so we can do a sculpt in a session and the parents response was that GREAT, we are
227		going to do that, shall we leave the talk about weight this week if you are happy for us to manage.
228		And that was, that was very good example of parents being able to manage the physical health and
229		food and the kind of eating disorders side of, of recovery and wanting to engage in other stuff
230	R	Nnh, nh, nh. That was big step.
231	P3	Yeah, yeah, definitely. So :: so yeah> (nn). Its definitely reduce all this work to the parent.
232	R	Nnh, tell me about the sculpt then. I am interested, you know, how did that work eh
233	P3	So, like I said I asked them to choose :: figureee. And they did that (nnh) And and I asked them to set
234		the camera so I could see them and the table. I explain at the beginning that I am in the session but
235		not over the video (P3 giggled) that was the first time. And to be honest it did work quite well. Ehh, it
236		was interesting (P3 giggled) one point, my connection dropped (Ahh) And for :: probably a minute or may
237		be even less, I was out. But the interesting thing that we didn't even notice (nnh). So when I came back, they
238		were SO involved in their kind of, moving the figureees on the table that they didn't even realise that
239		my connection dropped and I was gone for a minute. [So eh
240	R	[They were IN doing what they are doing.
241	P3	YEAH, ye::ah, so we did, we did :: a before the illnesses. What was family like? And then when eh the
242		older sister physical health problem started, what was it like? In terms of, when eating disorder came
243		into the family what was it like? And we stopped, we agreed to do :: current and the future sculpts (nnh)
244		in the next session. So yeah, we were really engaged, really into that, yaa.

(31.83) 242	R	Are there any grandparent in the picture or?
246	P 3	(P3 hissed) ↓No, especially now. Definitely not. (Yes, definitely not now?)
247		Because we are in quarantine. But no, no they are not. I am just, I am just going to check if I got
248		genogram somewhere here. But, (.2) that's where you know this, this (.2). Eh. So her parent live close
249		but we never mention them. (nnh) And Dad's parent's lives far away. Yeah, we never, we never mention
2550		the grandparent were any support.
251	R	Nnh, is it that the sort of like typical, you know like eh similar to like you mention your Eastern European
252		sort of background. Is it something similar to theirs, you know like grandparent, is it sort of like, very
253		central unit?
254	P 3	Yeah, typical from the point of you keep your problems in the house. So that bit I could relate because
255		I think if anybody have mental health problem in my family it wouldn't have been discussed (nnh)
256		outside the house. Because you know you didn't want anybody to, to check or stigmatise or anything
257		like that (nhh). But I think grandparent would be involved (nnh) if a grandchild would be emm not well
258		or sick. So yeah, its I never thought about that (nnh). May be because these parents were so capable
259		I never thought about explore whether there is anybody else who could support them.
260	R	It doesn't feel like they need extra. [They are okay.
261	P 3	[No, no
262	P 3	Never felt like that, so (nnh) yeah.
263	R	And you mention the mother, that something about 100% focus on the elder daughter and now 100%
264		on the younger daughter (R coughed) pardon me. [Excuse my cough.
265	P 3	[nnh
266	P 3	Yeah, so she has been you know when the older daughter was ill, physical health. She ::: the mother
267		was very a kind of, you know get the best doctor, specialist, get all the test to make sure there is
268		nothing wrong, what could have caused those seizures. And there were emm like, I mean we did, did
269		check that one out. They make sure that she didn't go anywhere on her own and all those kind of things. Just to
270		avoid, she drove her to school, just to avoid any further seizures and putting her in a kind of extra

271		danger like that. And then when the younger daughter got ill with anorexia, it was a kind of same. She
272		said she did all the meals. She you know, she help, helping really well, eh distress, she takes all the
273		abuse and all that kind of stuffs. So Dad was more or less supporting her. But she did most of her
274		caring and eh getting there.
275	R	What is the meaning this family give to this anorexia?
276	P 3	I don't know. We never talked about that (nnh). We did wonder in one of the parental session, parent
277		only session about their Dad. Eh we did talk about (child name). Oh, mention her name (P3 giggled) is this
278		going to be?
279	R	Don't worry, I will just put a bracket, name. you know (yeah) I will make sure nothing will be exposed,
280		you know.
281	P 3	Okay. The young person feeling neglected (nnh) and emm because of her sister similar illness and how
282		this might have caused the development of an eating disorder. So we did discuss that with parents and
283		you know, you know whether that ::: made parent feel more guilty because they concentrated on,
284		on older daughter when she was physically ill (nnh) so yeah but that was what we talked about (nnh).
285	R	(.2) I was thinking about do you have any cases that might be race ethnicity and culture might be
286		central?
287	P 3	Nnh. (.4) sorry I should have thought about that before, before this.
288	R	Don't worry you know like, its its is whatever come to your mind, take your time.
(38.13) 289	P 3	Yeah, (.4) nnnn, can't think of anything. Err, (.2) I have, I used to work with this boy who was emm
290		uhh, again white British and he :: err he was I think <u>eight</u>. And it was EDNOS, EDNOS diagnosis, struggling
291		to eat, struggling to gain weight. Emm some fears about, yeah becoming <u>fat</u> and, and you know
292		overweight and and hence try to exclude the unhealthy, his view of unhealthy food. Make sure he doesn't
293		get THERE. But interestingly this boy, in the beginning, uhh ::: he following assessment, in the second
294		session. He said that he was not going speak with me. And I were like what, why is that and he said
295		that he ::: he thought that I am from Germany and my accent reminded him of his <u>German</u> teacher. And
296		who he didn't like and hence he didn't want to work with me or talk to me. So we had a session about, emm.
297		I explained to him that I was not German but I was from (name of a country) but emm, ::: ehh I think all in the head,

298		interestingly he became very interested in my country and everytime he would, at every session he
299		would come back and talk about. "Oh, I heard this about your country" or I read this about your
300		country or this is interesting, or this is beautiful. I look up and interestingly that, as we raise it, as we
301		talk about it. Err, us, we were able to clarify why I was strong, what kind of you know, I speak. That when we
302		help him building relationship (nnh) and so only we found this common ground, and common,
303		something which help him in the treatment itself.
304	R	Nnh, its nice, really interesting (yeah). The boy connected with your :: your country of origin, you know
305		like.
306	P3	Yeah,
307	R	Be interesting, if you are really German hypothetically.
308	P3	(P3 smile) No, I know. It would have been yeah, probably different but. Because I remember the mum.
309		Don't remember the Dad. But I remember the mum, the mum really apologetic. She thought (P3 giggled) I
310		was German and he was very, not going to talk to you. Because you are German and I don't like German
311		and I was like WHAT? What is that about ↑? Mum explained that he had teacher who he dislikes so
312		inside the mind of him. But she was, really sorry I don't know where this is coming and err err she. I
313		think mum was really worried that I will think that they are being racist. So I am not anything like that
314		and how, er how it didn't even cross my mind. It was more to me that, yeah I love this boy, you know
315		didn't like his teacher. I remind him of his teacher, so you know it is understandable. But he will not
316		want to engage this that. So yeah.
317	R	It is quite interesting err race or ethnicity being say in a way. I don't like you because you are this
318	P3	Nn, yeah. And I guess I get you know the, hhh, with me ::: having a strong accent you know :: that I am
319		not English (nnh), You know and especially for English people, so the race and ethnicity becomes
320		visible↑. (Nnh) where is for other people, it is invisible. If you know what I mean, so kind of Yeah. So
321		maybe it is easier to talk about it. Because I often, I often would, sometimes I make a joke of err
322		a kind of bringing in ethnicity into the session by saying, well, you know err. I understand you know it is
323		hard to, err hard to open up. You only met me today and I got this strong accent. You know and that
324		sometimes help to build relationship (yeah, nhh).

325	R	so that visible difference can be quite useful.
326	P 3	Nnh, I think so. And especially if you raise it. It helps with all sort. Err reducing those boundaries, so what
327		that hierarchy of you are the clinician, family therapist, and the family and client need that kind of. So
328		you know I sometime say, oh if I say something you don't understand just let me know and cause
329		sometimes I don't understand myself when I speak in English and they just laughed and you know.
330		And that helps (nnh). Helps to being on the same levels, so yeah (.2) yeah.
(44.59) 331	R	So I was just thinking about your experience in working in the field of eating disorder (nhh). How does
332		it develop your practice as a family therapist and on the REC issue, race ethnicity and cultural issue?
333	P 3	Nnh (.2) emm how does it help me as family therapist? I think err (.2) I don't know if eating disorder is
334		different any other families or any other illnesses. I think the only differences is that physical health
335		aspect and how :: severe and risky they might be when they are really malnourished or engaging in
336		various behaviours (nnh). So :: I guess ( ) as a developing as family therapist she uses the, emm so eating
337		disorder still have less effect on families ↑. (nnh). So especially so I work mainly with young people
338		with eating disorders and you know the effect it has on the family it just ↑massive and, and I guess
339		I get to see families how we deal with crisis, in the crisis and what happen after the crisis. And :: how ::
340		we reorganise after ↑crisis and (.2) to see whether they, that's where you can see whether they need
341		further support or not.
342	R	When you say effect on the family, do you mind say what are they you know just emm, give me some
343		examples? You know.
344	P 3	From eating disorder?
345	R	Yeah, you mention about the physical aspect of eating disorder and the effect on the family. So what are the
346		sort of things that er
347	P 3	So how, so family very often reorganise around the eating disorder to err kind of, things like, to do
348		things like to make sure that we don't, upset the eating disorder so things like Dad may be excluded or
349		other siblings might be excluded from dinner table. Or err food preparation might changed, so young
350		person might be taking food preparation or person with the eating disorder emm, a lot of things so

351		might even you know, crockery might change or, or plates might change and all those kinds of things. So but
352		also parents or siblings might do things which will maintain eating disorders. So, for example, ehh. I
353		don't know, everybody tips toeing around and trying to avoid challenging real person or eating disorder,
34		challenge those behaviour which will <u>maintain</u> the eating disorder (nnh). Ahh, things like you know,
355		the siblings being neglected. Parental relationship being neglected, often the child is triangulated
356		between the parents because sometimes eating disorders <u>love</u> having one special parent and one
357		evil parent. So often mum will be this special parent who can only refeed the daughter or, or son (nnh).
358		And then Dad will be excluded and Dad will be the one who start working a lot because of financial
359		reason but also because being excluded, and feeling incapable to help the child at home. So yeah ::: there is
360		the, there are so much and I think err. That's what that thing, that's what I like working with eating
361		disorders, of families effected by eating disorders, because there are <u>so</u> much ::, what eating disorders
362		makes, what eating disorders causes, disruptions causes in the family. And sometimes you know,
363		families will, will go back to the new normal, psycho and, don't need very much support. But other times,
364		we get stuck and you know. I am working with particular family who keep talking about, but the time
365		we have that before the eating disorder. " Ah, we used to go on holidays" and "We used to do
366		this and that". Then you know, "the eating disorder came in and we stopped doing that". And it is
367		about helping them to find new normal. Because parents still want to play Monopoly when the siblings
368		are like "NO, we hate it now. It's been three years. We don't like them anymore. We don't want to
369		play anymore." (nnh) so its about helping these families find new normal.
370	R	Do you think addressing race, ethnicity culture is relevant to that or
371	P 3	Yeah, yeah I think it, ethnicity and culture come in every single work. No matter if you work with
372		eating disorders or, or other kind of illness or problems. Because I think you know, there is a lot of cultural stuff
373		which comes into play because it include, it is SO :: ehh, so important, in every culture (nnh) and, not
374		only food but even you know the perceptions of urr :: BODY, body image you know err, whether you
375		are slim, whether you are big girl, whatever you know>. .hhh you eat healthy, you train or :: you know

376		you like TAKE away and all that kind of stuff. Now, you often will see :: mums get or Dad or parent
377		getting hurt when young person says " Wow, I don't want your lasagne no longer." and they will be like
378		"But you always love lasagne." (nnh) you know so and, and that's where I thinks culture comes in
379		because each culture had difference tradition around food, about emm body and all that kind of stuff.
380		So yeah (nnh) definitely. It is important to be conscious about it, in the work and because you could
381		easily prescribe, a specific diet, for the family. But it might be completely inappropriate for ↑them (nnh)
382		and you know, for their culture and and, and traditions within the family. So you know it is important
383		to be curious and that's why I think family therapy is, come in handy, has to be curious, exploring and
384		guiding them finding their word (nnh).
385	R	And You mention body image ye, one of the things. Em and I was just thinking about you also mention
386		at the beginning, you mention about err story about being thin is very similar to your own upbringing.
387		You know childhood (nnh). Do you think that similarity of, of body image culture, err, how how does
388		this develop in your work in this field?
389	P3	Nnh, I think it is about, again being open to different cultures and how different body image might be
390		seen differently in their own cultures (nnh). And you know I am very aware how :: body image is so
391		important in the current culture. In England and how :: you know social media keeps :: ↑filling that in
392		and filling that it err, make young people wanting to be thin. And and, you know kind of needs certain
393		criteria, certain image, be certain you know size and shape and all that kind of stuff.
394	R	How do you work with the family about that? [(.2) when it arise
395	P3	[(P3 sighed), I think about eh finding out whats appropriate
396		in their, in the family and in their culture, is nhh yeah because (.2) yeah you could assume but again guided by
397		your narratives. But it is about finding what's appropriate in their culture, in their family. In regard to
398		that because I think, you know ehh, it is like. The example was were one of the Dad emm, would make
399		comments about other overweight people and that would make the young person upset and anxious
400		about have becoming overweight and how she would be seen. So we in our work, we explored her

401		sister started relationship, and Dad, as a young girl, and developing and becoming a young woman and how
402		that relationship err, how we both struggle to change. And whats that still a kind of young, Dad
403		daughter relationship. We also explore the ehh, family scripts and how in a previous generations.
404		Within Dad's family, Dad was very ↑susceptible (Nn Nn) in remarks on you know, overweight people
405		and I think somebody in the family died from ::: what they were described as being fat. Obviously there were,
406		when we explore Dad did admit that other health conditions, which were the cause of the death. But
407		the message within the family was that particular person died because of fatness (right). So you know,
408		exploring genogram, and and looking at the kind of generations stuff, of how :: those, where those
409		messages might have a kind of come, help the young person to understand that sometimes Dad doesn't
410		MEAN (nnh) saying those. But also, the message is, even Dad when he was young, he found those
411		messages very upsetting (nnh). But he kind of repeated, where the pattern himself, in saying those
412		certain things >.
413	R	Nnh, you described quite a lot of family therapy skills. I was just thinking about ehh what you as a family
414		therapist bring to eating disorder service on the issue of race, ethnicity and culture?
415	P 3	Emm, (.2) I think eh, family therapist, I think from the personal perspective it is about that curiosity
416		and being open ( ) to other cultures and other ethnicities. And knowing that it will be, it can be a big
417		strength (nnh). In regards to you know, using the culture traditions where their strength inside the
418		culture to overcome. So to me ::: so it is about whether it is case discussion or, or case formulation.
419		To me is about thinking where, where Graces sit, where will Burnham you know, where families was a
420		ethnicity, culture and you know all the rest of the Graces. And how that could be used (hnn) and how
421		that could be used in the field, how to help a colleague and you know whether it is system supervision
422		or :: a meeting or case discussions, to explore those things (nnh). And use them in those, advance to
423		help the therapy, in the therapy room.
424	R	Nhh, right. Eh, I was just thinking about RISK, risk in eating disorder. Emm just thinking about a time
425		you manage risk in your work and and race ethnicity and culture?
(59.52) 426	P 3	So my :: my core profession is a nurse (nhh). I am a psychiatric nurse (nhh) I think I always reflect that

427		whenever I am placed (R coughed) by a very risky group, registration where, where there is low weight
428		or physical health complication or what. And risky behaviours, I often resolve into my safe certainty,
429		safe position of a nurse, and you know and that's where ehh, I feel like whenever I, I am faced by Red
430		is much more difficult to be reflective and much more difficult to, to be able to ::: keep in mind the
431		culture and Grace, and ethnicity and all those kinds of things. Because I think :: the fore kind of, the main
432		thing is to manage risk and to make sure you know, whether it is increase in the weight or rumination
433		of risky behaviour but that becomes the main thing. In those time, I think I need to remind myself that
434		there are other things need to be address, and often by addressing those. It helps with elimination of
435		risk or reduction risks (nnh, yes).
436	R	What do think about you know sometimes eh eh, therapist talk about taking a child home (nhh) you
437		know in the mind, not, not real. I was just thinking about the last time, or a situation where you might have
438		taken a child home in your mind. Do you want to talk about what happen?
439	P 3	Last time I took :: I actually took parents home, not a child (nnh) yeah. I took parent home. Ehh, young
440		girl who has anorexia nervosa. So parents are separated parents, very acrimonious separation and they
441		just couldn't. .hhh They just couldn't, we were stuck in the time of, of fighting each other (nnh) and
442		not ehh. I want, just not able to be see that the young people were suffering but they were able to
443		see. But we were so stuck in the process of, you know proving that they are right ::: in that, the other
444		person strong, that they were able to, eh help or help the young person. So that's when I think I took
445		them home and I, ( ) I felt quite angry about it but also I felt, kept thinking how ::: how my approach could
446		help, how I could help them (nnh). (.4) And that's, that's partly down to, you know my belief and emm,
447		not sure if, I believe it comes from my family from my culture or the child↑ is, should be a priority,
448		so you know if he, two adults I guess decided to have a, or has a child, that child should be a priority
449		and should be you know, if you have any negative thinking or negative feelings towards your partner
450		you need, that's your way of should that, that child is not at fault. And should be protected from any,
451		any harms. So I think that's where it comes from. So I think it took a lot of reflection and, and actually

452		err getting discussing that in the supervision. To to reduce my anger (nnh) towards these parents (yeah)
453		Because yeah, not may be not anger, may be emm being annoyed with them. (Humm) And you know,
454		feeling AHHH just, just stop it, kind of you know (nnh)
455	R	Yeah and, and did that allow you to be different with them or
456	P3	I think more compassionate, mo::re open to help cause you know when I felt annoyed, I felt stuck,
457		and I felt like (.2) at one point, I felt like you know I needed to get this two parents who refusing
458		to be even to be in one room. At one point, I felt like oh, if they won't come together in one room.
459		Nothing will change. I need to get them in the room, so I think when I, when I manage to reflect and,
460		and see where this wish of, you know, getting this parent in one room comes from that's when I was
461		able to be more open and hear their stories.
462	R	And what happen after that?
463	P3	Emm, we we manage to find a plan where parents were able to communicate enough with each other.
464		While the young person and be able to help her, with the meal plan, and you know, and with recovery
465		with treatment plan (nnh).
466	R	So eh, would race, ethnicity and culture come into any part in this example that you described?
467	P3	I think its part, you know my own own narratives from my:: my :: my upbringing you know that a child
468		is, should be protected from parental, parental (yeah) disagreements or fights or anything like that
469		because I think that was always the case within my family. Children were always protected from, if
470		parents are divorced or anything. Children would be, there will be always made attempts to protect
471		children from, from any (nnh) despair. So that's where things, if I wasn't emm aware of this. I would
472		have been stuck in trying to get these parent to agree, or meet or you know. >Those kind of things
473		which might happen, harmful.
474	R	Nnh, what sort of culture you think these parents might be coming from? Eh, race ethnicity and
475		culture.
476	P3	Ahh, I think ↑they are :: Spanish somewhere on the mother side (nnh) Dad, I think white English (nnh),
477		Yeah Mum not sure if she is mixed Spanish and English or kind of third generation of Spanish or
478		something like that, don't know, not sure.
479	R	And the belief about children's care, looking after children, are they similar or different from yours?

480	P 3	I think it was interesting that its, they were saying the right thing, so they were saying no, we
481		understand that the young person got, this kind of stuck between us two and it SOUNDED like it was
482		similar beliefs BUT we were stuck in, in that disagreement cycle (nhh), and and we were stuck (.2) in
483		trying to, I said prove children wrong (nnh) position. But it was allying, and and not allowing them to,
484		to see whats happening.
485	R	Its complicated situation, and you have to deal with in your field you know. And can I ask just slightly
486		the direction a little bit. And can you, are you able to tell me a situation where nice guideline been
487		helpful or restraining in your race, ethnicity and cultural practice?
488	P 3	Nnh, I think in general nice guideline is are helpful. In regard to helping the treatment emm, (.2)
(1.10)4 89		sometimes it feels like I don't know, I don't know how to explain it. But sometimes it feels like if I feel
490		if I feel like my ethnicity might be hindering the engagement in regard to, if I feel that family believes
491		that she, she is not English. That's when I will use the nice guideline in our discussion to show that I
492		am aware of those kind of thing.
493	R	Quite a good support for you then, because you are, eh from a expert position of a guideline.
494	P 3	Yeah, and as if, I don't know it just, it's a WEIRD thing but it somehow feels like far more English
495		family and I feel that :: they:: might regards me, I say not less but like "Oh, you are not from here so
496		you might not understand"(nnh). I feel like understanding their guidelines, the government guidelines
497		, in being aware of them puts ↑us on the same kind of page (nnh).
498	R	What do you think they mean when they "you may not understand"?
499	P 3	Nnh, sorry.
500	R	When you say eh when you mention they say you are not here, you are not from here, you may not
501		understand, what do they mean when they say you may not understand?
502	P 3	I think you know you are foregin name, not English you might not understand or be able to help.
503	R	Understand what? Understand?
504	P 3	Understand may be where they are coming from? What is like for them? What you know, what :: how
505		to help them, the specific problems.
506	R	Okay.
507	P 3	Specially may be if its in regard to, you know in a kind of disagreement or any specific tradition, things

508		like you know I would feel that sometimes from the older generation. So white British where they, I
509		don't know, if it is age, also but, whether I be able to understand what it is like to be a . I don't know
510		Dad in his sixty, in in a white British family, that kind of stuff.
511	R	So how do you go on then when they say things like that?
512	P 3	that's why I think I become an eating disorder expert (nnh). That's where I would use nice guideline
513		to support. But also you know, it depends, it depends on, on the risk. If its very risky ehh, ( )
514		regards you know, weight or any kind of risky behaviours, then its, it might be a expert position in
515		nice guideline but it is less risk. We then adopting a curiosity and you know, exploring and wondering
516		and all those kinds of family therapy skills (nnh). Yeah
517	R	And did did, was it helpful by adopting the, that position?
518	P 3	Oh yeah, oh yeah, often you know. Often, yeah definitely. Definitely I usually find that by adopting family therapy
519		skills is, is ehh much easier to engage and, and build that relationship whereas (nnh) if you, if you, if you
520		adopt that expert position often, that just builds more barriers (nnh). Ehh sometimes it nearly,
521		especially if, if you feel :: like there is no time to be curious, or to explore or you know and that you↓.
522		Of course you can still explore and be curious and expert position but sometimes you need to take
523		that risk, makes you take that.
524	R	So, is there a time nice guideline is restraining, you know you mention something helpful?
525	P 3	Yeah, restraining. Emm I guess when you, when people .hhh try to. It could be restraining when
526		family had read and start demanding for specific treatment (nnh). So you know can, my daughter need
527		CBT because, because you know I read this in nice guideline. So they said that. When you know, when
528		as a professional you feel like, there is need for family therapy or for more explanatory you know
529		way of working in regards to exploring things and, and yeah. So that could be unhelpful.
530	R	Nnh, and I was just wondering :: if your team, are there any different views from your team that might
531		answers this question differently?
532	P 3	Whether nice question could be
533	R	Eh, helpful or restraining?
534	P 3	Ahh, I thinking different profession probably will have different views (nnh). Because I know from my
535		nurse position you know. It would be possibly and lot about extremely helpful (nnh), whereas you know

536		from :: family therapist position there is this both and, and it can be both helpful and unhelpful. Though
537		similar view would be from different professions within the team (nnh) I would guess.
538	R	How does race, ethnicity and cultural discuss in your team, in your wider team?
539	P 3	I think we discuss it quite openly and you know often people will say :: if it is Spanish family we work
540		with, we might you know hear people say "Well what it is like, will it be different in this family or that
541		family?" you know or yeah. I think we are quite open (.2) to race and be curious about it.
542	R	Nnh, so can you tell me about arr dominant discourse about race, ethnicity and culture in eating
543		disorder you hold professionally?
544	P 3	Dominant discourse, Oh hhh.
545	R	that belongs to you, that you hold?
546	P 3	That comes from my personally life? Or professional life?
547	R	I guess both, I think they are both.
548	P 3	I think so. Yeah that's what I am thinking. Emm, I don't know (.2) I guess that goes back to (.2) I don't
549		know. It's a tricky one because emm (.2) I know REC is very different for different cultures and I am
550		aware of that. And I guess I am aware of the current :: need and want :: to be, you know how thinness
551		attributed with beauty outside. And kind of emm, in current society especially amongst young people.
552		(nnh) and how it is important, how it is real and how important this to the young people we work with
553		(nhh). So Yeah.
554	R	And how do think this discourse has develop in your practice?
555	P 3	I think ( ) the more experience I gain and working, the more I working with eating disorders it changes.
556		Because I think in the beginning, it was, ah just eat kind of attitude, and, and thinking ahh it just silly why can't
557		we eat and you know, and then, and then our time taking to eat the carbs, lots of different aspects, race,
558		ethnicity including intestogastro how it affects eating disorders and how eating disorders develops in different
559		cultures, and how they have different faces and different cultures and yeah, and how it is important
560		to understand that and be aware of that.
561	R	Nnh, so, forgive me when you say they are different. Can you give me an example that how it changed
562		over time for you?
563	P 3	Err, how it changed

564	R	or developed, you know my question is how it develops in your practice?
565	P3	The discourse?
566	R	Yeah.
567	P3	.hhh emm, maybe I just in the beginning I thought that it was the same for everybody (nhh). In regard to
568		you know, it is a kind of help like about not eating and that's it. It is about being thin, losing weight
569		and that is. But when you gain experience when you work with these families you realise that there is so
570		much <u>to it</u> and, and so much is in, in culture included, including culture and ethnicity, and you know. How current society
571		making, HOW current society causing or encouraging the eating problems and difficulties. So I think it just emm increase
572		understanding and awareness. (nnh) about the topic and what's happen, whats causing emm, what
573		why they causing it and maintaining it (nnh) yeah.
574	R	Thank you very much. Can you tell me about the experience of being interviewed, in this interview?
575	P3	It did felt like being interviewed (P3 giggled)
576	R	I am sorry (R giggled)
577	P3	It's okay, don't worry. It's nice, it's been (.2) it was okay↑. It was all right, somehow I don't know why
578		but I felt like I should have prepared a bit more.
579	R	Like what?
580	P3	I don't know, it just felt like. Oh damn it. I should have thought of cases or you know things like that.
581		But I know that it is not about that, you know. It is about now, whats whats relevant at the moment.
582		But maybe not. It is just that current, not current but constant emm culture of NHS or wanting, not
583		wanting but you know, showing people that you know your stuff.
584	R	You mean you like to show me that you can tell me. Is that what you say?
585	P3	Nnn,nnh.
586	R	I am sure you know a lot of things, you know you are specialist in your field you know. Emm, I was
587		just thinking the experience of interview by me, someone from a different ethnicity race and culture
588		from yourself?
589	P3	I think it help me in regard to be able to talk about other cultures (nhh) yeah, so. Yeah it definitely
590		been :: wasn't hindrance or anything. It was definitely helpful.
591		Nnh to be more open, to be more able to share my experiences.
592	R	Nnh, for example if I am white British English would that makes it harder or different?

593	P 3	I wonder if the content of what I was saying would have been different (Ehh). In regard to, emm I am
594		more aware of some of the example I have given was about white British (Nnh) So, I wonder if what
595		I was saying was about, it would have been slightly different, not wanting to offend your culture (ye ha).
596		So :: what, it would have been conscious about it (nhh).
597	R	The safety is always at the back of your mind when two people from different background (yeah) so,
598		can you tell me this interview, how this interview may made you feel about your race ethnicity
599		cultural practice, you know current practice?
600	P 3	I think it, it reminded me the importance of it, you know as I was talking I already thought NNH, I don't
601		know much about the first family's extended family. And you know I was so blinded by risk and thinking
602		about how to help refeed but you know I may be spent less time on thinking about culture or ethnicity
603		and all that. That kind of stuff. Yeah, so this interview definitely reminded me about the benefit of
604		exploring that with families.
605	R	So what, what do you think the biggest challenges in the field of eating disorder and race ethnicity
606		culture in family therapy? The cross over of these three aspects?
(1.26) 607	P 3	I think risk (nnh), definitely risk yeah (yeah). Because these patients can become risky so so quickly.
608		That you know, often that will paralyse you from doing anything. So you know if you start doing
609		sculpt and then somebody dropped 5kilograms in two weeks or so (nhh). That you would need to
610		(nhh) address that. And not, and may be there won't be enough time to continue with sculpt or
611		genogram or something where you would explore culture and ethnicity. So yeah.
612	R	Safety again is, is ( )
613	P 3	Nnh.
614	R	So may I ask about your context then, you mention community and working with the Maudsley Model
(1.27) 615		(yeah) and what does it mean in your team. Do you have a, a refeeding team, [or
616	P 3	[No, so everybody,
617		majority of people are trained regardless of discipline in Maudsley model (yeah) and everybody will deliver
618		because that is first line treatment (nnh). So everybody will deliver that treatment and then arr if once
619		the refeeding is done. That if, for example, the young person might need more individualised care, then the psychologist

620		might offer that and then emm, if there is family issue then family therapy might continue or take over.
621	R	Nnh, the model like you all do assessment and you all do treatment (Yeah). And then the
622		multi-family group? You know.
623	P 3	Yeah, we do, we do that.
624	R	And you all part of multi-discipline, multi-family group. (yeah) in conjunction.
625	P 3	I will need to finish soon.
626	R	Yeah, it is 5.01 I need to stop now (yeah) so thank you very much. So just one last question is more
627		demographic (P3 name) (yeah) It is about, I got your ethnicity, your setting and how long you worked
628		in family therapy because when we email exchange you say you worked in the field for one year, correct?
629	P 3	Yeah.
630	R	Obviously, none of these are compare or anything (yeah). It just part of the information really. So
631	P 3	As a family therapist (duration in the field) but I worked previously in eating disorders for (duration).
632	R	Okay, yeah. Err what now is like I will transcribe it, analyse it and then I write to you with my analyse
633		result, probably in about three months time. Because I got quite a few to write up (nnh) and then the,
634		sent it back to you err, inviting you to have a look. And then, with the question "what stood out for
635		you?" So you have a chance to say (okay) this is completely ahh not what you mean, you know. You
636		have a chance to say (okay) And then I will incorporate your response to the final data (okay), So so so
637		you have a second round, not just I take something you say and then, interpret without you having a
638		chance. So it is more recursive. And after this, if any of these conversation stirred up anything for you,
639		do come back to me if you feel, feel like to or use your supervision. (yeah). Because it is like talking
640		stir things up. Afterwards, you might think about other things (yeah). But if you think that anything that you
641		have missed out like you say, do drop me a line. I can take it as well. (Okay) So don't think that's
642		the end of it, you know (okay). And that's more or less I like to say. And a very big thank you.
643	P 3	That's okay. You are welcome and I look forward to reading it.
644	R	Thank you. Emm thank you very much. Take care bye bye.

645	P3	Thank you, bye bye.

Appendix 1d: Transcript for participant 4 – Diana

1		
2		R: Researcher
3		P4: Participant 4 - Diana
4		
5	R	Okay, I think err (.2) things are all in place, all the meters, all the timers and all the things should be
6		buzzing are. I think (R laugh). All right, thank you then. All the machine looks like is working, so emm,
7		so thank you again. And so this is a semi-structure interview, I will ask some question and you respond,
8		and we have a dialogue, you know. No right and wrong, its about your experience. Emm, so first of all I like to ask you how do
9		feel about this research title. And the title, just to remind you is Race, ethnicity and Culture in family
10		therapy with children with eating disorder.
11	P4	Emm, I, when I saw it first when you we:re inviting candidates to engage in an interview with you.
12		Em, I begin quite interested in it because emm, I begin fascinated about the people who come to our
13		clinic, but also on a cultural level because
14		emm when they, when people are talking about,
15		emm err you know weight for height, we do not BMI, and they are talking about cultural differences
16		and I↑ became interested in that, you know how do you know when weight is different from,
17		for somebody who is white British as suppose to somebody who is emm black African OR Chinese OR
18		Asian OR you know different cultures. Emm and race. And I begin interested in that and I always
19		being curious, Oh :: you know, because she is Asian her weight would be low. And I thought, Oh how do
20		you know that? I mean you know and also I became interested in it for another reason WAS because of
21		emm the beliefs, there are held from a cultural and a race perspective.
22		Emm, because when I work with two families. One family black African and one family Chinese. And
23		the voice of the child was not very present. And the voice of the parents were emm (P4 clears throat)
24		they :: my perspective was, when we are engaging in dialogue was, are they expecting us to tell them
25		everything and they came with a dominant story professionals knew. And this was a kind, with an
26		alien topic to her, and it was really interesting. That was not just say it is not alien to white British

27		Or :: err white people. But it is a very frightening illness anyway for some people but yeah. So I became
28		interested in, from a culture and race and eth, ethnic backgrounds. What is the meaning of eating
29		disorder from their present, from their experience? And what do they know. If I were to tell them
30		things about you know, particularly within psychoeducation domain. How would they receive it?
31		What would that mean for them? (nhh) Emm, yeah↑ SO.
32	R	So, do you think this emm what you just talked about, do you think how it connect with you personally?
33		or professionally?
34	P4	Emm, I think on a professional level there is one story. Personally, emm I think within my own culture as
35		well. You know because I am white Irish. (hnn) And :: in, in England or Britain, its, you know when I
36		join the team, professionally. It was almost like was rolling off their tongues. It was emm, a script
37		they knew very well. Emm, there was all the, you ought to, you should or the deontic operators
38		were very present. And, and I guess I thought that how do I be a systemic therapist here, with curiosity
39		when there is such a knowing truth about it (nnh). And it was very located within THE ↑Medical
40		domain. Yes, you eat food, then you gain weight and then they go↓. And I (P4 clear her throat) so
41		that's one aspect in the model and approach. And I wonder how, HOW do you become curious about
42		something like this. You know, particularly from a sense of, our our formulation you know. Err,
43		curiosity, neutrality, circularity. So I was thinking, well how do we apply this with all these truths. From
44		a personal perspective, I grown up with so many truth. You know when I, I think about the context of
45		religion as well. You know, emm and and about the different positions in the hierarchical structure
46		and definitely within the religious domain. In the Catholic, How :: (nhh) That sort of, there was, there
47		was almost a mirror reflection of Both And. Where :: you :: know emm :: you:: the hierarchy or the
48		magical model of dominated. And it is a bit like, well, your Catholic script, religious script dominates
49		and therefore, therefore. And I thought you know I, I, I, for me I, on a personal level the religious.
50		Although not so present, but it carries with me Always. Because you are kind of rub into your skin
51		almost. You know what I mean, but I have to question myself and reflect All the time. So from my

52		religion and my culture were very influential. Emm, on a personal level (nhh) and on a professional
53		level, those two were very influential in :: how do I approach? a hierarchical system with such knowing
54		and truths :: and with little curiosity. Particularly in phase three of the treatment which I don't go
55		one, two, three↓ but developmental stage. NO, yeah, so ::.
56	R	Err, (so) are you, are you able to give me an example of what you just said?
57	P4	Emm, so when em, when somebody come for treatment (yeah). And were very poorly, really poorly.
58		And it took me a while to get become Curious about emm, my position as a professional because the
59		nurses will be in their unique, to me. This is the meal plan, this is what you do. Now go home and do it.
60		Now, we adapted the Lock approach initially because that what they brought in for training. And I
61		wasn't very KEEN on Lock, at all. Emm, I have to see some some, er, some er Affordances. But I had,
62		to me there was some constraining factors because Lock did not see the approach anyway near
63		family therapist, anybody can do it. Well, I find myself caught up in a position initially. Emm, how, how
64		am I meant to be, as a systemic therapist here, with this. And where is Lock approach was very
65		dominated by the narrative model and Minuchin, etc. So I find myself more or less a kind of asserting
66		my position more, and almost finding my voice and finding my position in that. So I had to work really
67		hard, emm and to, more or less say well that's Lock. But the Maudsley would not have that approach.
68		So I, I kind of working more with the Maudsley (nhh). So and (name of colleague) and I, we went
69		through the Maudsley, both (name of another colleague) and I, emm OR OTHERWISE we would lost
70		our IDENTITY in that. If that makes sense (nhh). We wouldn't have an identity, it was err, to be
71		something that was more about the medical model and we would just brought in because the emm,
72		research said you must have family therapy within your team. And that's the kind of sense that I was
73		getting. I thought well, you know we have to have a voice in here, how do we work? How we were
74		going to be↑? And so I, I try to set up the reflecting team which work really well. But I go slowly↓, so
75		that I didn't, I mean a, come in and walk on people's toes. I had to be a bit Curious and work with

76		them, and embrace them which is the right thing RESPECTFULLY. Do I think for, so that is one example
77		of me, coming in there I think I got a voice in there. But I don't accept that to leave, when somebody
78		said this is what we do. I do challenge a bit more.
79	R	So, by the sound of it, correct me if I hear you wrong, is that you bring systemic thinking into a very
80		medical model. (YEAH) and I am just thinking in terms of race, ethnicity and culture. Do you, is it
81		part of it or, or, how does it emm show?
82	P4	Emm, I, I, I think emm, I think it is part of it. Because if I look at my own personal experience with
83		my race and my culture. Emm, my culture, my religion and culture I would think (nhh). Story is
84		quite dominant in my life as I was growing up (nhh). But you know, with, in in Irish emm,
85		err communities. Religion and culture, there was, hard to find distinctions (nhh) because they blended
86		in almost. ↑For me, when people come from race and ethnic backgrounds. I wonder how much
87		their culture and race, ethnicity was. How does it influence then. And SO :: I will USE my experience
88		as, as a <u>resource</u>↑ to become curious. Because I think our story lived and our story told, and
89		experience are very much resources for, enabling the voice of the, the clients.
90	R	So, carry on, sorry for interrupt you, carry on.
91	P4	So emm, for me it was when I would see some of the::se families coming. I would just hear them
92		sitting and listening, and not challenging <u>anything</u> (P4 taps the table rhythmically). I often wonder,
93		I would become curious about, you know will you, tell you about this? What do you expect? You tell us,
94		you know it all, you know so they came from that <u>decision</u>. Almost professional knew more.
95		And I was very cautious about, how I am positioned (.2) would, may be undermine people from
96		race, culture and ethnic backgrounds. (nnh) So there is that position of emm, how do you create
97		the relationship that meant to be you know, an allegiance and rapport. Emm, when they may have
98		these stories. So, I think for me when people come in, I become immediately, not immediately but
99		curious about their position, about us and what do they, what would they like us to be doing? What
100		would they like us to be thinking with them. Whilst <u>also</u> thinking alongside we got a very sick child.
101		(nnh) you know. So Yeah.

102	R	Nhh, so can you, just thinking about any family that you come across you feel that race, ethnicity,
103		culture is in the room that you need to↑be more mindful of?
104	P4	One stands out, TWO↑ stands out actually. (P4 put two fingers up, both P4 & R smiled). And, well the first one was
105		emm, she was emm, a black British girl, parents were from, they were black African. They were
106		absolutely lovely, really lovely people. And when they first came, the little one was emm, she was, she
107		was very sick, very poorly. And one of thing I notice every time she came into the clinic room, all she do
108		was cried, just tears. (P4 clears her throat). And it was very hard for her to tolerate the conversation.
109		That was my hypothesis, she finds it really difficult to tolerate this conversation. I wonder, you know
110		what might be going on that she finds difficult. Is it because we are trying to help her to regain weight?
111		Emm what does that mean for her? But when we put her in another room, she will immediately calm
112		down. And she like doing cross works, ↑Maths, anything that was problem solving exercise she like
113		to do it. When we work with parents, then in the family system they notice how insular she have
114		become, overtime. And there was emm when she was admitted to hospital they had to emm, take
115		her to the A & E because her bloods and blood pressure was really low. And really dangerous and she
116		became very distressed in hospital. And when they were there. Emm, they wonder were she being
117		abused. (Nnn) and they went through safeguarding in the hospital. So one of the things when they
118		came, they were real:ly more of less <u>traumatised</u>. Emm, by the fact, they might be <u>thought of</u>
119		as abusive to their child. And we became very interest in that (nhh) you know. Emm, because what we
120		learnt was the voice of eating disorder was so strong and the behaviours that eating disorder was
121		emm, engaging the child into, were abusive behaviours. And so the medical staff in the general
122		hospital didn't really understand this, see that. But I think for them, their race as well came up in
123		conversation about how the colour of their skin might have been an influential factor. They didn't
124		feel they had a voice. Emm, their daughter was very distressed. And the Yeah, so when they came to
125		us. I think they were very cautious of us. I was, our story now had been experience of emm, they been

126		abusive parents to their child. And that's why she was starving. So there was a very dominant story.
127		So they were absolutely adorable family to engage with. And once we (P4 clears throat) began to
128		also, as we listen to them and hear their story and hear their narrative. It was emm, it was quite interesting and
129		move along the child would stay in the room. The tears would sort of stop, they were, they stopped.
130		But no voice. And we became curious about other things as weight was progressing. There was
131		other things and we talked about, you know when you first meet children. When they first come in,
132		you not necessarily getting the, emm whole family picture. But once you get the distress down then,
133		you can go on start thinking about the genogram and their relationships and what they notice. This
134		girl emm, and she was fourteen at this point and weight restored. But we began to think about her
135		relationally and how she was at school and all other wider discourses. So and, and we learnt you
136		know, we had, we gave her questionnaire for emm social communication. And she came out so
137		positive on it. And she has now been diagnosed, weight restored, doing very well but in the team she
138		been diagnosed with ASD (nhh). Actually on reflection, they didn't know she was ASD, didn't think
139		worry about ASD. They began to learn about, I think working with (service name) were influential for
140		me as well. That we don't assume it is all eating disorders orientated you know. And also, with this
141		family of their race and culture. Emm, I became, well I suppose I became very passionate about this
142		family. And that they needed to have an assessment urgently. Not wait two years because that, yeah
143	R	= .hhh (yeah) when you say black? black British? What are their sort of country of origin?
144	P4	Emm that's not their country. No, not black British. No, their child is. But their country of origin is
145		Africa.
146	R	Africa.
147	P4	Yeah.
148	R	Sorry, I interrupt you because I am kind of forming a picture of
149	Diana	Yeah, and er you know. We got the most beautiful letter at the end. It was very touching, interesting
150		when you are talking with these people how much it will impact you, think you don't realise how much
151		of an impact. Well they talked about respect and about, thinking about their race and culture as

152		important influential aspect in the treatment as well. Emm, so you know their sense of food, you know
153		and from our perspective we were saying have this, have that. But their sense of food, what food
		would you eat, what food what she eats? What was her favourite food? You know, what kind of food
155		has become less favourite (nhh) and what kind of food had become more favourite. It was interesting
156		the food she did not know how to eat, the food outside their, their :: their dishes they would normally
157		cook. Emm they were raising other food as well, so we, I said how about we start with some of
158		those safe food you know. And they weren't within their kind of, wasn't their kind of belief that she
159		should have for dinner. But it was about first and for more, taking her out of the risk zone so the body
160		was in receipt, to be able to receive food. So er yeah, that was really interesting but what lovely people
161		, emm people, and both mum and dad :: came every session religiously. And dad was emm he was emm
162		a bus driver in London and mum work for a GP (nhh). And her GP was gorgeous, her GP spoke to us as
163		well. And you know, she said she is one of the most hardworking people in my surgery. And she pushed,
164		it was in (name of CAMHS). Emm, she pushed to have the assessment. So the influence of other people
165		to have her assessed quite quickly. (Aha) you know. I think for me, eh she felt the treatment they
166		got was emm FIRST class she said you know. With I think, professionally if my voice wasn't in there
167		how would it had been? Because I was very cautious of safeguarding and the impact on them. And
168		within their ethnic minority group and what that would look like? What that means? And we explore
169		that I didn't want to leave it there because I thought if we don't talk about this. They might form a
170		belief that we are joining, the people in the general hospital (yes, yes), yeah.
171	R	(.hhh) so just what are the specific eating disorder issue that you have to discuss with this family then?
172		Emm, what what, err. Mainly when they initially it is emm about weight. And weight is quite low and
173		also how we going to feed the child, a child who is refusing food (nhh). What are their narratives?
174		That oppress her or suppress her desire for food. And when we emm, looked at the family system as
175		well. And think about the dominant of food conversations. And how we can begin to organise the eating

176		disorder as suppose to the eating disorder organising the family system (nhh). So we would engage,
177		would engage the siblings, the importance of siblings their voices (nhh) and about bringing back voices that had been,
178		a relationship that had been forgotten because the eating disorder emm, has such a dominant
179		voice to forget people, to isolate people (nnh). So they would be the conversation from a systemic
180		perspective and we look at how the family are organised round the dominance of food,
181		conversation. Because, with this family food is a big part of their culture (nnh). And how they ate,
182		what they ate? (Nnh) Emm and also when she went to school as well you know.
183		Emm, when she moved into secondary school, then that was the moment. You know, mum would
184		always pack her lunch box. Mum will talk about you know the eating disorder, to begin to put food in
185		that look the same as others rather than different to others. That was interesting as well what would
186		be different why not have it the way you like it. You know, what would make you not want that food.
187		And I think it is about her, not standing out too much and the smell of food as well(nhh). So I think from
188		a systemic perspective working with family, there are lots of conversation and lots to be curious about
189		which are very important from a race, ethnic, culture perspective. Emm, so that we begin to empower
190		them, ehh as families. So that they are appreciated and, and and and and respect given to them, yeah.
191	R	So how do you think the low weight you talking about is organising the work you know. Has it got a
192		place?
193	P4	Sorry?
194	R	The low weight, when you, talking about this girl who is very low weight and had to be in hospital. And I was
195		just thinking about :: does it organise the work?
196	P4	Oh yeah↑, I mean it is obviously you know when it comes to emm the domains. You know emm it
197		would organise me. Emm but I find it is about. For me it is about how do I form a relationship whilst
198		also been very clear we have to feed the child yeah. And how we going to feed the child and the
199		approach for parents. So we doesn't become high expressed emotion in the home. But because there
200		will be enough of that from her initially. For that they, they very, how they stop positioning themselves

201		with the eating disorder are very control. They are in command. And so we do a lot of work around
202		when you see the behaviour, how do we begin to think about what response we are going to give you
203		know. So I think for parents when they were thinking about their culture and their err, well how they
204		behave because the behaviours they saw from, they saw their child engaging in were something so
205		new. They just said she was the most placid child. (nhh) so this were very different for them (nnh) you
206		know. Emm so I think what were, you know, communication is really important to think about. What is been
207		communicated, who was the child speaking with? (nhh) in that moment? You know, emm we would
208		think about the brain as well. And about when the body gets starved, the brain gets starved. And so all
209		those kind of, those metaphors. I used to draw images, I am not very good artist (R smiles & P4 draws
210		picture of body). I would draw the images, I will talk about how the brain, you know. I will do something
211		like this, I will show you. And the TEAM love it. I don't know how I, its not something in the literature.
212		(P4 draws matchstick person) I would just just do a matchstick man. And I would you know, emm,
213		do :: a speech marks and I would look at the brain, a kind of like this. And I would say (P4 continue to
214		draw more) the brain sends a signal to the body to say I am hungry. Yes (yeah). But the body, but the
215		body doesn't want to, won't response. Yeah. So I say this, you know it is like that (P4 draw a cross to
216		show message is not connect between body and brain) yeah it is only a one way system at the moment.
217		(Yeah) yeah. However, when the child starts to RECEIVE FOOD. Because the parent are really caring,
218		Then we get a circular approach. Does that make sense?
219	R	yes, yes.
220	P4	So my, and and they were looking at, and the children would response. OH, Is that what my brain is
221		doing to my body? So rather than going in, emm with you must, therefore, therefore you have to,
222		you ought to. We could say, we say to the children at that point because your brain is not operating
223		this way. We have to depend on your mum and dad to help you eat. Because of the eating disorder is
224		really caught up in your brain. Telling your body you don't need food. And that is one way of putting

225		it. There is all different ways we would do it. Emm, it is amazing you know. I mean the power of food,
226		the ↑power of food is just amazing. Emm, but interesting the power of food within the race and
227		culture, because their, their dish was mainly rice and all kind of favour food, potatoes and all. And were
228		all the food the eating disorder didn't want to have (nhh). But that's not too dissimilar to anybody
229		coming, you know what I mean (ehh). In terms of carbohydrate (nhh).
230	R	And then, and then you will work with the, what you were talking about in terms of like race, ethnicity
231		culture conversation alongside with what you are doing.
232	P4	YEAH. I mean when you, when I see emm the Maudsley model. We did this in, we were in a conference,
233		about the model. (P4 smack lips) And this was in London, we went on three days yeah. And it was
234		all about eating disorder conference for three days. And one of the questions was about the model?
235		Is it the eh you know, phases of the model. It was you know emm, yes this is the way we work.
236		And it was very compartmentalise. When I was there I said well, I think the model of this structure
237		is really useful, really helpful because it organises you, orientate you in knowing where you are at in the
238		treatment. That's the beauty of the model, where are we at here? It gives you a, a position to reflect.
239		And when I was there, I said I don't see it rigid, and fix. I see it as flexible and fluid. Because when you
240		are in phase one, when you are trying to help the child to eat, help the parent to feed the child. You
241		have to move in and out of the different phases where you would be going into phase three
242		developmentally even you call it. I call it relational actually, everything is relational (nhh). And how
243		we might stay there for a little while but return to a place. Are you okay now to begin? So I think you
244		know for parents coming from a race and cultural background its kind of with this family, knowing
245		how to position themselves with firm calm approach. But also having a story that they been accused
246		of abuse their child as well. And how they might receive, you see the complexities that we are in.
247		HOW do they trust us? (nhh) That we are going to be supporting them (nnh, nnnh). And also bearing
248		in mind that how the eating disorder as well organises the family system to such an extent that

249		where there was no fighting, there is fighting, where there was no swearing there is swearing, where
250		there was I mean it so it can be critique, pretty volatile and I think there can be corrosive
251		judgement made. Because it is become the eating disorder, such a volatile emm angry illness you
252		know what I mean. That emm
253	R	Ahh, I am just clarifying when there is no fighting there is fighting, you mean that is there, unspoken?
254		Is that what you urr?
255	P4	YEAH, yeah, where where there is no fighting, where there was no fighting, there is fighting (yeah) but
256		the embarrassment to talk about it, would (yeah) that was, on the, through the uncertainty of the
257		illness. But there is other story to emm, particularly when you use the. I like the ( ), the daisy model,
258		the atomic model. Because when you get into other conversation when you do that. It enables them
259		to be able to talk into something you consider it. You thought about it (nnh). So when you comes
260		into the context of school. You use the narrative the young person has, has experienced and in school
261		as well (nnh) you know.
262	R	So I was just :: thinking about :: are you able to tell me your journey at the eating disorder field in terms
263		of like a time line, you know. How, how you enter the field and where you at now, you know?
264	P4	YEAH, when I worked in adults in the er, and they were mainly 18-25. (haha). We :: had a
265		rehabilitation unit in the community and it was quite independent. It was trust emm, were the management of it. But
266		emm (local council) were the owner of it. They asked them to run it, we were paid by
267		(local council). And it was a mental health unit and we had all beds in there for eating
268		disorders and normally they came to us about 18. And :: these young people that came were expected
269		to be adult at 18. Well actually, when they came they were, they were :: their development at 18 was very
270		different to :: you know. Somebody who had not encounter an illness. And my journey with these
271		particularly the adult was when they came their teeth were all loses. Two of them, their bodies were
272		compromised. They were involved in compulsive exercises. Now, that time I wasn't really aware of it.
273		I didn't, kind of don't know what model was it. I did some reading but there wasn't much. And the

274		Maudsley multiple family therapy was out at the time. Emm, we engage family therapy with these
275		young people and the illness had been very much their best friend, if you like (nhh). And helping them to
276		eat was a challenge and one girl. Emm I did quite a bit on bulimia, one girl had a ritual every day, how she
277		set up her room, to eat, to binge eat. And and purge (nhh). And then went on, she came from an ↑very
278		affluent family. And all of them did actually, all of them. And there was a lot of theft going on in
279		supermarkets as well. So the illness had encouraged them to go for cheaper foods and, and to binge,
280		purge. And they were mainly too restrictive= I am going, because they were there for two years with us.
281		And err so our way of helping them to eat was very different from the model and approach of the
282		Maudsley. You know learning over the last five years (nhh). So we would have them to eat and we
283		have a dietitian on board. Emm (.2) but the approach to adults was quite different from children (nhh).
284		Because the family system, they felt very cut off by the family system. They felt there was ↑always
285		in er er er, there was always conflict between the parents and the child. So we work from there, what
286		we start to do interesting was WE work more or less from a different position from the model. If we
287		use the model as a framework. We wills start more at the developmental rather than feeding yourself
288		if that make sense (nhh). Some people were having ensures and they had a meal plan, and they, we
289		supported that. We didn't get into food diary really, but we got into dialogue about how they feel,
290		and how they experience, and about their identity (nnh). AND ↑more on their identity, we got their
291		preferred identity. Thinking about, you know, moment by moment with them. One girl in the adult
292		team, where I work. I said would you allow me to see your ritual, so I know whats happening. And
293		that was the most horrendous thing for her. She said no, no, no, no, no. You don't want to see it. And
294		I said, oh what would it mean for you for me to see it. You know why would you think I would be
295		thinking of you. What would be the meaning for me to know, how I would be position. And I think it
296		was the embarrassment. But she did let us in. She brought us into the kitchen to show us how she cooked.
297		And her way with food had become so ::: disorganised. You know she would put two packs

298		of butter into a pot to pour over bread into the pot. Hurry (name of the client) everything
299		is all mixed. And it was like a culture and she would go and she would sat with this big pot and just
300		eat (nnh). There was no rhythm with eating and food, almost completely gone. She didn't know
301		who she was, who food was. It just had gone (nnh). But we worked with her, and we and now, what
302		was really good for her was we started to organise her life without the illness dominating, bit by bit.
303		And we did it, because we are in the princess trust, so that we began to give context round her life.
304		As suppose the eating disorders, being the only context. So for me, it was a journey and I still know these people
305		today. I mean four of them I can think of, where they had not, are not engaging in the eating disorder
306		where they have jobs, they have their teeth attends to and you know I fought for their teeth.
307		This is part of their, your phase, your identity so they, they emm. They have their dental care done
308		free because of the illness (nnh). I wrote letters and I think (name of a doctor), who works with NHS in
309		the (name of area). Don't know where (name of the doctor) is now. Do you know her?
310	R	Heard of her, yes.
311	P4	(P4 coughed) She was amazing, she worked really closely with me. So that was my, just give you a snap
312		shot of that. And then I went into (service name), It was very different again. Emm and when I went into
313		(service name) and bearing in mind I work with psychosis and I worked in an inpatient unit as well, where I met
314		some people with an eating disorder. Although not all did, but it was how they were operating round
315		food. So I was very interesting at, at :: ward rounds and I said this woman is not eating. And she was
316		about 50, and I said why? Why isn't she, doesn't like the food? She doesn't like this. Well I said what
317		does she like? So to explore food with her was very interesting. Because they were given like ensures
318		because she was, she was not. And I said what would her BMI be, have you thought about her vitals.
319		And all of these things you know, which they hadn't done on an acute admission. Because she was not
320		a known, known to have an eating disorder (nhh). So that was my time there, I identified two
321		that were really went on treated, for it (nnh, nnh) you know what I mean. And everything else was

322		been looked at. But I also thought you know, with an eating disorders and psychosis that was very
323		interesting. When you think about it and how :: how distorted if you like :: OR:: confused I believes,
324		become about themselves and the world around them. And, and I always, you know, for me it was
325		almost like emm there was a sense of, I want and I did say this, a sense of madness with the eating
326		disorder. They don't know how to be with people (Nhh). So emm, I, I, for me psychosis er, the the term.
327		I am using the term vaguely you know not. I don't want to put, kind of dominate. But HOW the relationship
328		between the two became fascinate (nhh, yes). And about the open dialogue approach, it begins really
329		fascinating. About emm, you know schizophrenia and all those narratives and stories very medically
330		dominated. But I began to think about the relationship. With an eating disorder and psychosis some
331		what will be different, what would be their beliefs and instructions where it took their identity and their
332		relationships. But these were young people who was start to loss their families (nnh) very similar
333		to young people who I work with in Psychosis. They, the family would, just left them.
334	R	When was that?
335	P4	Emm, that :: was :: about (.2) 2012 to about 2013, to 2013 and to about two thousand, 2020.
336		Right so you were in that place, in that service before?
337		Oh no, before that em I left, I left em the rehab unit. Because that rehab unit which I, there was a
338		deliberation with me. I am, I work there from 1995. Yes, so I worked there for twelve years, as a
339		manager and instil the family therapy model in there. And I wanted a, a social constructionist model.
340		That was the model I call social constructionist. And I call about staff, and staff bringing differences
341		(nnh). So we had you know, two nurses. We had two counsellors and all different ranges of people (Yeah) But
342		I, I :: began to be curious about who didn't have a professional qualification. Because I thought their
343		voices might be really useful. So the mixture was quite powerful you know. Because we had, I make,
344		make sure that it wasn't all psychosis or all eatings but a different range of different diagnosis (nnh).
345		Those that, each one might be able to learn from the other (yeah). Does that makes sense?
346	R	Yeah, so I just, from a timeline so thinking about your eating disorder journey. You mention about

347		the unit that where people come in for two years (Yeah) and eating disorders. That was ninety-five to
348		2012 was it.
349	P4	No, 95 that was for twelve years. So 95, two thousand and. I left in 2012. Is it 95? Oh, two thousand
350		and NO. Twelve years I was there for, sorry. I confused with dates here. So I was
351	R	= Don't worry about the date, I was trying to get your time line in terms of like, the next question is
352		actually just revisiting your, your professional life with eating disorders what might be the things
353		stand out in relation to race, ethnicity and culture?
354	P4	Emm, the things that stand out for me on race, ethnicity and culture. Ahh :: when I worked in the emm
355		the inpatient, emm rehab unit. It was very interesting on an race, ethnic and cultural background. How
356		influential they were to the white people. Because it was white people that were very emm, they were
357		the only one that came with an eating disorder on adult side. We didn't have anybody from a black
358		ethnic minority. All we had affluent white people.
359	R	In your area?
360	P4	In our area. Yeah, emm they had come from (Private ED service) to us mostly (nnh). Emm, so, but it
361		was very interesting on a :: the the mixture of people from different cultural backgrounds, who
362		were influential for them as well. Their voices.
363	R	Just thinking about, er the area you, you are in is white affluent?
364	P4	I, I think emm from my knowledge and experience. I have been working in (name of the area) all my life.
365		And with eating disorders, it ( ) looks like to me :: it is predominant emm class of people that develop
366		the eating disorder. Now that is interesting that how it happens. Emm from a race respective
367		we see little of the err. Well I won't say like a black community we see less of. We might see more
368		from a :: oriental Asian background, yes. But also those people that normally come to us, are :: are from
369		an affluent background with certain high standards for their children (nhh). Am I making sense
370		charlotte?
371	R	Yes, yes you are, you know. [I was just thinking about, yeah. Carry on
372	P4	[That's what I am noticing
373	P4	That's what I notice. And I become very conscious of that as well. That within their, emm cultural
374		background what influences them. And how much their influence, influences the eating disorders

375	R	Yeah, can you give me an example [when you say white and the ?
376	P4	[Yes, I had an, I had a lovely young emm young person, female
377		(yeah) and she was from err. Now I am trying to think where she was from. But she was, she was
378		Chinese. Now, I say Chinese, yes emm (.2). And when I work with her, very much about her identity and
379		she was a very hard worker. Very emm academicly, very skilled academicly, very emm :: perfectionist,
380		have to have everything right, and when we got into the family narrative. That was a story from an
381		education perspective. There were expectation for children, would be able to do (nhh). However, you know she
382		did develop an eating disorder. And very rigid with the eating disorder. And she became a perfectionist
383		with the eating disorder. We began to think about her approach to learning things and developing things.
384		And in her education year, how the eating disorder, she became very perfect at it. So when we began
385		to think about her self-esteem and confidence in relation to people. Then we began hear stories about
386		bullying and her being put down because of her race. And it was a very emotional session and also
387		how she protects her mother was a nurse, in a general hospital and lived on a hospital grounds. And
388		her brother came to the session. And she said when they moved house because there was this thing we
389		need to buy our own house. When they moved house, that's when the racial abuse started to happen
390		and that's when she began to develop her eating disorder and how that had dominated her when
391		she went into school as well. She became more insular, not putting herself out there, too much to
392		be exposed or to be emm, abused. She would say that. And we wondered about her. How the eating
393		disorder was positioning her, to become so much insular and almost fading physically. That WAS she
394		emm showing herself more, rather than LESS. You know what I mean (yeah), the more of her being
395		seen :: rather, and actually was interesting when she started to think about it. She said the more I do
396		it the more they see me. (Yeah). You know, so she was trying to make herself invisible. And even with
397		the eating disorder which is er er so, was trying to make her invisible on a, on a weight level. We
398		began to think about how confidence and food. And how food was a substance which is a medicine

399		to help her get better. And how food will give her strength and resilience. And we talk about food in
400		so many different ways. And she had really restricted. Em and and by the end WOW, was she able to
401		stand up for her rights in school. Because she wants to do a particular subject, for she had been ill
402		with that. She couldn't emm, she misses the boat to apply for the course she wants to do, to go to
403		University. And err YEAH, we worked alongside her you know. We became the voice she didn't have
404		(nhh) and where she began to take on our voices. And you know, em you know in a very kind way. You
405		know so, yeah that, that to me emm stood out for me on er er culture, emm race and ethnic background.
406		And how parent as well, didn't feel they have much of a voice. It was very much how do we talk to
407		people in dominant positions. And I think their beliefs about how they saw people in different
408		hierarchies structures would very dominant in how they.
409	R	You mean the parent?
410	P4	Yeah, yeah.
411	R	And the father is also Chinese, both both parents are Chinese?
412	P4	Both parents, both parents were, yeah.
413	R	Chinese from China? Or or
414	P4	I don't think it was China, I think it was. They would refers themselves as Chinese (yeh). Now I am
415		trying to remember Charlotte (nhh). But emm, because I know Chinese are from different part, you
416		know and, and. You know, Singaporean you, you. Well, Chinese or not. And coming to my own
417		background I am very ignorant. Then what what culture you are from, whats culture like. I will
418		explore that you know, because I been travel a bit as well. Of all the difference, its all different here.
419		It is interesting to travel to get a sense of culture. Because I went to Beijing and Singapore. And emm
420		Kula Lumpar and went round. I was in Beijing for err, for about six days and that was fascinating and
421		↑food is such a big thing, you know. Big big thing and sharing my stories I think and my experiences
422		was a, there is something about enable them to bring forth their own stories. And when you share
423		a bit of your own personal stories as well (nhh). And to be careful about how you do that. Because
424		you own narratives about your own culture.
425	R	How old is this girl?
426	P4	Oh, she. That girl was emm a sixteen by the time she was discharged (sixteen). She came to us about

427		fourteen and a half.
428	R	Right, yeah. (.2) So you mention the parents are, and the whole family are a kind quite, very respectful
429		of hierarchy. And and and the bullying err started when she moved out of hospital ground. The family
430		bought their own house (yeah) and I was wondering is that a family conversation together. They
431		talk about these things or just specific to the girl.
432	P4	Emm, NO. This came out in the session.
433	R	Ye, in the family therapy session.
434	P4	The family therapy session, we wonder about the move. What was that like then? (nnh) And it was
435		emm she began, she tells us she couldn't walk down the road. She couldn't get on her bicycle. Her
436		brother would stand VERY firm about them, emm, you know emm, tell them to sort off basicly. But they
437		were very alone in the new house, her desire to go back to the old house. She said I will never
438		see it as my home.
439	R	The old home is in the hospital ground.
440	P4	YES, yeah. And because it was in the hospital ground. Everybody knew them (yeh). Because all the
441		other doctors and the nurses that lived in the hospital grounds. They knew the children, they were
442		brought up in a hospital ↑community in a way. You know where staff live on the grounds of the
443		hospital, which is ↑unusual today. But they, you know they bought their house about, well they
444		got discharge last year. So they bought that house about five years, four years before she came.
445		She was about ten (nhh).
446	R	It was a very very moving story, of a very nice
447	P4	= very moving, yeah.
448	R	.hhh So, I was just thinking about this case you know. What, what would you say the specific
449		eating disorder issues and race ethnicity culture issues, in this particular case you are talking about?
450	P4 (54.07)	I would say emm. For me, if I was, I would say the eating disorder was conveying so many messages
451		about her loneliness (nhh) her (.2) abuse (hnn). Her sense of who she was, her sense of power or
452		empowerment. Her sense of emm (.2) having ownership over her life (nhh) or not, in this case. Em
453		and that one, part of her that she held very closely was her education. Because she is really good at
454		it (nnh) but also she became doubtful about that. So I would say from em ( ) ethnic, race, culture
455		background. She felt emm very oppressed, depressed. Emm, food was her way of managing her life, or one

456		way of controlling it. Er and I find that word control about that ( ) emm, vague. I think that needs to be,
457		( ) was about her ↑control over her life and she is so young (nnh). Emm and not having the power
458		(nnh). And also she had lost her friends, was a HU::GH emphasis on loss, for her, not knowing who
459		she was or a sense of culture and race and who she was↑. How could she be proud of it when it
460		was being bullied (nhh). You know and and yeah.
461	R	So, these, I mean your, your view is generated from your work, from ehh with them, in the family
462		therapy. These sorts of themes emerges, is it? Is that right?
463	P4	Either emerge, yeah. They are emerging stories (nnh). I think when people come to family therapy
464		is when the clinic, is a kind of what's the meaning of that for them. What are they expecting :: from
465		the treatment. How, do they want? I have to tell I always start about; would you like to know
46		something about me? Would you like me to tell you something about me and how I am with the team?
467		(nnh). Emm, you know I talk, I do give a part of myself. And I, I, I, I name myself (P4's name), I am from
468		(a place), been born bread in (a place) and I have came here when I was young. And I went to
469		University here and talk a bit about my school, a little bit. And about
470	R	=To every client? Or is it specific to people you might think
471	P4	= change, it changes a bit. I would say. Emm, that's interesting on a personal and professional
472		level. Who do you say it to? Who do you not say it to? (Yeh).
473		I would say, now that you ask me that question. That's interesting. I would more or less, I would
474		probably say that more to people who have got a cultural background, of different culture and race.
475	R	(Nnh) so I was
476	P4	You see, that that, yeah. Even with another family with a Dad white British, the Mum
477		Singaporean. Emm, I would talk about my culture a bit more, definitely.
478	R	Nnh, whereas you described a group of affluent white :: eating disorders patients (yeah) they might
479		hear less of that, is that correct?
480	P4	Ah ( ) you know, this is only just emerging from me how much I would think about it with more race.
481		With people from emm, from minority backgrounds (nnh, nnh). Yeah, and I wonder about that? Is it

482		for me on a personal level? What does that mean for me because I think affluency or wealth in
483		particular my grown up, in my Irish life. It was very much em, you know people with wealth, had a more
484		of a voice (hnn). You know, emm and there were certainly, emm a class distinction within Ireland
485		and I wonder about culture, race, ethnicity and class distinction with that as well.
486	R	So if they kind of like, fall into the group of emm, affluent white patient and come into your session.
487		How do you think about race, ethnicity and culture?
488	P4	You know that is fascinating, emm because I would think about it more when I do the family genogram.
489		And I think it is in the genogram these stories emerged, you know (yeah, yeah). And I think it unfolds from there.
490		And I think as well Charlotte, when you WITH families (nnh). YOU, it is really interesting, you got a
491		sense of how they are position them, and they walk in the room. You can, you can feel it, see it,
492		hear it, you know. And it is interesting how the families position me, as suppose and them, both and,
493		BOTH AND really. And and so I think when you beginning a therapy session. Or beginning to get to
494		know you. Emm I call it a getting to know you session. You know, an introductory. It isn't a, a therapy
495		session. But it is not a therapy session becomes a therapy sessions as well (P4 & R both smiled).
496		And I say that. There is always like a deliberation, I am not expecting this to be a therapy session. The
497		minute I do that, I said I get a sense of your family and that's nice to have and I sense your family
498		system. You know, I will be really interested in hearing about you as a family because we are
499		thinking about eating disorder. We want to think about family matters (nhh). Because the impact of it.
500		So I always going on that line with everybody anyway. Emm, so I think within the genogram. You will
501		see lots of cultural, cultures and race at times coming into it. And class.
502	R	So :: yeah. I felt, I just kind of like, thinking about your experience in the field of eating disorder. How
503		do you think it develops your practice as a family therapist in race, ethnicity, culture issue?
504	P4	(.4) How it develops my practice?
505	R	Yeah
506	P4 (1.01)	↑As a family therapist, I think how I was brought up with (X, name of training institution). Well, brought
507		up with X (P4 smiles), and other things. Emm, I, I think it is, it is important for me to know

508		life about the family and not just about food (nhh). Because, if to explore the narratives and the
509		family system. Got to think about MORE race than culture people. Oh God, I am thinking about other
510		people as well. That would just seeing you, that was interesting (nhh) and how it get focus when
511		it comes ((P4 seem excited) (Ah ah). Emm, I think it is really important to explore that, not just from
512		emm, from the parental approaching, emm as well WHO, how do they organise themselves parentally
513		emm within a cultural, race, ethnic background. And how they been mothered and fathered. How much
514		of that has influence them in their position with their daughter or son (nhh). So, its, its, its, its yeah.
515		And, and I think about communication pattern, and how those communication pattern even
516		generationally have carried forward. And how they can impact on the recovery of their child (nhh).
517		So does that make sense?
518	R	Yes, I am hearing you say the, your family therapy knowledge, getting to know the family and work
519		with their struggle in eating disorder. (Yeah) and I am just thinking about having work in eating disorder
520		for a while and how do you think it might have shaped your family therapy approach.
521	P4	Ah now, I am thinking about a few things, how has it shaped my family therapy approach? I think there
522		is urr few things that shape my family therapy approach. And I think for me, not to be in the minority
523		as a family therapist. But the Maudsley has been hugely influential for me (nhh) that I have a, a place
524		of, emm a place where I can connect to. Be it in script or be it in conversations with them. Emm,
525		has really shape my knowledge and in relation to approach, method and techniques, of err, err
526		working with families with an eating disorder. And I would, and I think it is a different approach, and to
527		some extend but I think it is other family in my other domain of practice. You know, within mental
528		health, be that. They have also influence because when I think of my life and my experience. I think
529		about age as well when you go forward. What you are going to do when you are eighteen? You know,
530		with eating disorder follow through with you, will you, do you want to leave her behind? How do you
531		want your future to look like and there is a real opportunity working with this group of people. As
532		suppose to adults where err I feel I got a lot of experience and knowledge to know what it could look

533		like when you go into your future, you know. Err post eighteen (nnh), ah I, I think err race, culture has
534		always been something with me. And, and, and also my training and the voice of (famous trainer)
536		will definitely be there (Another famous trainer) you know. Their voices are still influential to
536		me and (two other trainers). ERR, they are ↑still so, Oh (another trainer's name) still supervise
537		me. So I still have his voice anyway, you know what I mean. So they are hugely influential for me. And
538		I am one of these people, I think Charlotte as well. That when I am stuck I have to be open and
539		transparent and I am not afraid of that (yeah). Because I want to know what are my bias-ism? My
540		prejudice-ism, so I might be carrying with me. (Nnh) and because I, I think I always wanted be alert to
541		it. My belief is when I am stuck I am carrying something that I am not agreeing with. (Nnh) and where
542		am I position when I am not agreeing. Or when I am agreeing, you know. Emm, so I, I, I think emm.
543		Can I, and I, I think as well with having my experience of my <u>age</u> as well. I am, I am less ↓afraid.
544		I don't know if I have got knowledge, and I am not afraid to speak or to have my voice or make
545		some mistakes (.). Emm, have I answer that question.
546	R (1.06)	Yes, you know. You are talking about, you begin to talk about your identity has changed and (YEAH)
547		what are the influences. [all the
548	P4	And Yeah, [And is it? Is it Yeah, my identity has changed and it is interesting
549		to not have my family therapy. A bit like when you were talking at the beginning you retire and come
550		back. And you know, as life moves on, how would I like my life to be when I go on, you know. Because I, I don't,
551		I, I think > at the moment. I think at the moment this is where I want to stay, to like end my career or
552		DO I? I begin to wonder about that, do I, DO I want another challenge? (nnh) or opportunity rather.
553	R	nhh. Lovely to hear that. But can I just ask you, can you think of a time when race, ethnicity and
554		culture hinders your work?
555	P4 (1.07)	YES (.) emm (.) and I think when I was working emm when I was working with emm. I think this is quite
556		personal but it became professional as well. So I was working with a black African nurse (.) and she is
557		lovely. Well, was. I have to be very careful here Charlotte in some ways. I am going to be open with
558		you. When I was working with her, I came to the team. And she will refer to me as the mad Irish woman.

559		And I took great offence to that, but I think she was thinking it was ↓funny. And that's what you do. And
560		as time got on I thought you know. I am beginning to think there might be some race issue (P4 smiled)
561		going on here. What is happening? And when I would work with the family, to be curious and (.) all sorts
562		of things. When I was working with that a particular family was very distressed with the eating disorder. In
563		the background, it was coming near Christmas and I said look I like to book some sessions ahead. Because
564		Christmas is coming, this is about November. And (.) her voice in the background was just BIG, BIG voice
565		and laughter and saying CHRISTMAS, Christmas is miles away and all of this. And, and I had to redress it
566		and I remember (name of a colleague) at the time was our manager. And (.) and I couldn't address from
567		a cultural. I felt very vulnerable because I didn't want to be ↑accusing. Emm but I address the
568		language and the tone. But also with the family, working in with the family. I found her voice was
569		distracting me. And I couldn't work and I, anything I want to do on a cultural level. And I couldn't, I
570		couldn't get in there. Whatever I tried, I thought why am I having this battle. What is, what is stopping
571		this dialogue. And and you know overtime I did get to know her. And and you know she, she judges me
572		that, she would say things like emm, well you wouldn't shop there, would you? Emm, that wouldn't be
573		good enough for you. (name of P4) only shop in the best, everything is quite expensive you wear.
574		So I, I hear the judgement stories. And I said why do you have such a picture of me? Where did you
575		get your picture? Well, you dress nice, and you. I said, look how I dress. I said is part of me. It is not
576		all of me. But I said, you know, you work in an eating disorders and appearance is a context. You
577		know, and err, I think you know when I think that. I think she ::: maybe have a story about herself.
578		And about her own identity, and how she felt about herself. And I felt good about myself but then
579		suddenly I wasn't beginning to feel good about myself. So I, I can see you know in the workforce,
580		WHERE I felt my culture and my :: my culture particularly. How do you, can you say race from my culture
581		but (.) ↑can you OR you know my ethnic background. But I was a minority in there. You know,
582		in that in that time, how is emm? How it effected the family been work with when I work with her alone.

583		Because I needed the nurse, because she, lots of medical monitoring. And every time I would
584		become curious, she would say NO IT IS NOT THAT. It is this. And my↓ voice so (.) and I had to work.
585		How am I going to work with this? And then there was this family complained they didn't want to work
586		with her. So oh my goody Ann. How am I going to have this conversation with her. Did have a
587		conversation, say look this family feel that, they :: not wanting emm : certain aspect of the treatment.
588		Emm, you say they don't want me. I said they have said they don't like the approach. Emm :: so
589		could we just meet with them and discover, err explore this a bit more? And that moment, honestly
590		Charlotte she just left me, wouldn't talk to me, wouldn't join in the family sessions. And to take it to
591		(manager's name). It became more than that then, you know what I mean. It became, it became sort
592		of a performance issue you know. And the dominance of, of one's position and the power of your
593		position as a professional. But also how the culture and race became intertwined in it with two
594		professionals. And I thought what are we going to show to families (nnh). So, yeah and respect
595		came up for me (nhh). You know, about being respectful for all, our voices. And the importance of all
596	1.12	And I get on with her now interestingly, but we never talked about that. I get on really well.
597		But I had to work really hard. And I, what I had to more of, maybe she doesn't appreciate enough.
598	R	I am glad that you get on with each other now. It sounds like there is a, there had been a long
599		journey of like (yeah) assumptions and judgements and hurt.
600	P4	Oh, GOOSH. Yeah. But what I did a lot of was, I started to (.) think about and then flip it on his head.
601		And this is something I learnt what I am feeling, may be that's key to how we work together. And I feel
602		judge and criticised and reduce. And I am thinking, has she got stories about being judged and criticised
603		and reduced. [And so
604	R	[And sorry to interrupt, is she white, white English or?
605	P4	Oh, emm err she is black, she is born in Britain. She is black and you know, she did share some personal
606		stories (nnh) which are very endearing. But emm, and I think she did feel on the margins in the team. And
607		not appreciated and not respected. And so that was the ↑rejected or to me, if you like, you know (nhh).

608	R	Thank you for sharing that (P4s' name) you know. And, but I need to move on because I got couple of
609		more questions to ask you and I am mindful of your time as well, you know. Emm, arr how are you
610		doing with time? Emm, I notice it is ten thirty.
611	P4	I GOT to be finish by ten to Charlotte. Because I have emm, another meeting to go to at eleven.
612	R	Yeah, we tried that. Emm, so if you like, come to questions about, can you tell me a time when you
613	1.1415	manage risk in your work and the implication on reflexivity and race, ethnicity and culture.
614	P4	.hhh (.4) when I, I had to take a position of emm risk and with emm a family. Now race, ethnicity and
615		culture. When we think about, what are we thinking about when we say that? Emm, it is race, ethnicity
616		and culture, absolutely. Emm, with a south African family and where the little one is very poorly and
617		went into admission. And as they come out, and I have been working with them for a year. And she is
618		so caught up with calories and numbers. And has to know, has to know. And it was nominating so
619		much, now when they were in (inpatient unit). A story came out about with us, to say her name, is that
620		okay?
621	R	If you say her name, I will just put it as bracket as a name, so it will not be shown.
622	P4	Or I will stick to young person, mum and dad and young person. And so the young person, I was
623		working with (colleague name) as well. And (colleague name) handed over to me that Dad
624		had emm, had a sex, emm offence. And he just did, you know they are living together. That's just
625		the brief. But now been working with them, emm for some time. And working with a medical model
626		and it was all about numbers and calories. And DAD never look happy coming in, nor mum. And I
627		wonder how their, to try and get into family therapy was really hard. Because the numbers were
628		dominating all the time. And was screaming, swearing, and shouting. And I became curious about it.
629		Never feeling good enough, never good enough for you. This was a common emm, a common
630		speech act she would make. And when I met with mum and dad I asked about their relationship.
631		And they just you don't want to go there. You don't want to go there. Now, me mum and dad, and met with dad
632		briefly on his own, and the mum, and he said you know (Mum's name) they are, she's Afri:: what's

633		the word. In emm, in South Africa she is AFRI:CAN (nhh) White Afri-can. And they never spoken, she
634		never spoken to her parents in sixteen years and the children had never, stop seeing grandparents
635		for years, don't meet with them. NOR he and I wonder about that, and they spoke about their
636		relationship and about how their families were different. She was quite emm Afri-can and he was
637		from another emm group. And there was class distinction in there as well. And er, but they had a
638		daughter and she is emm, white British and, and the children came. And :: I was looking at how dad was
639		positioning himself and he would be very angry, very dominant with me. I thought you know, on a gender specific level I was
640		thinking about a ↑man and, their voices and in the last three, err I took it to supervision because I
641		said I want to be respectful to this family. But there is something in this family, that is disabling this
642		child. There is something. And I met with the child on her own. And where he :: has emm, he has a
643		criminal background. Err err well sex offence. But no one knew what it was, what it meant. We got
644		into the family therapy and he was. I am over it, I have done it. It's all done. Well, she wasn't over it.
645		So, I asked him would she, would he tell her and what would that be like? Well, I can't tell her, he took her to
646		the (name of a place) to tell her. That he had exposed himself and she asked what did that mean?
647		And he said well, he said why don't you google it? And when she google it, it was, her face, it was just
648		so sad. But interesting, when I get into the conversations about that. We don't hear food at all, at all.
649		Or we think about the relationship between the food and her, and mum and dad, my cultural
650		perspective as well. And a race perspective, but how she, mum in fact, he did something so bad. And so
651		I began to think about how abuse she become to her body. She was self-harming; she is self-harming
652		as well. And also Dad sees upon her to do things. So from a culture, was just emerging is in the family
653		therapy is about his expectation of her, as a female, a girl, a woman (nhh). Now, there is I, very
654		positioned about safeguarding here. Because how can she flourish and grow in this family. And
655		because they can't bring any children into the house (nnh). Because of his conviction, if he is there, they

656		can't come in. Anybody under the age of eighteen. Well she feels she's been punished but actually
657		when you think about, and I don't know how much of this is emm cultural led, gender led or there
658		seems to be, you know he was, he was the, he is the dominant one, finances things here. And so I had to
659		talk about something that, didn't, wasn't get spoken about. And about women, and about their culture and
660		how they, how they met. How they think about each other, and about men being able to do what
661		they like. But also women, emm expecting them to do the right thing. And when they do the wrong
662		thing, how awful that is for them. And they are a Catholic, religion is very incumbent in that as well.
663		They are Catholic family as well. So yeah, this is grant acts with this family (nhh). Very complex family,
664		well not complex you make that sense. It had been made complicated, I think BY a sex offence.
665		And I think the young person, I, I. (Name of colleague) told me and they haven't been spoken about
666		this yet, its in the back of my mind. About having sex with an under emm young girl, underage girl.
667		And she felt pregnant, and he wants to call the child the same name as his daughter in family.
668		And I don't think they know about this. (Name of colleague) was telling me this, I said my goodness.
669		So they don't know about this. So yeah, I don't know what that would mean. So, on a safeguarding.
670		I ::: you know, have to be on her side, that's the difference (Yeah) and
671	R	So you hold the safeguarding as well as the history, race, ethnicity and culture of this family OR
672		at the moment, sounds like it is an ongoing situation
673	P4	YEAH, I holding <u>so many</u> ↑things and YET yet been also cautious about she is a child and my position
674		and my accountability, responsibility and I am looking at the domains. I am working with a doctor
675		and I said wow, wow, wow. And the doctor were saying to me. No, I think they are going well, she is
676		lovely. The doctor I work with was amazing. But I am saying this is on the verge of safeguarding (nnh).
677		I said how do we know when it is not. And I said Iam beginning to feel really anxious here (nhh).
678		Because, she is at home and mum wants to protect dad because of finances. But, they, they are not
679		husband and wife.
680	R	But, do you mean the doctor who normally hold the domain of production are less anxious than
681		the therapist? Is that what I am hearing?

682	P4	YEAH.
683	R (1.23)	.hhh, Emm so just on that note you know. What are the dominant discourses about race, ethnicity and
684		culture you might hold professionally?
685	P4	I, I, I think I, I, its really hard to get into the culture and race. Because something else dominates you.
686		You can't get there (yeah) and I think that is a dominant. For me, I want to hold a position about that
687		with the parent. And we just started work with the parents. Because I said we need to see her on her
688		own and see them on their own. Because she wasn't managing when there. And I think there was
689		a lot of expectation on her (nhh). And so, I like to get into this couple relationship or brought them
690		together and all kinds of things. And and the story of a lie, there is this dominant you lied. And I want
691		to know what that means. And also in their culture and race, what are their expectations of woman.
692		Their daughter growing up to be a woman (nhh, nhh). You know, because the young person spoke,
693		she said when her brother was sharing ur news about a girlfriend. And he was too tiny, his dad, she
694		said my dad started laughing at her (nhh). And I said oh what happen to you? She said oh my brother
695		is not like that. Why would my brother want to behave that way with my father? Is that a way of
696		forming a relationship or they have you know, rapport with each other. And I began to think about
697		culture and race. And about man in that, in as you, a father was growing up (yes) what meanings?
698		You know, happen for him, or how is he influenced in this gender role as a south white, white south
699		African (yeah).
700	R	Very complex piece of work, you know.
701	P4	YEAH.
702	R	(Name of P4), I am just mindful of the time. I apologise, I still got three more questions.
703	P4	Okay.
704	R	So, I am. It is best not to rush through. Because you know, obviously it is important, the juice is in the
705		conversation rather than rushing it at the end, you know. And also, you need to go. So it is, we got
706		few minutes, six minutes left. I don't know whether it is, it is cheeky of me, whether we, I can request
707		another fifteen to half an hour, the max from you?
708	P4	YEAH
709	R	When you are free?
710	P4	YES, no, no, that’s fine, Charlotte

711	R	Is that okay? I am really sorry.
712	P4	Yeah, no that's okay, that’s okay with me.
713	R	Ideally not far apart, so we can
714	P4	I can do, I can do next Monday morning at nine.
715	R	Nine o’clock, that would be grant. Yeah.
716	P4	Yeah, I was going to have an annual leave but I am interviewing that day. And I am not interviewing
717		till eleven, so I can see you at nine.
718	R	Thank you so much, you know. Yeah.
719	P4	I put in an hour, Charlotte
720	R	Yeah.
721	P4	Okay, because I then got a meeting at ten, which is near ( )
722	R	Thanks, so much (name of P4).
723	P4	Oh, that's great. Know it is lovely to have these conversations, isn't it? It is really nice, make me think
724		a lot as well.
725	R	Yes, and that's why in the information sheet, we say that any kind of like, might emerge from it, is
726		like you have conversation around the subject and kind of, getting you to [think about it, you know.
727	P4	[think about it.
728	R	So I am going to stop now, is that okay?
729	P4	Yeah, yes that's fine Charlotte
730	R	So you can have a little rest, prepare yourself for other meeting. But I, we will meet again next
731	P4	Next Monday.
732	R	9 o’clock, yeah.
733	P4	Okay, Charlotte. Take care
734	R	Thank you so much, Bye.
735		
736	Transcript 4b	
737	R: Researcher	P4: Participant 4 (Interview continued a week later)
738		
739	R	Recording ( ). Okay,.
740	P4	Nice warm day, isn't it Charlotte?
741	R	Yes, the weather is changing for the best, looks like we are going to have a week of nice weather.
742	P4	Oh, I know. That would be nice. I am off Thursday so that would be fine.
743	R	Fantastic (R laugh).
744	P4	Yeah.
745	R	. hhh. I won't hold you up, try not to over run like last time. And er I have about three questions to to

746		(okay). They will
747	P4	Yeah, if I am speaking too much Charlotte. Emm, please interrupt.
748	R	No, no, no. That's what I would like to have you know
749	P4	(P4 clear her throat). Okay.
750	R	Thank you for sharing you know. So before I start may be just check out whether you like, have anything
751		from the last conversation you would like to pick up yourself you know.
752	P4	Yeah, it was emm (P4 clear her throat) it was. I suppose there is one or two things that kind of go
753		through your mind. And you think you know about race, culture, ethnicity and I suppose, it, its sort of
754		when you feel it yourself (nhh). And when there are difficulties in relation to another person. And you
755		are thinking I feel there is a race issue or it could be another issue. How do you know when it is or
756		how do you pick up on race, ethnicity and culture in a relational exchange? Do you know what I mean?
757	R	Yes.
758	P4	So I kind of, its heighten my awareness, my own experiences has heighten my awareness towards
759		others (nhh). Emm, particularly when people come to clinic for treatment is something I am very
760		aware of, be curious about their culture, their race in relation to eating disorders and how food
761		emm. It's symbolic of how they do relationship (nhh). And and particular when there is a very sick
762		child with you who has mental distress with food. And how do you begin to navigate your way
763		through, being curious about their backgrounds, which I always think is really helpful because you
734		always find strength in people (nnh). That's really important for their recovery (nhh) and I think in our
735		British culture and with the Maudsley model as well. I mean I am reading it because I like their model.
766		Its rich with material. I am going over it again you know, it inspires to go back to read it actually.
767	R	Yes, yes, yes.
768	P4	I am having had the training on, just a couple of months ago with him. I was full of enthusiasm. It is
769		lovely to have training. Emm, and about culture and race and ethnicity. And how do you embrace that
770		within, when you do an assessment, how do you bring forth those key, emm things. Into the treatment
771		as well. And not to be, how do you become curious when you don't see curiosity (nhh). Yeah.
772	R	You mention the word heighten
773	P4	Yeah

774	R	You know like, is it through this conversation or you already
775	P4	I would say yeah, it certainly you know having the conversations (yeah). Keeps the message and, and
776		keeps the emm. Keeps that alive (yeah) because I think we can get, sometimes for me personally
777		you can get drawn away from err contexts that are quite important for a conversation. Because we
778		put so much on the illness. And try to, have to get the child better. I wonder the anxiety we might
779		experience that is transferable from parents. Because you want to soothe everything down to get
780		the treatment moving in the direction that. We hypothesise will be the way forward. Not always
781		necessary do so. Emm, Yes, so is a kind of those, those conversations are so important at the very
782		beginning of treatment (nhh). Emm, you know rather, sometimes they are missed and you go back.
783		And I have a way of not, really do anything compartmentalise that you do your assessment.
784		Assessment is the beginning of a conversation I see it as (yes). It is the beginning, and sometimes we,
785		maybe we haven't started at the beginning and how would we know it is the beginning (P4 giggled)
786		you know what I mean? Emm, it is just two kinds of USE the assessment as a platform to build on (nhh).
787	R	Yes, so these is quite challenging for therapist to hold on these heighten sense of
788	P4	Yeah
789	R	And and not, and also holding on other things as well. Not just race, ethnicity and culture (yeah, yeah)
790		so many to juggle.
791	P4	And I think the, you know when I say heightened is being aware of my own race, ethnicity and culture
792		as well. Being aware of that and how much of myself is in the conversation.
793	R	Do you want to say more about that?
794	P4	Well I suppose I am always, I don't know if I do it intentionally or not. But I am always, err you know
795		I share stories about myself when I introducing myself. I say I am (name of P4) it is a (area) word for
796		(long name of P4). And I say a bit about my name which is located in (religion). And the family story
797		round the name. And I became that name, not (the long name) but (short name of P4). I talk about,
798		you know ( ) ism, how important was very important in name, giving you your name and I talk about
799		my own culture. And it is really difficult to distinguish you know, because religion and culture ae very

800		intertwin in (name of country). I often wonder, you know when I am telling my stories I began to say. You
801		know, I am sharing some parts of me and I am wondering if you connect with any of those for
802		yourself.
803	R	Do you find that normally help your connection or?
804	P4	I think it does because I think the power of the therapist. I remember one English man. They were
805		British family who came, and the little one was really poorly, very very poorly. And I knew there was
806		emm, there was a lot of stress in the family system because of the eating disorder. And I, you know
807		my hypothesis was their distress is stopping them from accessing emm, the love of their child. And
808		that was getting a kind of confused with the illness, how she was recruited in. And I remember all
809		broke down with the family, you know with the care coordinator and supervisor. And it was
810		becoming a safeguarding issue (nnh). And it had access safeguarding because the parent was trying
811		to do everything at home. And they didn't want her to come to clinic. Emm, we spoke. I said look let
812		me join you because you know, now that we move safeguarding this is intense possibly. Matters for
813		the family, because now they may be seeing themselves as the <u>bad</u> people and being blamed for her
814		illness. And I said, want you emm avoid is, is saturated blame and shame kind of narratable. Because
815		it will affect the relationship. And I remember the care coordinator, she is a <u>fabulous</u> eating, on the
816		eating disorder nurses. Very experience, I remember what the father was eliciting for her in relation
817		to gender. And I wonder about her experience of the Dad. Oh, she wouldn't go there. She was so tense,
818		I wonder how she wanted me to be positioned in the work. Did you want me to form part of the
819		reflectig team. Did you want me to take the job of therapist and you take the reflecting team? Could
820		we do it more jointly together and this was a very sick child. We wanted to avoid admission. Because
821		I think that was the major worry she is going into hospital. And they couldn't bear it. It was intolerable.
822		And when I met Dad, I, I didn't talk about the illness initially. I said, you know hello, how are you and
823		I said. And he said his name is (Dad's name). And I said oh, I introduce myself as (name of P4). And
824		(place she come from) and all of that. And I said where do you get the name (Dad's name) from. You

825		know, I have an uncle call (Dad's name) and it is one of my favourite names because he was, he was
826		such a lovely uncle, you know what I mean (nhh, yes). Oh, he said, my ancestry goes back to (similar
827		place to P4's origin) and we were emm Kings in the island. You know, it, it is just stretching the power
828		were starting to emm inform me (yeah). I said wow, I said how does that emm inform your, who you
829		are, you know. And he said emm, here is the umbrella. He said look at my umbrella, and he took off
830		into conversation. And the little one was getting more calmer, and calmer (nhh). My goodness, I said
831		you all have, all got nice emm stories. And I said when I said stories, got to be careful with stories.
832		I said lived experiences and great. I wonder how your viking or your king (nhh) and become a rich
833		source in helping your, your daughter gets better. And if you are a king today, what would you be
834		asking us to do? You know, so that was culture, you know what I mean (yes, that is) But it was in a
835		way of having the conversation, and the reflecting team was smiling. And I could see the nurse, he
836		do not tell you about the illness. I said well actually we are dealing with (P4 clear her throat) the
837		illness. The little one when I was talking to her, I said did you know that about your Dad? And I said
838		what do you think when you hear it and etc? And I said tell me you know how it is that home, you
839		know with all your lovely personalities, shall we say? How is it this illness positioning you? How do
840		we enable you to take more of that position then in the fight with the illness? Because this is the
841		enemy, so we are using the, the concept of externalisation. And and I said one thing the illness like
842		from you is to fight it (nhh). So emm, sharing that, that was an important moment in the therapeutic
843		emm relationship (nhh). And the reflecting team, you know, I had kind of set them up. Not, they
844		don't know about you know, Tom Anderson and all the reflecting team. I, you know I am winging here
845		as I am going along. And I said the only thing you could, is do not give answers. What I like you just
846		to be curious, and curious about what you are seeing, what you noticing. Emm, what are the things
847		she admires about Dad and mum, how do mum and dad, and you are feeling questions are very, very
848		interesting. Because I always avoided the feeling questions (nhh). My sense is, I remember

849		(name of writers) having a, this is really. I never forgotten that actually. Bowlby when he was having
850		supervision, he said ah, don't ask feeling question because you get a very linear response (nnh). And
851		if you ask about the experience, how do you experience this eating disorder. You get a, and I, I am
852		rarely use feeling but sometimes when talking feelings. You say how does it feel for you, you know.
853		I have to join them in their language rather than avoid it as well (yes, yes, nhh). I don't know if I have
854		a kind of ( ) the child.
855	R	It is lovely to hear your experience. Emm, I was just thinking about how NICE guideline (yeah) in your
856		work. Has it been helpful or restraining in your race, ethnicity, cultural practice in particular.
857	P4	Emm, I would say, you know NICE guidance informing our practice. I think well, on a professional
858		level. I think it is really helpful. Particularly in the emm, the dominant medical discourse. Because,
859		it become very medically orientated. And they, I don't know I think there is now when I was meeting
860		with the Maudsley. They are very systemic, they got a lot of systemic family therapist whereas at
861		our team it is very much nurses (nhh).
862	R	Are you the only family therapist?
863	P4	At the moment, I am interviewing for one today. We normally have two. And it is really interesting
864		how people's professional identity. Emm (.2) governs their decision making on what the team should
865		look like. As suppose to what NICE guidance might say you know. We don't really get into those
866		conversations. Because I think there is emm a description in mind. As (name of a nurse) and (name
867		of another nurse) were the only two advance nurse practitioners when they first develop. They
868		would see, they and they would see this is her baby. She has expanded and develop it. Emm but I don't
869		emm :: in relation to NICE guidance, its useful to use it (nhh). To::: kind of bring a
870		different lens to the conversation as to how the service should be emm developing. And I think there
871		is emm some. I don't know Charlotte but one, one idea that comes to mind is that because of the
872		medical discourse. It, it bypass NICE guidance, if that might make sense.
873	R	Do you mean that NICE guideline helps you to bring in different profession as to a nursing lead.
874	P4	Exactly yes, I think and I do bring it in. Particularly for reflective practice, or one might having each,

875		( ) team meetings. I bring it in. And I suppose I am very outspoken Charlotte. I suppose like, you know
876		like I have to be very careful how I say things. So I am not reducing people. Or they feel reduced (yes).
877		I am, or you know. And I think there is a vulnerability for some of them. We got to kept, yeah, I suppose
878		its in the relationship as well. But I mean, think of power of some manager to develop what they
879		want and me being the only voice for the last year and a half has, has been difficult to, kind of keep
880		my eyes on NICE guidance which I don't always do. But go back and read it, is really important (hnn).
881		Because it gives me a voice if that make sense.
882	R	Through the guidance.
883	P4	Yeah, gives me a voice. Emm, its our voice, its its emm because I think the medical domain takes
884		NICE guidance as verbatim sometimes. When it is guidance (yes). Yeah.
885	R	So has it been a time restraining then, you know like, I hear the, the usefulness. Emm (Emm) or there
886		might not be restraining, don't feel you have to.
887	P4	Yeah, I mean I, I think you know to have a dialogue, a kind of bring forth NICE guidance as a context
888		for an open dialogue (nhh). It would be really useful but I, I think emm sometimes it is not. I am not
889		able to do it, if that make sense. Because it becomes like constraining factor for some and then I feel
890		that my experiences when I can hear the constraints of it because of what other people want. It emm
891		it, it, it, it closes me down. So I think NICE guidance gives me a voice when you are alone (yes, okay).
892	R	So does it mean you are the stake holder for NICE guideline in your service or other people use less
893		of it?
894	P4	I think it is forgotten about (right) you know. I think it is forgotten about and there are assumptions
895		being made about how people emm work with emm our patients, our clients. Because in the Maudsley,
896		they don't have any support workers. And I remember emm (name of colleague) is talking about
897		the support worker helping, supporting family in feeding those children, in becoming role model. One
898		of the most difficult jobs of all they were given. And I think, our manager would not see it from that
899		angle. She would say it they were very skilled. And there again, you can hear that kind of, emm feeling
900		reduced. I know more therefore I, I am, I am the kind of. I develop the service, you can hear the

901		kind of CMM, err kind of contextual factors you know. Emm, influencing and constraining or err you
902		know influencing whatever way. Ah be a negative or be a positive (nhh). Yeah, so
903	R	What about family do they bring NICE guideline into, well I think the question going back is like err
904		within the context, that is race, ethnicity and culture have a place or?
905	P4	Yeah, I think when we bring in those description of families into the team (yeah) and we don't err just,
906		because NICE guidance is talking about families and treatment of an eating disorder. And NICE guidance
907		also talks about children being, have an individual space as well. And siblings and there I, I strive to do
908		that. In the treatment, give the siblings a voice. Emm, on their own and with their family, client the
909		young person. Because I think their voices sometimes they don't know how to do their voice when
910		their parents are there (nhh). Emm, they don't know how to begin to talk. I think their voices are
911		really important. And I think from a culture and ethnicity point of view, I think sometimes stories about
912		what you can and can't do in families, ethnicity and race inform that. The voice of, the voices of
913		children or not having a voice.
914	R	Okay, so I think last time I mention about discourses and I think it was because towards the end of
915		time. It was a bit rush. I just felt that I, I. If possible I can ask again about this dominant discourse
916		about race, ethnicity and culture that you hold professionally.
917	P4	Can you say that again?
918	R	Because you, I hear you, you kind, talk about dominant discourse about the risk case that you were
919		currently working on. (YEAH) Because time was rushing. So I didn't want to rush something that is
920		quite important. I think you know in general, in general what do you, how to you feel about dominant
921		discourse about race, ethnicity and culture that you hold yourself professionally?
922	P4	Emm, I think those different levels (yes) emm, and one, one thought or ideas I have is that emm. It is
923		how does that influence or constraint families when there is an eating disorder (nnh). And I think for
924		me, to be aware of it. And to not be afraid of talking about it (nnh). Because of other voices that
925		might be informing me (yes). It is really important to open up the dialogue (nnh) whether I like it or

926		not. Because when you are there, and if you see anybody from a, an Asian, Arab, or European
927		community before you. I think it is really important to talk about their lived experience and how that
928		emm informs them, how they are in the treatment of an eating disorder or informs them how they
929		are with me relationally as well (nnh).
930	R	Do you think this discourse, this idea you just talk about. Has it evolved during your practice?
931	P4	Emm, I would say :: emm definitely has evolved from I trained. I think it became a very important
932		discourse, to or context, to think about when I work with emm psychosis and particularly about there
933		are stories about psychosis and how that position, they, young adult in their family system. And what
934		stories they described to schizophrenia. And because when I first worked in psychosis, this young
935		female and males have lost a family. So there was a lot of loss there, and that loss was very stressful
936		when we think of stress for a young people, young people who develop, develops symptoms of
937		schizophrenia. Emm, its, its, its very telling how much emm at times culture plays a huge part and race.
938		In what can, what happens in the relationship. And living within a British culture society (nhh) and how
939		they, stories are minorities that become priority (nhh).
940	R	And that transcend into your current children eating disorders.
941	P4	Yeah, yeah, yeah. So I, I, I always thought about it and it is very much you know. When you see colour
942		before you. It's you can see it. You know what I mean. It is when you don't see it (yes). It becomes
943		invisible or you refuse to see it. You know, but when you see it. I remember the young girl coming to
944		me. Mum and Dad were black African, like was telling you. It was lovely people, so respectful but
945		that was respectfulness. Do you know that kind of, so much agreement with the person emm, believing
946		us, as if we have this huge power and I was very aware of that power (nnh). You know the power of
947		my position in relation to their race, culture, ethnicity.
948		So, I mean that's very interesting. You know when you don't see, and when you see you are heightened.
949		When you don't see what might be your experience of continuing enabling yourself.
950		So, yeah. It is really interesting but, I, I. What I do normally, because I love the atomic model, you know the

951		daisy model. I love that. Because I like to use the Graces. And the Graces are always, are acronyms I hold
952		Have I asked enough about you? Culture, race? Have I asked these questions in here. That's why I like
953		those acronyms. Because it reminds me that I haven't enquire anything here. I focus more on you know,
954		may be appearance. Well appearance is a really interesting as well. I felt it is more of an appearance.
955		And I remember a family coming and I remember you know what they were wearing. One day when
956		they came to clinic and I thought wow. That dress coat they are wearing today is so different from
957		what I notice them wear. And I began to think about what does that mean, you know. It was, it was
958		like a costume (nhh). But I didn't want to be rude to say OH, you know. It was amazing, but I was in,
959		in my ear, Charlotte. I was thinking that's really strange with her wearing, you know. That was really
960		strange and when emm. When I was talking to them in the next session, I saw you the other day and
961		I thought would I avoid it or do I say it? To not say, when it is so obvious in front of you. Emm, because
962		she has snow white hair (nhh) and she has this pink kind of eyes but it was like. Er they were Polish
963		(nnh). And she has this, I can't remember the word you use it for, when you see people with really
964		white hair and white skin. So white, it was pale beyond believe. You know, but mum look I could see.
965		She had much colour in her skin (nhh). And Dad was a very dominant man, you know. Looking
966		presenting as angry. But actually wasn't angry at all. It was just the way he spoke, you know what I
967		mean. But when I, I remember I thought I can either avoid this question or I become curious about it.
968		And how much meaning that has in, in the relationships. And what might have interpreted. Because
969		you born in Britain and then she emm grew up in a family that were Hare Krishna. And I began to
970		fascinated about that. And then going to these meetings and redress code was all in relation to
971		religion. But also, in relation to their culture that this is where their beliefs. But I also became really
972		worried about emm the young person's voice. And to not being in that religion with her mum and Dad
973		would have marginalise her (nhh). But and to be in it, was actually not allowing her to develop
974		towards her prefer identity. So there are really, I suppose you got to work with these levels that

975		actually how do you allow people. Some of this become what they want to be. How do you kind of
976		be on their side when there is sometimes abuse in there with the, with the religion inform by err,
977		religion and culture (nnh, yes).
978	R	Wow, this is fascinating. Can I, just thinking about the experience of this interview? How does it feel?
979		What the experience is like?
980	P4	Do you know it is really interesting you say that. Because I just emm, its been lovely having these
981		conversations (nhh). And :: also it er, I think for me it enables me to think more systemicly and keep
982		my voice of systemic mindedness as well you know. And thinking about how theory inform practice,
983		and practice inform theory. Because when I ask, when I hearing you speak I can hear my, even going
984		to. You know emm, I remember writing my dissertation in my final year. And it was emm the client
985		informs the therapists story (nhh). And that was my title you know. And it was really interesting about
986		what was being evoke or elicited. What has been elicited for me? But how my own stories, my own
987		experiences become err contextual forces and resources to be able to engage in a conversation,
988		where we are using hypothesis, curiosity, neutrality, you know what I mean. So I think when I am
989		speaking to you, I, I definitely I would say my, my theory informing practice. And sometimes I forgot
990		all the names, like Monica McGoldrick and (name of professionals). People that are more significant
991		to my mind. When I am, when I am talking is (list of professionals) and all my group. Well, when
992		I read the theory, I know about Tom Andersen. I met Tom Andersen and people who have more lived
993		life in common. Just in like Harlene Andersen and so many people, rich in theory and experiences
994		(nnh). For me I just I just think emm you know, theories always been something in my mind when I am
995		working. When I haven't got those voices, like having them with you (nhh). I, I, I feel. Sometimes I feel
996		( ) I don't think I know my theory anymore. Until I start engaging in conversation with you (yes, yes).
997		Does that make sense.
998	R	Yes, it does. Because we start off with saying this is a very interesting research that you are interested.
999		And then we have a conversation and then yeah. And hearing your experience. I just wondering about
1000		talking to me eh as somebody have different race, ethnicity and culture to you. You know does it

1001		has any component to, in our conversation.
1002	P4	GREAT
1003	R	Talking to me as someone who has different race, ethnicity and culture to you, does it influence
1004		anything? You know.
1005	P4	OH, that's interesting conversation. I suppose (.2) I become emm, I think what it does for me. It
1006		enables me to talk about it more if anything (nhh).
1007	R	There might not be anything. I was just asking
1008	P4	It enables me to talk about it. You know what I mean because I think we see race, ethnicity and
1009		culture.
1010	R	I er, what did you just say? (name of P4) >I didn't hear.
1011	P4	It is interesting how we know when it is race, ethnicity and culture (yeah). And whether or not it
1012		influences it. And it was interesting when I talk with you, I don't think race, ethnicity and culture.
1013		I am thinking about the conversation we are having. And it is really interesting when I be working in
1014		(name of a systemic training institution) as well, when doing other parts of my training. I, I may be
1015		this is naïve of me. But I, I take people emm at face value. I think oh, this is my naivety because they
1016		work systemicly and they are trained. They know about being eloquent, they know about being
1017		respectful and, which you are. And I was you know, in some ways I have found that not always
1018		to be the case (nhh). And I think emm and I certainly would have thought that in my own practice as
1019		well. And that's not necessarily so, and how do you open conversations professionally with people.
1020		We are doing with family, do we talk about them professionally how much it influences one’s practice
1021		or not (nhh).
1022	R	Yeah, interesting. So, last question in terms of time management. Can you tell me how this interview
1023		make you feel about your race, ethnicity, culture in your current practice?
1024	P4	Well, that's interesting. I think this interview has made me :: you know enable me to talk about my
1025		lived experience in my practice (nhh) and about how much might (P4's country of origin) and how
1026		much of those stories are lived within, in this the British wider discourse. And when we are working
1027		as well with people. How much of, what are the assumptions, beliefs about can you hear my voice?
1028		Because my voice is very (P4's country of origin) apparently (hnn). When my home is not (country

1029		of orgin) at all apparently (both P4 & R laugh). And it is really interesting how you can be seen or heard
1030		with your culture. Or do I have a race, it's the culture I am. Am I a race, or I am a culture, whereas
1031		when we look at, you know people from ethnic backgrounds, minorities. They, race and culture and
1032		when it comes to been white (country of origin) what, have I got a race? (nhh) you know, it you know,
1033		sort of noticing that as well. For me professionally and about being respectful of about what you see.
1034		Because our, dare I say the colour of our skin has given us more privilege, I believe (nhh). Then other
1035		people of black, Asian minorities. I am very conscious about how being white, we have been more
1036		privilege. Even professionally I think (nhh). I am not saying I know that but I hear it, I feel it. It is a
1037		feeling (nhh). It is an experience if that make sense. Emm, and I, there there there for me,
1038		professionally when I work with a black African nurse and I got on with her really well now, Charlotte.
1039		And I am really please about that. And I would never ask that question you know. What was it about
1040		me that was difficult for you or with those things that you find difficult about me. Because I think
1041		you know emm, I think because I been seen as, heard as an assertive person. And confident, I don't
1042		always feel that though (nhh). You know it is interesting and I think I always been a child growing
1043		up my mother said. Sometimes (P4's name) you didn't know when to stop talking, that punctuation.
1044		Don't ask that question. You know I always been curious, would not been a way of intentionally
1045		harm but to. I was always interested in people (nhh). Emm yeah, I suppose professionally I think emm
1046		it is quite interesting how I am positioned with my, my culture. Am I allow to say race, because of the
1047		colour of my skin. Just that you know.
1048	R	When you say am I allow to, what do you refer to, what are you thinking?
1049	P4	All I mean by that, emm are you know coming from (country of origin) and coming from my background
1050		in (country of origin). Is race part of our discourse, our identity? Do we skip race and we are culture
1051		more because the colour of our skin. Do you know what I mean?
1052	R	Nnnh, nhh, yeah, okay
1053	P4	So it is hard to know
1054	R	= so what do you think then?

1055	P4	Emm, I, I for me is more about in our culture in (country of origin). It is more about religion and
1056		culture.
1057	R	For yourself?
1058	P4	For me (yeah). However when I am in (country of origin) living. There is a distinction they would create
1059		about race and about their view is, not, not now. The younger people are much, not now. Or or
1060		even my sister growing up with me, where there was a belief that you marry into a race (nhh). And
1061		I think moving into, living in England is more versatile and working in the team in relation to my
1062		professional identity. It is something about who I become in my identity as I have evolved over time.
1063		(nnh), My name is (P4's surname) and you couldn't more (country of origin). But I did marry an
1064		(country origin) man. But background is and he often seen as (country of origin) and he will say I am
1065		not. I am actually British, that's it, very much so (nhh). And where I will hold onto my (country of origin)
1066		To kind of :: part of my identity I suppose. You know and even in my profession, is part of my identity.
1067		Emm when I see people coming to us, it is part of their identity, be a race, culture. Do we skip it all,
1068		do we talk about it? (nhh).
1069	R	Very interesting.
1070	P4	Yeah
1071	R	So what do think is the biggest challenge in the cross over in eating disorder and race, ethnicity and
1072		cultural practice. Going forward.
1073	P4	Going forward, for me I think it is important and something I would like to bring forward is not to skip
1074		it. [When I said skip it. It is NOT TO SKIP it. OR you can call it whatever words skip,
1075	R	[What do you say not to skip, yeah, yeah
1076	P4	miss, ignore, emm if you don't see it, talk about it, you know be curious about it. Emm, because they
1077		are rich err rich stories in there that can be really helpful in talking about. Emm young people emm,
1078		become getting better (nhh). And I think it is really important to talk about it. How they are being
1079		positioned when they go into. When they are moving through their rites of passage (yes). It is so
1080		important because in primary years, they are very much kind of, we can for one. Some of them are
1081		really protected and its quite pastoral kind of care. When they move forward to secondary school, it

1082		become a different dialogue, different conversation (nnh) and their rite of passage when they
1083		are emm celebrating be it err Jewish religion, err Catholic religion. All different religions informing
1084		that culture and ethnicity as well. And I think you know Yaa, I think for me its, its not religion, culture
1085		or ethnicity and race is important. But the context of religion is, can be also quite important in
1086		relation to (nnh) how they talk about things.
1087	R	Yes, yes, its lovely. Thank you for your time. This ends our conversation. Thank you very much.
1088	P4	I hope it is been helpful Charlotte. Its been helpful to me.
1089	R	Let me just stop.
		Interview 2
1092	R	So, yeah, the thing is buzzing (R laughs) okay, so eh again this is about your experience, your
1093		view point and there is no right or wrong. So all the data are confidential and anonymise. Emm,
1094		so yeah. Do you have any question before we start.
1095	P4	No
1096	R	Okay, emm, at any time if you have, you can pause and stop, check, you know etc. So, eh if I start
1097		with, as you are family therapist working with children with eating disorder. I like to ask you
1098		something about your experience of food, eating and feeding. Err so, if I start with, tell me
1099		what is your experience of food and feeding (emm), eating and feeding.
1100	P4	Ehh, working in the service emm food is very interesting. Emm particularly, you know as we (.1)
1101		come from non-pandemic into pandemic, is become more complex I suppose. Emm, particularly
1102		with the family meal. Emm because when you are in clinic, you got a more control if you want to
1103		call it environment where you can focus more and you can be with the distress of food and refeeding.
1104		When you are on zoom, sometimes the children will run away and they gone into the rooms. But
1105		in another sense, you getting a perspective view of family life at home. So its both and. So I would
1106		be emm (.1) viewing it within the family system particularly in the home, when the child move
1107		away, so you get a real good sense the family system in their own environment (nnh) and : on,
1108		on another level to:: discuss food and eating on zoom you have seconds of, kind of miss

1109		communication and : when you are trying to : collaborate with them. You trying to take a
1110		reflexive stands. And I have learnt more and more that when following the Maudsley model. Its
1111		a kind of knowing where you are in the stage of the treatment. What stage am I at here? And
1112		normally phase one is quite complex, complex where you trying to : enable parents to take a
1113		position to feed their child and that can be difficult because patterns are really interesting,
1114		because the patterns of the child eating, you almost brought back to real primary age, year which
1115		seems on a age level, on an age context, its quite unusual and unfamiliar, it feels like for them (nnh).
1116		So, the work of the therapist in there, you got to work quite arduously, to kind of enable parents
1117		to take that position. How do you do that, emm particularly with refeeding and food, when
1118		actually they have develop narratives that food is not good for you and parents are, and there
1119		are polar opposites. So the therapist, for example myself, I have to do a lot of psychoeducation
1120		and reinforcing that with parents, with children, young people. And sometimes age is a really
1121		tricky one because we get children sometimes at age eleven and nine. And they are not in the
1122		adolescent framework with us. But there is nowhere to go with them, only us. Does that make
1123		sense (yes, yes). And from an age perspective, with food and eating, its its complicated because
1124		the narrative develops by the young person and the rules attributed to food at eating are very
1125		much located in a lot of narratives they heard within their social context, social media and
1126		particularly in the pandemic the whole narrative of health and wellbeing, at times has been taken
1127		so far out of context (nhh). Emm, and its interesting combine with food and eating you got
1128		people who are compulsively exercising and to, move them and re-pattern their, what does
1129		exercising mean in the context of human life. You know, would your body and so exercising can
1130		sabotage the food, because they would eat it but then they have to rid of that some way. So
1131		they are caught up in a really complex emm web if you like. And I suppose the job of me is to
1132		really deconstruct quite slowly. And : interesting when you hear the voice or the no voice.

1133		But you see an expression but no commitment to talk about food, you can almost see the
1134		restrictiveness of giving their voice to you. Because of the rules and the values, the eating disorder
1135		holds. So there is almost two dimensional people here. We got an eating disorder and I want to
136		externalise. Its quite hard to externalise because they see their identity really located within
1137		the eating disorder. The job of the therapist, learning the skills of the therapist is to develop
1138		a narrative of what life was like before it. SO you get a real sense of you know, the genogram,
1139		the family life, and what life was like. They, the, emm relationship with the young person had.
1140		How the eating disorder has position them. How much of that life has been kind of taken away or
1141		has disappeared in their mind's eye (nhh). So you kind of snap shots of how complex it can be.
1142		Because sometimes, you know within eating disorders generic family therapy. I am calling it generic
1143		(P4 laughs) family therapy, for for. Its very different from eating disorder family therapy. Some of
1144		them are similar. But I think the, the distress you are dealing with for parents ↑and, and for their child
1145		and the other siblings. It its emm, for me I need to know where am I being positioned, in the
1146		approach method and technique (nhh) in working with the family who have an eating disorder
1147		in their home.
1148	R	Nnh, well this is very rich. I was just thinking about whats going on for you when you are sort of
1149		like trying to work this very big picture that you just described, you know how you, you needed to
1150		deconstruct the narrative of the patient who have no voice, restrict by eating disorder and the family
1151		and their parents and their social media you know. So if I go : little bit slower, so I can understand
1152		the various aspects of, when you are facing with all these things, trying to deconstructs you know,
1153		I wonder what, what might be your own personal, if I start with yourself, your own relationship
1154		with food and feeding, and then moving into how you associate with the family, is that okay?
1155	P4	Yeah, emm I suppose my own relationship with food and eating, coming from an (country of origin)
1156		culture background, food is a big social emm aspect (P4 hissed) of life. Emm, and, but and also
1157		when you think of the ehh British culture and other cultures. Food again (.1) is a context for

1158		how we, or discourse in how we engage, PARTICULARLY in our you know in our modern day
1159		world. Food is a huge commodity of how we socialise, we use food to socialise, we invite, so
1160		I use that emm particularly my own narrative, about to formulate curious question and circular
1161		relational questions. So my own, my own stories that are listed and in through the conversation.
1162		I find them really useful so I don't, I try not entering assuming conversation, ehh ehh narratives or
1163		questions. And if I were doing an assuming one, making assumptions, I will name that. I would say
1164		you know I am going to say something now. That might seem as if I know but can you tell me
1165		what you think about my idea or my story. Yeah, (nnh) that way sometimes is a way in, of
1166		engaging the person. So you take it away from them, and I kind of own it with myself. Am I
1167		making sense?
1168	R	Yes, I was just thinking about ehh, can you give me an example you know how you might you use
1169		your own personal experience and
1170	P4	Emm, I would say, you know when I introducing myself, you know I am (P4's name), I am from,
1171		I am (country of origin). I grow up with emm a family and will give a little bit of narrative
1172		background of myself, with the HOPE that might engage young person to share their narratives.
1173		And I found that works a lot, emm I say its really hard to talk about yourself at times, you know.
1174		And I said particularly when emm their trust is not available to you. With eating disorder there isn't,
1175		trust is a huge emm discourse. Emm, and I talk about you know coming to the UK, and being in
1176		England and the cultural difference from me. How awkward that was : and how I notice the social
1177		interaction was different. In (country of origin) we say hello, when people coming to your home,
1178		they always give food with a drink (nhh). And I said when I came to the UK, I was always asked if
1179		I want a cup of tea and I would be asked if I want biscuits, where is the sandwich you know, or
1180		a piece of cake. I am not saying they don't do that, don't want to be ehh so kind : of linear about it.
1181		But I said that was a social difference, cultural difference for me with food when I came over.
1182		It was always, very generous, would you like a cup of tea and I said. And then I will go on

1183		and talked about the social interaction, how hard it was, how in isolating it felt. You know in
1184		(country of origin) we will always say hello to people on the street whether you knew them or not.
1185		You smile Hi, you always give a, a greeting and a gesture whether you knew them or not. And
1186		coming to UK, you know emm I found that, that wasn't so and I, and then when you go into
1187		education, people were, I found people were a bit kind of emm (P4 hissed) distant (nhh) to get to
1188		know. Once I got to know them, they were lovely, really rich friendship formed. So, and and there
1189		is other things I would talk about you know when somebody has a problem. And I said how do
1190		you talk about a problem, when, how does a young person talk about a problem (P4 hissed) and I
1191		would give some story about you know sad story, but I am not working on myself in the therapy.
1192		But I am talking about you know sometimes growing up, you know emm I would share a story
1193		about awkward moments talking with friends being judged on appearance, and judged on your
1194		academia, you know these judgement stories that one would form in their minds. And how
1195		difficult it was to trust people because of their judgements or assume, assumptions about you.
1196		(nhh). So and, and you know that often (P4 hissed) and I, what I am telling you these things is not
1197		in the first moment when I meet them. Its as you moving along in the therapeutic relationship.
1198	R	So you when you find the timing, you make a clinical
1199	P4	Its about timing, for me its about timing and pacing, and its about manoeuvring your way in and
1200		around : to see how can I, emm I think it is Charlotte, I think it's a real skill you develop over time.
1201		So how do you form a relationship with the young person who is telling, swearing at you (nhh).
1202		REALLY angry who is having a huge melt down in front of you. How do you begin to talk about food
1203		when you have that level of distress in front of you (nnh). So, I, for me, HOW do I, what happens
1204		for me as a therapist. I begin to connect to my own whats been embodied in me. So embodiment,
1205		I think its really important. Given we are talking about the body and how you feel and all of that.
1206		So I use the light of embodiment, and it is interesting with mindfulness because you know I was
1207		thinking about the mindfulness emm exercise you did with us when we met as a systemic group.

1208		And I remember doing that, so much with adult mental health. I said oh gosh I know this one so
1209		much, I haven't done it for a long time. But doing, one has to : kind of think, is it too far away
1210		for them. How do you get into mindfulness in the moment, that I, I, mindfulness is really
1211		complicated when people's minds are wondering. And the heads are so full, they are not able to
1212		get present within themselves.
1213	R	Do you mean the mindfulness with the, with the young person or with yourself or grounding or both
1214	P4	With myself, I apply to myself, mindfulness with me, how do I, what is happening for me and my
1215		body (okay) So I connect, think in my body, what is happening to me. And I just think gosh. I feel
1216		I am holding someone's stress and I would use that. And I said what is it like for you to experience
1217		talking about food, what is that like? What is it like for you to hear we have to eat to live (nhh)?
1218		What do you hear when I say that to you? (nhh) and you know because interesting things with the
1219		brain and what I learn over time in the eating disorder team and how when weight is drop so low
1220		that the cognitions are not switch on as they would normally be. So when I must be mindful of that
1221		(nhh) that their brain is not working in the same way. And you know I learnt so, so much for,
1222		particularly for the medical team. And that’s why I like the partnership working and I think its really
1223		important when working in, in the family system, is that I learn so much about starvation and the
1224		impact on the body and the brain, and the hormone all switch off, the pituitary gland is not switch
1225		on. Its switch off now. So when that is switch off, you need FOOD to get things switch on.
1226		And it is like a miracle and you get, so I use inside to get outside. So inside to get outside. So I move
1227		into the body.
1228	R	Do you err, use that with the parent as well, you mention young people you know, because very
1229		often you see the whole family with various people there
1230	P4	Yeah, emm its interesting with food, particularly with animals in the home. And other small, smaller
1231		children, and often, and I externalise the eating disorder. Externalisation is not emm, you know lets
1232		break the plate and pretend you are angry or you know err, and err express anger about the
1233		eating disorder. And I, I, I hold some kind of reserve in doing that (nhh) because they might like

1234		breaking the plate and those risks in breaking the plate. And all kind of things you got to take into
1235		account. But for externalising I, I use imagery, you know like, being in the deep ocean. You know mum
1236		and dad are like two dolphins trying to bring you out into the clear blue sea and the warmth of the
1237		sea. They like that. Lots of them like that (yeah). And I also emm use like the animals and the dogs,
1238		and the cats. Because they are really important. Emm, ( ) the eating disorder got hold of your dog,
1239		or your pet, what would you do? Amazing now, I wouldn't let it, you know I, they really get into
1240		that. I wouldn't let them have my dog you know. I wouldn't let them have my cat. Okay, what would
1241		you do. How would you feed it? How would you do that if your pet or dog was barking and
1242		wouldn't do anything. OH, I would hold them, huddle them and I, and so I said, and I use that to kind
1243		of transfer that to mum and dad (nnh, So) and and
1244	R	Go on (P4) you were saying something
1245	P4	And, and I was thinking about you know, in addition, there is lots more I mean you know. In addition
1246		to that I might begin to say the stress of the body and, and how do I use myself. What happens to me
1247		(nhh). I might say to them, you know when I, when I think of my body right now and I think about
1248		your brothers and sisters. And they wanting to rescue you, you know I feel enormous emm concern
1249		and worry in my body, do you feel worry and concern you know (nhh) How does that impact you
1250		that worry and concern. And I talked about the time of day, is it more in the morning or the evening,
1251		what time of the day but also the siblings would come in. And say yes, no, lunch time dinner time.
1252		They would come in and say I am being fed too much food. So interesting how food becomes
1253		ehh, parents become almost blinded to know how much to feed your children. And often in that
1254		feeding process, parent eat more than they need to eat (nnh) and so they are regaining, they
1255		are gaining weight, that their bodies don't need (P4 nervous sound) to kind of role model to the
1256		children (nhh). And then, then you need to really complex, complicated stuff. So I am very
1257		cautious about that you know, and saying very explicitly in the session. My mum, my mum doesn't
1258		eat very much, I am eating more than her. The difference between a child being refeeding, being

1259		re-FED and a parent, the children need a lot more food than they would have, if they were weight
1260		weight restored
1261	R	Yeah.
1262	P4	And that's difficult for them. They need so much more food (yeah) than they normally would had.
1263		And then they start comparing with parents, and parents try to eat as much, and so I caution them
1264		to say we mustn't you know. One of the things I said, we mustn't over feed you, to overcompensate
1265		your daughter, your son. We want to keep things normal, the rhythm of food and the family
1266		system, and you eat as a family. So I am going through a lot, how they eat, how they ate, can we
1267		return to that (nhh) and keep it moving. And I think the embodied sense for parent, they do
1268		talk about stress and they role model eating the mars bar, eating the, they wouldn't, they don't
1269		need really (nhh) but they are trying to kind of role model, demonstrate food, to children food is
1270		okay (nhh) when food is very scary.
1271	R	So I was just thinking about (for the young person) yeah, I, I am hearing you talking about the, the
1272		day to day feeding in family emm, I was just thinking about does it touching your own experience of
1273		daily food eating, eating, feeding within your own personal experience.
1274	P4	Yes, I, I, yes, yes, one of the things that we notice emm, and not just me but clinicians I work with.
1275		Particularly when its coming your, your, your helping emm, parents and children to get focus on
1276		eating and you might be in the clinic. And you are going to have the food, and sometimes you got
1277		to fake it as a therapist. YOU SEE I am not going to be, so that's okay right. Now that's okay, and
1278		we are not going anywhere till we have our food. So I have to be really, really in my voice going
12279		nowhere, I got all day, I set lots of time out for you. And they say, em, em then suddenly they, well
1280		I am not staying here all day. You know, aren't they relieve. And I you know emm, but also in that
1281		it will take time for them to eat, and, complicated, emm food when you, when its not complicated
1282		for yourself. Sometimes I get more hungry than I would normally because in our rhythm of our
1283		day. You have your breakfast, your lunch, your dinner and your snack in between may be. And
1284		there is something about the aroma of food, you see food, in those moment when I would not

1285		be particularly, I try to eat my lunch before I do a lunch with them. Because I got overtly hungry.
1286		And then when I finish the session, I notice I would eat more. Or I would (P4 laughs) go with
1287		something, I would go for something emm, that wouldn't represent my lunch normally. So I have to
1288		be really mindful of that as well. Because my body, it starts to stimulate these desires for favours
1289		for different foods. Because you are with it, quite a lot. Or you are talking about food, or a meal
1290		plan, what would it look like you know when you start to. I mean I remember one day, I don't eat
1291		chocolate, not really. And I might have a little bit occasionally but chocolate wouldn't be my thing.
1292		And this girl wouldn't break her Easter egg. So I had to demonstrates this easter egg on screen and
1293		open it and break it. There is a bag of chocolate buttons inside. And I was demonstrating eating
1294		the chocolate fudge and I thought to myself what am I doing. Because normally we don't eat in
1295		the sessions (P4 hissed), and the team, the reflecting team are eating chocolate as well. They all
1296		had a piece of chocolate. I said it is okay, it was very nice, it taste lovely. Or by the end of emm the
1297		day, it was a big bag of buttons. I said I had eaten all of them, just nibbling (P4 laugh nervously) them
1298		away, but what have I done you know. I a kind of reflected on that, and I thought would I do that
1299		again NO, I wouldn't do that (because) Because emm, it got out of my normal rhythm and sync
1300		with food (nhh) and it, it kind of my balance was. First of all, having had all the chocolate I felt a
1301		bit unwell. My head was, was a bit headachy afterwards (yeh, yeh). I, I, I over done chocolate (nnh).
1302		And I knew that, that was my care. I was about to gives, so I thought I went more than the
1303		extra miles there. You know I, so that's why I wouldn't
1304	R	It sounds similar to the parents that overeat to encourage the kids to eat.
1305	P4	EXACTLY. So once, got to be careful about those isomorphism, and those parallels, that you know
1306		you don't move in with the family but you stay far enough in, far enough out to be able to be
1307		therapeutic effective (nnh).
1308	R	So I was just thinking when you say moving, ehh the rhythm you know. What might be going
1309		through your mind as a therapist when you, when you meet them. I mean you talking about

1310		embodiment, your bodies feelings and does any of your own personal experience of food and eating,
1311		food and feeding, sort of things come to your own mind when you are with the family?
1312	P4	Can you say a little bit more there, about my own personal experience [in relation to food.
1313	R	[yeah, because you know
1314		when you met somebody they might trigger some thoughts and feelings in you. I hear early on
1315		you describes not just, you are sort of focusing on your bodies, embodiment experience and use
1316		it therapeuticly with the family. I was just wondering whether there are aspects of like, this
1317		might makes you associate with your own personal experience.
1318	P4	Yeah, I mean the one thing that I would say has come up for me is, is, is, it took time. And about
1319	28.15	boundary. Because when I was growing up I can see, when I witness some of the families. It is as if
1320		they gives so much control and power with food to their children, and one of the thing for me, and
1321		I say it even in my sessions now. I think so when I looking at the family, this is a thirteen years old
1322		child whose been cooking and feeding the family with having very little for herself. And I, I thought
1323		I used to think when did they decide a thirteen year old was responsible for feeding the family.
1324		Because in my own family system, and me as a mother I never gave that to my children up to the
1325		age of eighteen. Yes, they could go out and get lunch with their friends, they will be out at the school.
1326		There was that. But I was always there to provide the family meal, to bring us together in the
1327		evening. Or breakfast time, both of them. And I was struck by I suppose oh my giddy Ann I used to
1328		think in my mind. What are they doing? Because my mother never did it. I never did it and I am
1329		thinking what, and and they will say, she does the most amazing food, the most amazing dishes.
1330		And the amount of preparation, thought going into, couple with the school work and all of that.
1331		I would hold, I remember me thinking, oh my goodness me, what have the parent done. So, in my
1332		mind I would be in a way, blaming you could say. So I would, I am very cautious about when I
1333		had that belief formed in my own kind of mind and the feelings in my body. I like my, I always listen

1334		to my body which gives me loads of information to kind of construct what are the beliefs going
1335		on in my mind. And I will use that in the therapeutic process. So I would say you know I have these
1336		ideas. But I like to hear your views and what point did you think it was okay for your daughter or
1337		your son to feed themselves. And in, it has happened time and time again, and they would stop.
1338		She was twelve when she started. And they would come back the next session and they say.
1339		I said anything you want to connect to, say yes, how could I given her that, what twelve year old
1340		feeds the family and they all kind of mesmerise, how did we do that and I said my guess is that
1341		you didn't intentionally go into do that. But they have this narrative emm, I think there is class
1342		involved in this some level, that, because their daughter is so bright and intelligent or son, yes. They
1343		wouldn't become unwell and they saw they are so, and independence is very interesting (nhh)
1344		because she is very independent, she has always been, she is so intelligent. But taking on all that
1345		responsibility for a young person at thirteen or fourteen or twelve even, enormous is what you
1346		begin to think about. You know how does she gets look after or he get look after. How do we
1347		look after our family. So food is a massive area, what informs us when we are doing our parenting.
1348		So if you are not feeding your children, yes, what are you doing instead (nhh) and what we found
1349		is, what I find, find is when you get into that kind of scenario that, they don't realise their child
1350		has becoming very unwell till they see them getting so thin. And then the alarm button goes on.
1351	32.58	To (.1) when they gone to the GP and they are so unwell. They are massively compromise
1352		physically and mentally.
1353	R	So I am beginning to think (so) about, thinking about there is one strand which is the sort of like the
1354		logical side, the, you know like parenting, the emm valuing independence and not seeing whether
1355		that is age appropriate. I am just wondering the emotion aspect of when they are doing this.
1356		What, what is the family, how might they describe or how might be your sense of their, their
1357		emotional exchange in those kind of process, whether
1358	P4	Absolutely, I mean when the emotion exchange when you : when I witness families and they are

1359		extraordinarily anxious when they come to see us (nhh). And they almost come with, particularly
1360		when you think about, oh I am going to see a family therapist, or a psychiatrist, or professional.
1361		They are almost coming gear up to be blamed, you can hear it. Oh my god, what have I done,
1362		you know. Emm, how did that happen. Emm, its your fault and you get blame, sort of getting
1363		switch between mum and dad. You see anger getting play out, you see emm, the love is gone out
1364		of the door because they are trying, you got to be eat, you got to eat, you are going to die. That,
1365		they they, ENORMITY of emotions that coming to the therapeutic space. And one way, and I hear
1366		that because you know, I suppose Charlotte you, you don't become immune to it. But I expect that
1367		(nnh) coming, that is two different narratives that can come in. Even more than one, one is
1368		there is something wrong with my child yeah. So they are protecting the child and won't allow the
1369		therapy to, they won't engage in it because they are sort of avoiding (yeh). My child is perfect,
1370		she hasn't got a mental illness. You know there is a kind of taboo about mental illness and about
1371		an eating disorder. They already learn so much about it, about eating disorder and the illness,
1372		and the impact. So sometimes, they come avoiding and sometimes they come over their, so
1373		over exposed because of their emotions. They really yeah. SO, you, you, there is a lot of
1374		emotions that comes into the room and the way in which I got to be VERY careful, so I don't lost
1375		the therapeutic rhythm and the relationship. That is the real kind of job that I was, how am I
1376		going to contain this, how am I going to work with them, to be with them, instead of getting
1377		booted out, believe you, me I have been booted out several times. But they they take me back in.
1378		Or I had the pizza come flying at my face, you know. Food just (nnh) been really, the eating disorder
1379		is, has got no boundaries, no respect (nhh). So I use those, as no boundary, no respect. And what i
1380		do is, I really hear the parents. I said this sounds really distressing and I often, if I say that, they
1381		say no I am not distress, I am not distress. Okay what would you call it, we are okay, we don't need
1382		to be here, who send you here, how, how come they send you here. You know, I can't make you

1383		engage but I am here and I said we are not here to blame or shame you. That is something we
1384		are not, we don't do.
1385	R	So, in those moment, how do you feel (P4)?
1386	P4	Emm, in those moment, I feel, I am walking on eggshells and I am sure they are feeling exactly the
1387		same (nhh) and I do say it. I said you know, well I am, I am speaking with you I feel I got to be
1388		really careful because I don't want to: I feel like I, I have to be really careful and at times I am
1389		feeling I am walking a bit on eggshells and not knowing whats the right thing to say or the wrong
1390		thing to say. And I said, do you experience that, you know yourself (nhh). And, and that's the way
1391		I connect, that that is, can be a good connection to make.
1392	R	Those sort of relational exchange between you and the family that's from the, from the being
1393		together. I was just thinking about whether there are anything that coming out from your own
1394		personal background in terms of food and feeding, that come to, comes to you?
1395	P4	(.2) my own experience with eating and food growing up.
1396	R	Food and feeding growing up, you know.
1397	P4	Actually (.1) yes. And personally for me, I never had a problem with food. I love food growing up yeah.
1398		(nhh). So, I a kind of when I come to the eating service I just, why wouldn't you eat, like you know. I
1399		mean it was like, why would you not like ↑food, how could you not like food. I remember speaking
1400		to (colleague), he said no, I can't do eating disorder. He said well, I like food too much. I said oh,
1401		I said its good that you like food too much you know, you like food. He said I don't get it, people
1402		don't want to eat you know. But that's okay because we all decide to go into different pathways
1403		as a family therapist. I guess for me (P4 hissed) emm, but that's one aspect you know, food is a huge
1404		emm, I came with the beliefs that of course you can't not eat you know. So I think the training
1405		on eating disorder really help to me, to kind of reposition me. HOW do I as a family therapist
1406		begin to engage food and helping children to eat when I actually have a story that you know, you
1407		can't live without food which is true. But also food is great you know. And I got a, a person sitting

1408		with me who thinks food is most awful thing in the world. So how do I begin to wink from,
1409		where do I sit in that, also on a personal level, I, as a mother. When my second was born, and as
1410		he moves into, he went off food. And he had, he likes food but he is limited and I didn't mind
1411		the limitations with food as long as he was having enough. And, when we went to France, he
1412		would eat nothing, and the only thing he would eat was bread and salt. And I got really worry
1413		that he is not having any food. He was drinking plenty but not food. And as we came back, he
1414		wouldn't eat any of the food he eat at all then. And I thought how am I, how am I going to do this
1415		you know. And I remember feeling really distress as a mum. Now he didn't have an eating disorder
1416		but he had eating difficulties. And so the yogurt I gave to him, he loves yogurt. So I thought right,
1417		we got yogurt you know (P4 laughs) I got limited food. But when I, he would not eat the food in
1418		school but I didn't know he wasn't eating until I put his trousers on one morning and I thought
1419		that’s really strange. I thought, I mean the last button of the trousers. He was only four and a half,
1420		five. I mean the last button of the trouser, you know those one you can get from Marks and Spencer.
1421		I don't know if you got any boys or children, that child (I got two boys) you pulling the elastic to
1422		get to the last. You pull in the elastic of the side to get the side to get to which button you want to.
1423		And I was on the last button of these trousers and it is falling off him. And I, the penny drop, that
1424		I remember this, when I talking to parents when I talking with parents. Penny drop, old my goodness
1425		he has lost so much weight but I wouldn't have known that (.1). Only in that moment, why didn't
1426		I see it. I just didn't see it. And I think parents often find that, I didn't know it and the weight get to
1427		a point where you think, oh my god. But you haven't seen it the week before, the week before. So
1428		I do understand (nhh) and then when I went to school. School said oh it is pointless giving him
1419		money during school lunch because he doesn't eat anything. But that, he was almost three months
1430		into school. And I said my question was, I was so, I was angry and I said, did it not occur to you
1431		to let me know he wasn't eating all day. And I really wanted to, poach some accountability and

1432		responsibility over to the teacher. Because I thought hang on, I can't be there, and, all of this.
1433		But I thought to myself there is no point, because I pack him a lunch and then when it came to
1434		the summer and the yogurt, warm in the lunch box. He wouldn't eat that and so I found out that,
1435		there is more happening here. And he had indeed food texture issue, he has sensory issues (nhh)
1436		and there was OTHER things you know, but everybody thinks he was all right, he was just arr,
1437		a child that was perhaps quite wilful but I knew he wasn't a wilful child. I knew he was a very gentle
1438		child and later eventually found out he was on the spectrum (nhh). So you know, when you, my
1439		own personal experience in working as a mother and with eating disorders. They are almost
1440		mirror versions that can be similar to asd sensory issues and the eating disorders because they
1441		become very rigid in the patterns with food (nhh) and a lot people when I notice with some
1442		family therapist. I think they are on the spectrum, and I would say oooh, I would always say
1443		its really important to get into developmental history. You know how was your child (yeah) because
1444		we all have patterns that can be a bit rigid. I don't know how the family system do their structure
1445		their times, and I, I have a real emm, I ↑suppose what happens to me personally I, I, I a kind of
1446		hold caution to that. And I ask, please don't do that till the child is re fed. I mean know how they
1447		are functioning because you don't know. One does not know, how and I, I, part of me forms
1448		this opinion that there is something for us as therapist, that we find it difficult, and intolerance to
1449		be with food because we think they are on the spectrum. But that's an avoidance of doing the work
1450		I am thinking. Am I making sense Charlotte
1451	R	Yes, it does
1452	P4	So we have to diagnose, but you know diagnose or not diagnosing you got to work with food
1453		whether they are on the spectrum or eating disorder. The child is starving (nnh). SO, having had
1454		that experience myself and you get into narratives with food with families. Oh, he or she only eats
1455		about ten foods. And, and I am, I am thinking thats GREAT. You know Oh, but it is only ten foods
1456		because, they are, they are, they are watching others, how they are eating. I done that myself (nnh).

1457		I thought he is, got to have (.) because it look odd in the face of others. So there is a way of
1458		protecting your child that you don't want them expose, how other people commenting on their
1459		you know, I remember my child are going to birthday parties and he didn't want. He wouldn't
1460		want to eat the food. And I meet parent say, oh look I am really worry he didn't eat. And I would
1461		have said it to them, if he doesn't have the food please don't worry. The main thing is that he has
1462		a good time at, at the party. (.1) I remember, I remember him having children of err, dinner and he
1363		said mum, please do a spaghetti bolognese. And I thought you don't eat spaghetti bolognese, you
1464		know. And I was, and I pour it all out, and say lets see, he said he wants to do it. And he was only
1465		six at the time. And he was eating this spaghetti bolognese with every, he was six or seven. And
1466		he was (exclamation sound) and I could see him trying to eat this (nnh). And I am thinking please
1467		don't be sick. And he used to be sick if you gave him food that he didn't want, he just would
1468		throw it all up and it was HUGELY distressing for me (nhh) so I learn over time, I am just going to
1469		give him food, he can do. Because my relationship with my child, was a HUGELY distressing and
1470		that was not the relationship I wanted. So I do understand families when they are with this food,
1471		the distress of them not eating is huge. And where you can move and shift as a parent with your
1472		boundaries. I remember myself saying, OH for goodness sake you got to eat and this little boy
1473		looking at me in tears. And I used to think what can I do. I remember taking him to the paediatrician.
1474		They say no, he is fine. And he was saying he was fine. When I knew it isn't fine. He wasn't fine.
1475		(P4 hissed) so I learnt a lot in my own experience with food. And now look at him, am I am so please
1476		that I did what I did. Because I just took my time. I mean I took my child to, emm a, a different
1477		therapist with nutrition. I got tablet because I thought may be he is not, and the responsibility
1478		of being a parent. You know, I took them to a brush therapist, emm, all kinds of things. Emm,
1479		because I thought how I am going to, and you know, the one thing that actually was really good
1480		for him and talking about his emotions was for me to go to a therapist, just to be with him. Emm,

1481		talking emotionally with him. I was really good for him, to kind of, she was amazing, didn't tell me
1482		anything, very little. But she develops his emotional : language. Language is again another emm
1483		areas as well. Because how do you begin to talk to a child about food, and where language is
1484		really complex and the frontal cortex is not developed with language. They have not acquired
1485		you know a richness of language and words, to be able to describe. So you know she use a lot of
1486		pictures, and I use pictures as well, and drawings. So, and I am not an artist, so its great I am not and
1487		artist (P4 smiled as she speaks) because they can be better than me. But, yeah, so I could go on
1488		more about my own personal experience which was quite traumatic for me (nhh).
1489	R	I was just thinking about this (so) very emotion, sorry you were going to say something (P4)
1490	P4	(.2) And one of the things when you are talking with families and they want to develop flexible
1491		eating and bring more variety into their diet (P4 clear her throat). We are not, I am not really
1492		interested in that. I am more interested in child getting enough to live, for they don't die. You
1493		know because they, they will die if they don't get food (yes, yes). So you know, its very emotional
1494		because you feel such a level of responsibility in my own personal experience. My child is going to
1495		die if I don't feed him (nnh). And also when I am with some of these families, there is a cross
1496		narrative going on. You know, cross reference of narrative (yeah) that the realisation that your
1497		child will die if you don't eat.
1498	R	I am just thinking about these very powerful, like you say distressing emotional experience of feeding
1499		your own child, and then facing a family needed to feed their child. I was just wondering what,
1500		what happen in their relational, how do you manage that, how you all manage that?
1501	P4	With my own story and when I am with a family (nhh). I think my own experience has certainly emm,
1502		certainly enable me to be more passionate, more considerate (nnh) for parents and to:: be there
1503		on that emotional level for them. Because there is you know language is very interesting and I,
1504		I would never have done this before, sometimes it is the only word they hear. For example,
1505		I might say sweetie, this is really difficult for you. I remember (P4 smiled as she talks) the therapist

1506		doing that to my boy. And how that just, that's the only word you could hear. Hear sweetie or
1507		lovely or my goodness, what a lovely darling you are you know. That's the only word they hear :
1508		but is that part of my own emm language. WELL yes, I would use that with my children. But to do
1509		it in a therapeutic discourse, parents are so grateful of that times, that they feel you connect with
1510		them. And the child does. The young person does. NOW, I remember working with (name of a
1511		colleague) interesting, well, I can't do that darling, sweetie thing. And I thought, oh you might not want
1512		to but I said sometimes you have to do the strangest things as a therapist to have people move
1513		beyond, if that. SO, its really interesting. I was talking to (same colleague) the most time I called
1514		my children angel. But I wouldn't do that with them. Because it is a, for (same collegue) it was
1515		like about boundaries and about, you know that's, and you know that's something she : may have
1516		to learn or develop, or not develop, you know what might be going on for her: to : shift, or not
1517		shift you know. What might they be experiencing, for me, my own personal experience when I heard
1518		the therapist talking in those words to my child. I knew my child was being care for. And being
1519		thought of (.hhh) as a nice child.
1520	R	Probably, I was thinking about race, ethnicity and cultural differences, may be, would it be certain
1521		words more endearing, sweeties and
1522	P4	Yeah, for me in (country of origin), we wouldn't have used that in (country of origin). So there is a big cultural difference.
1523		But in the UK, my mother used to call me chicken, you know there is different WORDS and language
1524		you use. Are you okay chicken, you know. Or pudding, she always calls me pudding. So you say
1525		sweet, sweetie. We say okay pudding (nhh) you know. SO, (P4 coughed) whats in language and how
1526		you do endearment or affection become I think in different ways and culturally I have notice,
1527		you know particularly, may be, I don't want to be too : absolute. Emm, within some, I am going
1528		to say some Asian communities or family systems. They have a different way of doing affection,
1529		some of them and I always curious how you do you do affection, how do you do emotions.
1530		Because I can't assume my way is the right way, am I making sense (yes). But I, and I have to be

1531		very cautious about using some of those words. Because some parent might not like you using
1532		those words (P4 laughed). Although I found it very little, VERY little, whereas somebody called,
1533		said to :: my son darling or sweetie. I would say, that, that's my job. So don't take over the parent
1534		role, that's mine you know. And I would have it, remember looking back, I would have a resentment
1535		with the relationship she would have had, that I wouldn't have had. Am I making sense? (yes, yes)
1536		or not had. Or wanted to have because the food had kind of move him away from me. Because
1537		he was terrified of, possibly about food with me. Emm because of my distress, he would have
1538		embodied a lot of my distress (nhh). And I guess that's some of, sometimes I can see mirror
1539		version in the family where the child is moved so far away from the parents (nhh).
1540	R	I am thinking about
1541	P4	Because of food distress
1542	R	I was thinking about, the food, given your experience with bringing up your own child (P4), I was
1543		thinking how to you bring, how about joy, enjoyment of food err, is it missing between the family
1544		member, the family you work with, or or with your own family.
1545	P4	Is it missing the enjoyment of food?
1546	R	Yeah, because of you have a long journey in
1547	P4	ABSOLUTELY missing, we were very limited, me, when I was growing up as a parent were very
1548		limited where we could go, it affect our social. I found ways round it, particularly going into other
1549		families, when I would say oh look I brought some food with me. Oh no, and they would have
1550		there is, well you know we let him taste it. And they will be forming all these, and I, and I used to
1551		get really distress and emotional about it. Say please don't do that. I don't want to talk or privilege
1552		food in the way you want to privilege it (yes) you know. And it a kind of expose me you know, to say
1553		Look, he has got limited foods. At that point he wasn't on the spectrum and, or anything, and they
1554		used to think that I spoil him, he was, I love him. Yes, emm so spoil that he can what he wants.
1555		And I had to be really careful with (son's name) because I didn't want to, be really you know. He
1556		wasn't a wilful child, he he, he got diagnosed with Aspergers, not, ASD is now called. But look at HIM

1557		now, he is amazing what he is doing now. You know he just fantastic, he is at university, he is eating
1558		a range of food, so he is influence by his social peers. You know it is lovely, but his brother was
1559		so protective of him, and the only place we could go to Charlotte was Pizza Express. So, he would,
1560		he wouldn't eat, he would only eat pizza express. He wouldn't eat my pizza, whether I buy or I made,
1561		NO, only pizza express. So he was, we had to really find our way round things, so but I remember
1562		the judgements and about avoiding going to places where there is food. I said will you come for dinner,
1563		but I would have said (son) would have had his. It is because I have to make up a story.
1564	R	Is that isomorphicly parallel with your clinical family, you know people that you work with?
1565	P4	Yes, it does because the timing with food. If they are going, I just say how do you begin to say to
1566		a family (nhh) you know. Would that exposing their vulnerabilities, because people are judgemental
1567		when there is a mental illness and you know. And I would just say, how do you, just say she would
1568		have eaten or bring our food with you. Just bring the food with you (nhh). Sometimes [they are
1569	R	[Do you feel
1570	P4	afraid to tell their friend.
1571	R	your, your work ignite the families', like emotional connection with the kid?
1572	P4	Yeah, I wouldn't necessarily share my, my own story with them. I don't, I don't share that because
1573		I been, I got to be careful. How much you give yourself but I will talk about my experience with
1574		food, working with children with sensory difficulties. And about the emotional distress of the
1575		parent. So I will go in on that level, and use my own story in a, in a more subtle, draw on (yeah)
1576		am I making sense? (absolutely) Yeah.
1577	P4	I could, I got another appointment, they are DNA.
1578	R	I better let you go, thank you very much (P4) and arr lovely to talk to you. I will transcript and work
1579		on it, and come back to you.
1580	P4	Err, I have to say, yeah, as I was talking about my own experience with you there. Going back, I did
1581		become quite emotional (yeah) You took me there.
1582	R	[I was hoping to check in with you how, how your experience of
1583		this conversation. I can't. I don't want to delay you.

1584	P4	That's fine, it was really, it was really rich. It was very very useful about my own narrative. Its
1585		really important that you know yeah.
1586	R	How we may or may not be aware that we are using when we are with families.
1587	P4	ABSOLUTELY, yeah.
1588	R	Emm, I better let you go then (P4), let me stop this one.
1589	P4	Okay.

Appendix 1e: Transcript for participant 5 – Eve

1		
2		R: Researcher P5: Participant 5- EVE
3		
4		
5	R	::: recording , the light is buzzing and all my machines are buzzing. Em (.6) okay. So all start, all start
6		em:: Yeah, here we go. We can start now (R laugh) .Yeah, em, so I got few question. This is a semi-
7		structured interview. So I ask some question, you respond and ( ). So urr, so if I start with, can you
8		talk about how you feel about this research title. And the title is race, ethnicity and culture in family
9		therapy with children with eating disorder.
10	P5	I think, I feel very interested because it brings a new light to a theme that is been neglected by the
11		research for many years. (Nnn) because if we think about the historical development of all the
12		models we know. Emm, I mean here I have to make a distinction because being (country of origin).
13		My first memory would be going back to Mara Selvini Palazzoli, think about mainly Italian white heterosexual family as such.
14		(Nn) I guess it is the same could be applicable to the model of Minuchin, or even to the Maudsley
15		you know (Hnn). It is something more kind of close to us. So race, ethnicity and culture hasn't been
16		really spoken about so far. So I feel very interested, that think it is really relevant. I think it is when
17		it is particularly formative for the work we do in London. (Hnn). Without being too London-centric.
18		Of course, that's problem that effect (.2) Er. It is not problem but you know that's the topic we find
19		ourself talking about. In :: many (Hnn) ↑countries , even you know teaching ↑NATIONALLY culture
20		and eating disorder seems to come up a lot. (Yeah) Because teaching in (country) in (city in that country) and (not audible).
21		That's a side job err, and they have lots of problems with certain ethnic minority. Second, they don't
22		seem to <u>understand</u>. (Nnn) Err there, people has history of migrations, where people sees migration
23		back there. It is much more modern than in the UK. But even if I think about the UK you know. Emm,
24		basicly a lot of emm (.) unknown customs and systems of meanings that we don't necessarily think
25		about the cultures. (Nn, SO) And mix race children as well.
26	R	Mix race children, yeah.
27	P5	Well, think about you know the second generation European or children that come from parents with

28		different backgrounds, being born in London. So we have got (yeah) three cultures mixing up.
29	R	Yeah, so I am glad that you feel this is relevant you know. And I am just wondering how does it
30		connects with you personally and professionally.
31	P5	Personally and Professionally. Well, I am a systemic practitioner so I think during my frame have the
32		chance reflect on m::y diversity cultural background, pride and shame of my culture and all the
33		likes of that very much. And in particular part of my training as such. Also, I am a diverse therapist as
34		well YOU ↑know, so bring diversity with me and I don't. I THINK I never shine away from it (nnh) arr,
35		I think that's change over time, because probably when I first moved to London err, there was very
36		much of arr a sense I have to conform and to comply with the dominant model. So probably my diversity
37		didn't come into really very much. THEN I think I went (.) through a phase where I was finding my foot
38		around it (nnh). ↑So, I didn't know how much I was allowed you know to bring it to the table. How
39		much I was really taking the risk to do it. And then I think steadily (.) it became the diversity (.) topic
40		become more political issue when the Brexit came on as well (nnh). You see 2016, so probably since
41		then I pretty much feel that something I never shine away from. So I always say you know for example,
42		when people feel not sure about my name. I always say you know it is (country) name. (nhh) emm so yeah, it is almost about the pride really. Err
43	R	The pride.
44	P5	PRIDE, pride (Hnn) yeah. So being somebody highly skilled who brings you know a high level of
45		contribution and technical skill to this country (nhh) emm :: (P5 hissed), so how does it connect with me
46		professionally? Well again, sometimes I feel that professionally I am fighting a bit. (.2) On an
47		uncertain waters because again all I am doing with my own diversity and when I meet the diversity of
48		a family. It is not something I read and sight in a book (nhh). It was in the team, there isn't very much.
49		(nhh) especially eating disorders. For example, if you think about all the evidence base models we use.
50		These are main research on white British samples (nhh). Or white American (yeah). And although in
51		the National training. Do you want me to say what National Training is so at least we don't make
52		assumptions?

53	R	If you say it if there is anything confidential, I will bracket them to make sure that it doesn't show.
54	P5	In 2018, all the CAMHS for eating disorders. 2018, no, what am I saying, 20::17. (nhh) So we had a big
55		training bit, nationwide and training of nationwide and we were given some training by the Maudsley,
56		Anna Freud, by GOSH as well. But there was, probably only one lecture on eating disorder and culture.
57	R	nnh, nnn.
58	P5	Then by (name of presenter and where presenter was based). (nnh) That was still pretty much what
59		you are doing at a doctoral dissertation presented for wider public (nnh). There is nothing
60		you know already researched. Let's say you know, nothing belonging to a textbook or evidence base model or
61		empirical experience that was transport to us. So again, even if you know, even in a national wide.
62		Initially like that one, there was no space for us to talk about culture.
63	R	Nnh, nnh, yeah the literature is a bit thin, yeah, yeah, yeah. So
64	P5	= the even with children with eating disorder, was again it is not just talking about children of second
65		generation but children of different mixed race.
66	R	Mixed race, yeah.
67	P5	But equally with three culture, for example, an Italian, French and English that me and my husband err
68		(.) living in England.
69	R	Yeah, yeah, so already three cultures (yeah) in one household.
70	P5	In one household, yes. Different languages and eating different food for example.
71	R	Nhh, yeah. Okay. Thank you for sharing that you know. So, I go to the sort of race, ethnicity, culture in
72		your work, you know in your work. Are there any memorable moments that you can remember?
73		that in your work?
74	P5	(.) Do you want me to talk about a family?
75	R	Yeah, yeah. Give me an example if there are any family that is quiet memorable that got you to think
76		about race, ethnicity and culture issue?
77	P5	Nnn, (.2) Well, I think you know, in my previous job I was working probably one of the most diverse
78		area (name of area). I was covering all the (area name). You know, we used to have like a very big
79		South Indian community, South East of the continent, Err big Polish community (Nnh), other Europeans
80		especially on the (area name) side. And I think that's it really. And I think I found very interesting
81		to work with Indian families. (Nhh) Be::cause, I mean when you train systemically there is a lot

82		discourse around not being the expert, and not taking on the expert position. But in these type of
83		family, I found that they really want us to be the expert.(Nhh) and almost to dictate should have
84		happen at home. And how would meal plan should have been like and very you know. ( ) I remember
85		me feeling very rough taking these sessions. Not necessarily be::cause (.2) how can I put it. Nnh, (.2)
86		I don't know why this happen but I feel, I felt that (.2) because of the background, especially fathers
87		were valuing a lot the EXPERTS opinion (nhh). Emm whereas sometimes that something I don't,
88		I don't find with white British family (nhh). Especially, those come from very well off background,
89		very well read. So they almost seem to come with an idea, with an expectation into the room. (Nnh)
90		and you almost operate as an equal sometimes (nnh). And actually it is a problem when you have to
91		prescribe something. They will challenge you or they will think (nhh) they know in a way that,
92		you know. They give it their own twist but they don't follow exact what you say (yeah). Err, whereas
93		with Indian family they found very, again very easy to follow the trap of becoming the experts. But at
94		the same time, when it was needed. There was not very much, err need of pushing, negotiation. They
95		will happily follow. And I think one of the best example of the :: of clinical work experience probably
96		the girl that I present at the (name of conference). Family with err, family of Punjabi background, very
97		orthodox Sikh family and err the way we, we bonded with them is been very strong. Probably, nn told
98		you probably yeah I presented this. There were three cultures in the room, there was me, psychiatrist
99		in the room, (nhh) it is me, my colleague from (country in Middle East) and then from err from
100		Punjabi, with children born here. And it was very interesting to spend lots of the clinical work getting
101		them to understand anorexia (nhh). And dad would get there, because he was a teacher (yeh). So
102		because of his background as well. Mum had less spoken English, learn at school. They didn't want
103		interpreter but mum was very gentle, nurturing, hands on parent. So she, the whole refeeding she
104		did well. And when we, and I think when we went, was phase three of the treatment. When we had
105		to talk about identity, psychological leash or more individual, individualise of it, relevant to the girl.

106		I think the brother was very helpful to us, pretty much as a mediator between the two cultures.
107		Being an orthodox Sikh and Indian background (nhh), but equally knowing the British, the dominant
108		culture (nhh). We were thinking each of them really wrote, that they want to contribution for, for this
109		pain (.2). Very culturally main type of work (nhh).
110	R	You mention the stage model, stage three. I was just thinking about how does this stage model might
111		be showing in, in their, in the room, in your session?
112	P4	Do you want me to say something about the stage model?,,
113	R	Ye ::ah, I think generally the stage 1, stage 2, stage 3 and I was just thinking about how it show? How
114		do they respond? The family respond to it you know?
115	P4	Okay, well, the stage model I am referencing to the err the Maudsley Model (yeah). So we are talking
116		about, I mean whichever we want to think about. Whether we think about FBT or FTAN, FBD has
117		three stages. FTAN has four stages. But, there is lot of commonalis, commonality behind these models.
118		So:: and I was actually use the Maudsley models. Stage three actually thinking about the identity of
119		the illness and helping the family moving out, moving away talking about anorexia and embracing
120		normal life (nhh). And it has, as a protagonist very much young person (nhh). Young person will be
121		involving lots of conversations about type of people they want to be, their identity, what sort of
122		life stage challenges and all the risks phase 1 and two. I mean phase one is basically refeeding (nhh)
123		to help the parent refeeding their child. Then bringing the weight up. phase two is very much
124		managing anorexia day to day basis (nnh). Emm, so do you want to say something about how the
125		culture may
126	R	Yeah, so when you tell them this is refeeding and how race and ethnicity cultural conversation might
127		look like? Or challenging?
128	P4	Well> it is very difficult to say. I mean I had so many different responses in different, I would say
129		clinical scenarios for different cultures. ( ) What would you like me to say? With this family or with
130		other families?
131	R	Err, it is up to you, you know like err, but they might be easier because you started describing this
132		family.
133	P4	Them, phase one refeeding was very much. I mean (.2) It was probably challenging at the beginning

134		because she came in on a very low weight (nhh). So we entering her into inpatient straight away (nhh).
135		I would say we probably pick her up from phase two. So phase one was very much done on inpatient
136		basis, I would say. Emm, with phase two managing anorexia. I think, it was very challenging because
137		parents, although they had a lot of family therapy inpatient. They had interpreters in every CPA, so
138		they knew what we are talking about. They were really struggling to manage the girl at home.
139		And the turning, the turning point was very much when she er, she was already on a section.
140		And she couldn't resist, at the end so she burst and she literally pee on the chair. I never seen anything
141		like this in almost you know. In fifteen years of being a psychologist. So I think that was the turning
142		point that made them understand the extend of emm, of the illness. So I would say probably (.2) phase
143		two, I think they learn from experience in that session. So they saw with their eye, with their, what
144		was going on (nnh). You know what I mean, as parents mum didn't know very much English and so,
145		probably didn't come with a very, with a theoretical background, with theoretical knowledge of
146		anorexia. But when they saw it, they were able to change and take a more active stands.
147	R	So, does the family have stories or meanings give to the eating disorders then?
148	P5	Nnn, you mean their culture?
149	R	Yeah.
150	P5	Well >, that's something (.2) they didn't show it very much (nhh). And they say it multiple time that
151		they didn't understand what eating disorders was (Yeah). So they probably came to CAMHS more or
152		less (nhh). Emm [and they really, it was to us you know. To us, showing our experience, or talking to
153	R	[And they
154	P5	other patients or err, or seeing how we interacted with tier 4. Because they bonded particular well
155		with tier 4 as well (nhh).
156	R	So, yes that's a very interesting case, situation you know, yeah. I remember they got, the girl got
157		better after the brother.
158	P5	She did, she got better. She was completely weight restored. She was no longer anorexic. So I think
159		she went straight to Uni, study law. I didn't know when.
160	R	And if I remember right, the change started when the cultural conversation gone into (yes) the family.

161	P5	That was in phase three, maybe I didn't say, should say more about this. So when we spoke about,
162		I then yes, I actually had a warm, want to be, and especially you know the idea of wanting to move
163		away from (.2) the female identity that portray by the mother. And looking for something else, but
164		she didn't know what, how this would be like somehow. So remember, spent a session talking ab::out,
165		you know looking for female model outside. How to approach them what to take away from them and
166		you know (nhh) how class, in terms of how she feels that? She has got lot of questions that nobody
167		can answer about her identity, you know. And I remember she asked me this very powerful question
168		you know. She was very stuck and we ask if she want to ask any questions. So that's okay, let’s see
169		if you could use the session, ask me a question, ask me and my colleague a question. I remember
170		she asked her where she was from, and then she asked (P5 laugh) she asked me err why. Did I say this
171		in the conference. Why do you never wear trousers? And it is true I never wear trousers or very rarely.
172		Say yeah once a month or something, probably never at work. And I said aah, because I like it best.
173		You know I really, really like skirts and ↑dresses. Or you find me wearing dresses THAN trousers. Well,
174		and then I even gave her a, a real answer. I said you know until I was twenty six, I was ashamed of
175		wearing trousers (nhh) because I had very muscular legs because I play volley ball. And I was even err
176		and I was ashamed to wear sleeveless top. Because I got quite big shoulders because of volley ball still.
177		So I think you know that, the end of the conversation. Then she say to me you know what. I asked
178		you this question with a thought that you were the type of therapist, thinks women can be only
179		feminine if she wears a dress. (.2) and of course that's not the case by the way. That's the way
180		probably she can constructed me (yeah, yeah) like being :: therapist in my thirties, nnh, coming from
181		a European background and she knew I am (country origin). So that's very much the er, type of
182		assumptions she did about me.
183	R	She began to show some curiosity about you then?
184	P5	Yes, yes, which I didn't mind actually. Because I was, very very relevant to the question of identity
185		she was going through (nnh, nnh).
186	R	So I was just thinking about this family you are talking about, I was just thinking about what might

187		you say about the cross over between eating disorder and race, ethnicity and culture for this family?
188	P5	Well I think the eating disorder was very much influence by :: the quest of identity (nhh). Yeah, I think
189		the quest of identity is very much common theme in eating disorders where they become the priority,
190		
191		are much more :: post an distress for this (nhh). We have very, I mean we live in a very demanding
192		society where the expectations are pretty much set and if you don't find yourself fit in any box,
193		whats left (nhh)? Sometimes.
194	R	So the identity :: struggles (yeah) kind of like link with the race, ethnicity and culture (nhh).
195	P5	I think so.
196	R	And, and kind err, yeah so:: and then it shows itself in kind of eating disorder symptom, is it? I am just
197		thinking about how it cross over (yeah) a bit about, ↓yeah.
198	P5	Well, of course there has to be like a stop street, like position (nhh) people otherwise. Every child
199		of a second generation would go to my ( ) to eating disorder or develop an eating disorder. So
200		almost sort of mild eating disorder, for those who are very perfectionist, high achieving, extremely
201		sensitive or people pleaser as such (nhh), much a pass lay (nnh, yeah) (P4 speak softly not audible).
202	R	Yeah, yeah, okay. So :: I kind of like very interested in the, how family therapist talk about their work.
203		So I am going to ask you another questions about. Do you have any family that come to your mind
204		that you might be able to tell me about, and there are?
205	P5	Are the families?
206	R	Any work that you have done with families that er you like to share?
207	P5	Yeah.
208	R	That has got race, ethnicity, culture issues.
209	P5	I am thinking about a boy of Polish background with Bulimia Nervosa (nhh). And his sister has bulimia
210		Nervosa as well. But she was treated by the adult service of our trust. And the boy was with us. Dad
211		wasn't part of the picture and mum work long hours. She couldn't speak much English, and er so we
212		have to use one of our Polish speaking therapist. And, at the beginning again it was very difficult to
213		set up all this sort of meal, we didn't have to do the refeeding plan but we still have to, you know.
214		Sorry, manage bulimic symptoms as such and mum wasn't ready to make any exception or any

215		amendment to her working day. So the plan didn't work, because :: emm, the symptoms didn't stop.
216		We both, I mean the boy stuck with sertraline, other medication. We did CBT as well for a bit.
217		And in this case, I was involved ( ) with my CBT head on (nnh). Err, but the we did a lot of join work
218		with the family therapist later down the line. Because we felt that we couldn't use :: FT family base
219		treatment basically. And there were much more suited for generic systemic approach as such. And that
220		become very very relevant when, he became dealing with drugs. How do you say? Yes, dealing with
221		drugs basically. So he
222	R	What do you say about dealing drug?
223	P5	Dealing drugs
224	R	He was dealing drugs yeah.
225	P5	Dealing drugs (yeah) so he did some videos of him. Err using some drugs and I think he poses on, online.
226		(ahha) so the video went viral. School became involve and you know, school actually realise there
227		were, like a pocket of person (nhh) dealing with drugs in school (nhh). hhh so of course
228		you know there was police and staff. And only at that point, mum understood
229		the issue around his child's mental health (nhh). It was too big, she actually started taking bulimia
230		seriously as well (nhh). And the way we conceptualise, you know bulimia or err sensation seeking
231		behaviours or the drugs as well was to elicit family attention. Well, you know raise the temperature
232		Polish mother with children born here. And it was very interesting to spend lots of the clinical work getting
233		the only (.2) way, the only way into the family. Otherwise, the sister were doing her individual
234		treatment in adult service which I was pretty much left with on his device.
235	R	How old is he?
236	P5	Err, sixteen or seventeen.
237	R	Sixteen, so I heard the bit you mention, mention family based FBT didn't work. Did you say that?
238	P5	Well, it was we thought it wasn't relevant. First of all, because there isn't very much (.2). It is still
239		quite controversial how to do it with bulimia (nhh). They, needs training, at least ( ) there is only a
240		manual with lots of code with FT-AN but with a lot of caveat. That when there is comorbidities or ::
241		other more impulsive behaviours is not treatment of choice (nhh). So we thought, you know doing

242		thing for, not simple but generic family therapy as such. Because there is systemic issues where ehh
243		quite prominent (nhh). Absence of the father, mum being the main weaner, being extremely isolated.
244		Mum feeling she had no connection what so ever with London. Although, she had the children here
245		and she was here since 2005 I think (nhh). There were lots of issues and discourses around what the
246		NHS and what the clinician may have. That’s, you know that's the theme that I found very much.
247		When I work with Polish families, I found a very much of self-reliant community where you know.
248		You only go to your own doctors, Polish speaking doctors, Polish speaking therapists, and we don't get
249		you know. They don't get very much out of their own way to both the NHS.
250	R	Nhh, so somebody speak their language is important then, is that being one of them?
251	P5	I think so, as well as probably being Catholic or even understanding the system of values. I think that
252		sound very much with Polish families.
253	R	Nnh, I am just thinking really, you know like of, because I am thinking about what, what is the main
254		issue for them. Err the specific eating disorder issue and the race, ethnicity and culture for them?
255	P5	Well it is, I think it is a struggle of adaptation, like for example in the sessions Mum wanted to speak
256		Polish, he wanted to speak English. Mum was mad at him for not speaking Polish (right), he have to
257		act as a translator (right) and he was saying to me you know, like yes. But, because there again all
258		these strange street where polish community as such. But even within the Polish community, kids were
259		born here wanted to speak English (yeah). So basically, when mother speaks to kids, the parent always
260		spoke Polish (yeah) and mum & sister are more comfortable speaking English. Because of the English,
261		the TV you know because of difference, influence from the outside
262	R	Nhh, so I was just thinking about, in terms of family therapy managing eating disorder and the race,
263		ethnicity and culture. What are the like, how does it show? In in the process?
264	P5	Well, do you, okay. Well probably at the beginning, I mean at the assessment phase, emm how does
265		it shows? Well, we may find ourselves talking about family background, family traditions, how the
266		family traditions were religion or cultural habits might be relevant from err, for us in the process (nhh).

267		The, the I mean for example something I ask very often is I mean I try to probably dig around their
268		identity as such (nhh). They feel whether the young person feels that they belong here or their
269		might be other influences or their might be other system of meanings that probably take over what
270		they learnt here. What they, what they grapple with here? Like for example I work with an orthodox
271		err British born girl, I will rather ask :: connection (nhh). You know, orthodox err :: Jewish means
272		of what type of traditions, what the cultural expectation would be? One being a teenager,
273		born and bred in London with that backgroud. There then the life cycle expectation of, I don't know,
274		obedient, becoming married or studying, having children at certain age and all this. Nnn and probably
275		if I sense that there may be an identity trouble as such I will this in a one to one in the assessment. I
276		wouldn't know I mean in the assessment phase because I don't know whether that can be a
277		contentious issue in the family or not. And probably if these not the case I would have more join up
278		conversation with the parent as well (nnh).
279	R	So this kid he came into the session to see you for initial assessment without the mother, is it? Right?
280	P5	Who? Oh YES, yes.
281	R	This child and then, and then later you involve the mother.
282	P5	Yes.
283	R	And so :: I am thinking about emm how did, what happened to him? You know like eh, what happen
284		to the family? Yeah, the Polish family, you know like er you had a Polish colleague to join you?
285	P5	Nnn, yes, yes. And what do you want to know?
286	R	Did they engage, what happen to them?
287	P5	Well, yes. After the er, the child. So, they didn't engage in the treatment of anorexia. But they engage
288		when the child was caught having, you know doing drugs.
289	R	Right.
290	P5	No, I mean to me. It was almost
291	R	Did you say he got Bulimia? Not Anorexia.
292	P5	He had bulimia, yes.
293	R	All right, yeah, yeah.
294	P5	To me, it was felt like the family was not acknowledging anorexia very much (nhh). It only became
295		a concern when the behaviours escalated (yeah).
296	R	So they engage after he was found
297	P5	doing drugs.
298	R	Doing drugs. And put it on the face :: on the face book, is it?

299	P5	Yeah, I don't remember
300		= Something online, something online.
301	P5	Yeah, yeah.
302	R	Yeah, and the problem get much bigger and the mother has to arrive?
303	P5	Yeah and out of hand.
304	R	Yeah, and and did that work when she arrives?
305		Did she work therapeutically?
306	P5	Well at least she was much more able to listen (right) and :: I remember we did the genogram as
307		well to see how addiction and bereavements. Like there was a lot of, there were lots of err
308		bereavements, losses and addiction history in the family. So we did the genogram (nnh), so to
309		track down the intergenerational story or coping with loses or misplacement as well. Because the
310		family, family from Poland had a lot of trauma related issues. Especially in the second world war (nhh).
311		almost every member of the grandparents' generation had an addiction problem, like drinking problem
312		Right, right ,yeah. And the father? Did they say the father why is not on the scene?
313	R	The father never came.
314	P5	Oh, he is around but never came.
315	R	Around but never came.
316	P5	Around but never came and she didn't have much to do with the child.
317	R	Oh, are they living in the same household.
318	P5	No, no.
319	R	No, okay. So he is around but err not very involved.
320		So what is the outcome then? I am more a kind of following this family like a story to just thinking
321		about them. So what happened, how they arrive and then what happen, what happen?
322	P5	Well, when he was put ::on medication and he engage in family therapy. He became more able to
323		take his mother's point of view. Because deep down inside he was very resentful to mum for not
324		being around (right). She was working mad hour from seven in the morning to ten oclock in the night.
325		So you know, it was mainly on his own when meal time or ( ). So when we did the genogram, I think
326		he became more open to taking her mum's view as well. Of being single mother being on her own,
327		being misplaced and you know far from home (nhh). Not in touch with very much, to treatment.
328		Even the sister had been, and I think he was very short of being caught out you know, by school

329		and by the police. That was a very powerful motivating factor ( ) in his life. That, I think at that point,
330		he became much more able to manage himself. (nnh, nnh). Then he understood mum's struggles
331		and, and it was not only school but having a criminal record for life (nnh, nnh).
332	R	Yeah, so he got discharged and ?
333	P5	He got discharged yeah.
334	R	How long was he in your service? You know from not engaging to engaging, to discharge?
335	P5	All in all ( )
336	R	Did you say two years?
337	P5	Yeah between sixteen to eighteen yeah.
338	R	Okay, so I was thinking about did this story, this family you, we just talk about? Does it sort of like,
339		err connect with you anything personally.
340	P5	Nnn, well if I think about my own family as well. Well we all did you know, we all suffer very
341		traumatic loss in the second world war. None of us have any addiction problem or any mental
342		health problem after the war. But err (nnh) I can empathise with the sense of loss and misplacement
343		coming after (nnh). Well, also again being a woman, ( ) on my own at the very beginning err when I
344		came to (UK). But then again (.2) well I feel somehow privilege before you know. I had a job,
345		but with this job I could manage myself, support myself and I don't have to work mad hours like from
346		seven to ten and you know. I have time to have my own life, have friends. Emm but if my husband,
347		my boyfriend and my husband afterwards, but emm (.2) I think I reflect the sense of privilege that
348		some migrants may have and some others don't have (right). Because especially if you think about,
349		you know what was said about Brexit you know (nnh). It seems at last, they said migrants. That's it
350		migrants (nhh). So I think, who I say migrants as such well again have to go through the Visa application.
351		Why do you come here? What have I done with my life? And every bit have to be explained.
352	R	Oops, sorry some noise from the computer. It's the computer, its all right.
353	P5	So I think there are some other minority that have a much tougher life and (.2)
354	R	Does that come up in your conversation then? you know you mention.
355	P5	2016, and I think that was very much of a skeleton in the room. In the room, yes, in the closet, or
356		elephant in the room as we say (nnh).

357	R	Yeah, yeah. So thank you for that. If I move onto something slightly different if about your journey ::
358		hear the conversation and see what you think, you know. Emm, can you tell me some, your experience
359		of working in the field of eating disorders develop you as family therapist on the issues of race,
360		ethnicity and culture.
361	P5	Say that again.
362	R	Your experience of working in the field of eating disorder develops your practice as a family therapist
363		on race, ethnicity and culture issue (nnh).
364	P5	Well I think, there have been many difference teams and I think my position around (.2) culture
365		issue had changed, everything might changed. Because in my first team, it was a tier four team. Emm,
366		we didn't have many diverse patients. So may be I wasn't, no may be I wasn't necessarily always
367		advocating for talking about issues around diversity (nnh). Then in my second team, the (name of the
368		area) one, we all come from, I mean from, was very very much diversity. Emm, so that point you know
369		I could feel that, the position was very alive in the team. There was an awareness here now, working
370		at (name of service) white British :: are:: workforce. This might, ethnicity in the team. And so, I feel
371		I am becoming a bit of ambassador may be. So I can see it is always me bringing that topic on the
372		table (nnh). Emm, yeah, I think in my clinical practice again (.2) I became much more aware of the
373		identity struggle. We were then, you know I think I am very privilege because I can sometimes do CBT
374		with my patient because I am a psychologist and sometime I do family therapy. But I think either
375		way I tend to draw on the cultural issues very much (nnh). Where I can see that sometimes other
376		colleagues don't dwell on it. They don't make a meal out of it. So, and I think within the team I also
377		address as an expert of cultural diversity as such (nhh). And I think because I am from another
378		background and my assistance in family therapy was notoriously. We seem to be the most inclusive
379		professional body around diversity. There again, we think about the type of conversation I have with
380		other psychologists, I would say they different very much from the type of session we have when I am
381		with my family therapy head on, if you see what I mean (nnh). That culture, identity and race are
382		comes up in the position of most often when I, you know in mt family therapy shoes (nnh).

383	R	So, I mean in your family therapy shoes, as an ambassador. You know I just wonder how, whether
384		eating disorder make a different to your race and ethnicity and cultural practice?
385	P5	Well, I think (.2) I think I have become an extra horse shoe therapist. Because again, in eating disorders
386		we have lots of issues around risk and risk management. AND physical health, so I don't know if I
387		becoming, I could protective. But I want to always make sure that, the cultural background doesn't
388		become, doesn't get in the way with. Because, understand of the risk (nhh). When some other culture
389		may feel a bit more emm oblivious of the risk or they don't conceptualise risk as we do it here (nhh).
390		For like example, in some :: countries they wouldn't even do a risk assessment to a patient, you know.
391		They would say okay the type of therapeutic work need to be doing is this, we don't necessary do
392		risk assessment. That's something doctor would do. You know, when you do family based treatment
393		and you are the care coordinator, you need to think about risk management (hnn). And I have seen
394		for some culture are not very straight forward from the notion of risk management (nhh). That's when
395		probably emphasise, explaining more or adjusting my language more. We been trying to find the
396		translated resources as such. At least, we all can share the same meaning right from the outset.
397	R	Nnh, so let me reframe it, see whether I understood you, is that I hear you mention err (.2) risk in
398		eating disorder (nhh) are being considered in a sort of culturally and err kind of like sometimes you
399		have to like make it more :: make it clear to people is there, make it clear or like, give a meaning to it.
400		Is that what I understood, yeah? Because I think, one thing I was wondering err race, ethnicity, culture
401		presumably needs to be applied to all families regardless what issues they bring (nhh) But whether
402		or not eating disorder bring something more specific? Emm changing how we, how we talk about
403		race, ethnicity and culture? So you mention risk is something.
404	P5	Well,
405	R	Eh, eating disorders bring.
406	P5	I will say also diet, in food, and in each culture.
407	R	Sorry, what did you say?
408	P5	Diet (diet) and the eating as in (eating) the food we eat (diet and eating) in each culture.
409	R	Nnh.

410	P5	And that's particularly tier four err settings. There isn't any room for cultural adaptation of meal plans
411		(yes, okay) may be there is something else we should have more, other talk about and discuss so that
412		he knew what meal plan would look like or what could be an hindering fact or I don't know. Or ring
413		the mother to cook something doesn't belong to the Indian traditions as such (nhh, nhh).
414	R	So I am going to ask something slightly the other side of the angle. Do you think what you bring to
415		eating disorder emm service as a family therapist for race, ethnicity and culture? What do you think
416		you bring to the
417	P5	Well surely, emm, awareness, sensitivity and possibly or not. I don't know how one phase it. Not
418		shine away from talking about this (yes, yes).
419	R	I think earlier on, you use the word ambassador.
420	P5	Ambassador, I like ambassador
421	R	Yeah, yeah.
422	P5	Well and I think in the end I am an ambassador because you know I am a foreigner (P5 laugh) both
423		of my own culture and my own you know, cultural experience I think.
424	R	Yes, .hhh, so emm so can you think of a time when race, ethnicity and cultural issues hindering your
425		work then, hindering your work with a family with eating disorders issue?
426	P5	Nnn (.2) I am thinking
427	R	Yeah, yeah, there are so many families you have seen.
428	P5	(.4) nnh. I can't think of an example but I can think about what :: triggers me as a therapist that might
429		be related to culture (nnh). Like for example, extremely :: orthodox family. Like family who don't want
430		to embrace main stream way of living (nhh). And, I mean all these families who are really close off,
431		don't mix up too much. The, with the dominant culture. Oh yes, I am thinking actually. Oh yeah, okay.
432		Families of a seventeen years old (R cough) severe anorexia. Question mark whether she was on
433		the spectrum or not. Err Dad came to every session. Emm, Dad didn't speak much English (R cough).
434		They were here probably for twenty years or something like this. And they didn't want the interpreter,
435		they were expecting us to :: translate every, every written resource we gave them. So at first, she
436		ended up in hospital almost straight away because parent couldn't do the everything at home,
437		understand anorexia. So I thought (.2) what really make this piece of work difficult was that the

438		family wasn't making any effort to come out of the shell (nhh). I remember Dad once had almost had
439		a go at me. Because I translate the routine of the day , they were saying err we speak Punjabi at home.
440		Fine so, I got the punjabi translator you know. I had all my material translated and err. He then err,
441		and then they said but I don't read Punjabi, I read only Hindi. And to me, I don't know. To me, I couldn't
442		see any difference between them. I don't know to me, Hindi main stream language, Punjabi is a dialect
443		and that's the way I understand it. Pretty much like saying, I don't know. (Language of a country)
444		is the main language and (a regional place within that country) is a dialect, pretty much. So but I guess
445		you know, if something is not written for (P5's country of origin), so we had a very hhh, very big
446		problem with them. They were doing things the wrong way, the child was deteriorating and in the
447		end, she ended up in hospital (nhh). Well I think generally speaking, I struggle with these families who
448		were resistive of any input because of their culture (nhh).
449	R	It is very challenging. And what happen to this kid in the end? Did she?
450	P5	Well, she went to inpatient. She was discharged, she started losing weight again and then I left the
451		service but I think she was still monitor by them. And they only did physical monitoring (nnh) and
452		she was approaching eighteen so. She might have been sent the other service I think.
453	R	Yes, so it sounds like ( ) what service can do, offer is to refeed her, give her food and then well enough,
454		and then start again. Very sad (nhh).
455	R	.hhh right I am going to change the direction a little bit about, talking about risk, you started talking
456		about risk you know. Emm, so how, how, can you tell me a time when you have to manage risk? Err,
457		in your work and how does it implicate on your reflexivity and your race, ethnicity and culture
458		approach?
459	P5	Nhh, (.4) you want me to talk about case?
460	R	When a time you have to manage, yeah, a case to have to manage risk and what might be the sort of
461		like triggering in you and also how you manage it race, ethnicity and cultural aspect of it.
462	P5	Nhh (.4) okay I am thinking about :: does it have to be a tier 3 case or tier 4 as well.?
463	R	Any, any case that you can talk about, you, you come across that you work with?

464	P5	Nnn, this girl who was, can't remember fourteen or fifteen (nhh), who was admitted then inpatient
465		where I was worked. And from an Indian or Bangadesh background? No, Indian background. She was
466		born here and the fam, and the, and the parents, mum was born here, Dad was from India. But, living
467		in here more than twenty years as such. And (.2) I remember when she became better like towards
468		discharge, no actually. No, let me, sorry I am trying to put things in order (P5 laugh) (nnh). There is
469		many issues here, one is the way the parents manage to call me. Because basically this child was asked
470		to travel up to (city) each time from leave. But parents wouldn't come because they have a shop
471		or something. I remember that I was very worried that she wasn't fit enough or well enough to take
472		the trains to go up to (city). And in the end the team, we almost turn an eye, a blind eye on this.
473		Because we assume almost that the parent would come on Friday afternoon, pick her up, take her
474		home, bring her back on a Monday morning. Or Saturday night or else Sunday night, whatever. But this
475		isn't happen and so I remember we, this were issue as well and we have to had this conversation with
476		parents who were ↓completely oblivious about the risk of having a child. I mean from an inpatient
477		with, you know physical issue was stable but issues was on the low end. I remember she was like
478		eighty five percent weight for height. So she wasn't complete weight restored. So in my mind, I
479		wouldn’t send anybody onto trains in summer time, during a very hot summer travelling up to
480		(city). So :: well at first I thought these are safeguarding issue we have to manage risk. We have to
481		have this conversation with parents. And I remember find myself very surprise when we had that
482		conversation with the parents. They didn't see the problem (nhh). I thought probably there was some
483		element of cultural understanding. But also (.2) something that didn't match up in our system of
484		meaning you know. As a clinician from them as parents because for us, may be as a clinician who is
485		still okay. Safety of the child first, then we will think about family constraint and whether family can
486		made some arrangements or you know can be more on us, our side as such. And then we will
487		consider anything else. For the family was, child is in an inpatient. So the child is still dedicated to the

488		inpatient. We have our work to do, other children manage these, always very independent child. Very
489		reliable, more mature than their age. Not worried about her, even if she has an anorexia. So, our
490		concept of her takes over the fact that she has anorexia.
491	R	Nnh, and she is one of many.
492	P5	And she is one of many. She is the eldest of many, so the Indian in that type of culture, what it means.
493		Well remember in the MDT, we have probably a bit of split between people would say this is
494		safeguarding issue, these are risk issue and you know we need to be more hands on, on this. And
495		other people were saying, you know that’s the way family life is that (nhh). So we can't use English
496		system of priorities. Err, so I think in terms of cultural reflection for me. And of course, I would have
497		like them to be more. I mean I would like parent more risk aware but I had to probably acknowledge
498		some families have very much task orientated or practical orientated to family life. And probably
499		thinking about risk is not their priority (nhh). Even in the life of anorexia, even anorexia is in the
500		background.
501	R	Did you manage to have a conversation with the parents ehh in the end?
502	P5	Well, we did it in a CPA, so it wasn't agreed and then it was more about (nhh, the team) conversation.
503	R	And their responses?
504	P5	Surprise, they clock the fact that they were doing something not completely, not quite right in the
505		end but it took some, some time.
506	R	Nn, so did they start picking her up or, [or like arranging some more safer plan?
507	P5	[Yes they did
508		They did, but I don't know whether again. That's the problem of cultural understanding (yeah).
509		Remember they then booked a ten days holiday in Turkey or something . So again very hot climate,
510		emm, a bit of struggle with food as well. And they didn't consider that NHS England would stop the
511		funding after five nights if the patient spends away (nnh). We are inpatient, so in the end we had to
512		discharge them and they lost the bed. Because they are CCG didn't want to pay. You know, they
513		didn't want to keep the bed open for him, for her to (nhh, nhh, nhh, nhh). So, it was natural,
514		pretty much for discharge, more or less (nhh).
515	R	So they are ready before the unit ready (R smile).

516	P5	Yes, so I don't know whether these are cultural understanding and I think there are two issues here.
517		One is the culture and one is also the, the, I don't want to say working class mentality. But I guess,
518		you know if you are parent who :: work all year round you know. You are feeling entitled to your
519		holidays, and want to be here and rest you know. Then if you make your own plan and carry on
520		as normal. I am not saying it is right, don't get me wrong. Sometimes it is not straight (nhh).
521	R	Yes, yes, quite challenging you know.
522		Just thinking about on the note of risk, just wondering the last time you had a child coming home
523		with you? Not I mean, not physically but on your mind that you take a child home, like because you
524		are worried and concern and. Do you have anyone coming home with you err? ( ) yeah?
525	P5	Every day.
526	R	Every day.
527	P5	(Both P5 & R smile) you want an example or you want to know what i
528	R	In terms of like do they have risk issue or race, ethnicity, culture issue or other issues?
529	P5	Well, can I say something about the lockdown (Yes). It is very relevant to your thesis
530	R	Absolutely, absolutely, yeah
531	P5	Well, that is a change of context you know. (.2) Again when I think about race and culture and ethnicity
532		here. I always think whether, there is also a class issue in that. In, in the blender I think. So I think
533		during the lockdown I was constantly thinking about my patients and whether you know they are
534		privilege enough to live in a house with, you know good food, access to computer, education and
535		nice little garden in the back. And do their own things in their garden on their leave. If they are on a
536		flat, block of flat very constraint by, by everything you need (nhh). So I think the underlying reflection
537		was the sadness for the social society (nhh). So I can't say you know I have brought that child with me
538		at home but I was thinking about how much disparity we have in (name of the area) (nnh, nnh). And
539		how poor some (yes, yes) more than the others. But (yes, yes)
540	R	It is a kind of like, somewhere the, the social economic, class background.
541	P5	Yeah, yeah, definitely, completely. You know, I lived in a very well off area you know. I mean in
542		(area name) between (area name) and (area name). We all have our own little garden, fine. But if you

543		are in a house or you know cramp house, or with many siblings. Have to fight for the computer you
544		know, whats going to happen to your education and mental health. People will believe err if you have
545		to struggle. I mean if you have anorexia (nnh) and you struggle to find your own safe food and you
546		do online shopping. What's going to happen?
547	R	Do you have more crisis lately then? You know like, during the lockdown?
548	P5	Nnn, I would say so. (yeah)
549	R	In terms of they can't manage they need, need to more input from your service. Or just needed
550		somebody to support them or or?
551	P5	Nn, well they still need many inputs but they don't think they see the way forward because of
552		lockdown. Although again to me, this doesn't feel like a lockdown, this been a complete joke.
553		What England has been doing? But emm, some people think it has been very effective (nhh)
554		When a child can't see their friend, or can’t go to school and they all, sense of normality get swept
555		away (nhh, yeah).
556	R	Yeah, that's a very sad situation. Different countries, yeah. Or different, the whole world is affected.
557		.hhh, can I just come back to this conversation sorry. Err, just thinking about dominant discourse
558		about race, ethnicity and culture. Just thinking about, can you tell me about the dominant
559		discourse that race, ethnicity and culture you hold professionally? And how that might have evolve in
560		your practice over time?
561	P5	The dominant discourse around culture?
562	R	Yeah, race, ethnicity and culture in eating disorder.
563	P5	(.4) Well, I don't think there is one (nhh). Based on a share dominant discourse I think it is very much
564		emm based on individual experiences. It is very subjective. I don't think they share narrative around this.
565		(Nnn) and of course, everybody knows pretty much that they have to make, to include culture in our
566		conversations about err. I am not sure (.2) even for the way that eating disorder team, I think
567		constructed you know (nhh). I am not sure everybody has the same idea or the same dominant
568		discourse. We have multiple voice for sure, but there is no share narrative in this (nnh, nnh).
569	R	But, if you just a kind of like take a step back. You know, what is, what might be your dominant
570		discourse about race, ethnicity and culture then.

571	P5	Nnh, well that's something we need to bring the conversation more often and I will say at the moment
572		I think we need train our eye, as much as we can. That's my own probably the main organising factor
573		as such you know. To train our eye and not to miss any chance, and to help, even between
574		professionals, help each other understand and notice how the culture place into the work (nnh).
575	R	That sounds very interesting. What might training, training the eye might be like for you?
576	P5	Ahh :: like I wish I could be more often colleagues saying :: you know, I had to make this culture
577		adaptation before ( ). I WISH (.2) you know I wasn't always the ambassador but other people may
578		bring cultures more often (nhh) into their explanation, into their formulation as well. Like for example,
579		I you know, I am supervisor for trainees, training student psychologist, but they still do some systemic
580		work such. We had, I have here about you know, culture informed formulations as such (nhh).
581		We should have a bit more cross fertilisation between profession, around culture.
582	R	But, what about for yourself? You know in terms of your, your professional journey. How might the
583		race, ethnicity and culture discourse you hold, and how it might have changed over time?
584	P5	(.2) Well, I think I always have high level of sensitivity about cultures (nhh). And thinking about Brexit
585		you know, start make me probably more aware of emm (nnh), how some people might see the
586		diversity we have in the NHS, and how people may see working with ( ) therapist or what is the
587		discourse around err visibility of some cultures (nnh). And even when I think about the notion of
588		BAME as such. European are never counted into the equation (nnh). As an European, at the moment,
589		you know we have something as Brexit that put between a very very uncertain position (nhh). What
590		this going to be like? How this going to pend out? BUT in some ways :: of course we are white, you
591		know, well educated, sometimes well off. And, and stuff that is, other that is not valid as other
592		type of feathers that is (nhh). I think probably Brexit has made me more vulnerable (nhh). It, so far
593		my understand of culture is been very intellectual, very few ethnical, very nnn.
594	R	.hhh. I am sensing that falling into the category of like all white are the same?
595	P5	Yes.

596	R	Err, which is not the case. I suppose.
597	P5	Ridiculous.
598	R	Yeah
599	P5	Because in terms of equal opportunities, you know. Err the few people, I don't know. White British
600		male who is my age, Oxford educated is going to be a or be, may be. But I won't (nhh). So I think, yeah
601		the Brexit has made me more vulnerable. I mean at the same time. More vulnerable as a human being,
602		part of this society. Probably more aware in the, in the clinical room (nhh). Because I am in this, able
603		to talk about this family completely being effected or families sometimes even been split apart.
604		Like for example, I can think about Spanish family I was working yes. Err mum and Dad, both from
605		Spain, children born bred here. Bilingual, children fluent in Spanish but err the mother want to go
606		back to Spain. Dad who had an affair who didn't want to go back to Spain. And the children were
607		spilt and anorexia become a way of keeping the family here (nhh). Because they couldn't have been,
608		were able to receive the same level of care in Spain, than here (nhh). Emm, and that was all because
609		of Brexit, you know because the student said this family is feeling and how do the future might be
610		like? So, I think to ↑me. The topic is still a bleeding wounds somehow (nhh). Brexit, and how people
611		be welcome or allow to stay, you are tolerated by the system with them all. So in some ways,
612		probably these events has made me more cynical (nhh). Not, not, feeling was strong, not delusion.
613	R	Delusion?
614	P5	Disillusion. On the one hand we do everything to think about culture and to make people feel, you know
615		accept it, ahh. We tried to train emm clinicians with a huge cultural awareness and then we have a
616		society really go against this (nhh, yeah). Put people in boxes (yeah). I have done all of these, I studied
617		for fifteen years of my life. Is this really relevant? What's the point? Sometimes, I feel what's the point.
618	R	Nnn, yes when you are facing with the
619	P5	The wider context.
620	R	The wider contexts, yeah, yeah. Does it show in your sort of your local context? Like your work place
621		and your families?
622	P5	In what way does it show?
623	R	Kind of like the discourse around how it shows, you know.
624	P5	Well I think I always been very vocal about Brexit (nhh). Like for example, on the 31st January. One of

625		my colleague said TODAY is Brexit day. I don't think she meant it in the wrong way, like you know.
626		Proud, oh yes, we are going to get out of the European Union. She didn't mean it that way, I remember
627		SNAP you know. Kind of sarcastically and I said not something to be proud of. And that is the type of
628		political comment I wouldn't make at work (nhh). At least not in England (nhh). May be in (country
629		of origin) people talk very informally about politics or they share their political views or who they
630		vote for and stuff. And not here.
631	R	Nnn, so it is very troubled
632	P5	Well, and I think you know again. When a family brings something like this to me in the session. I will
633		shy away about from talking about you know. There are some family even ask you know, are you
634		going to be affected? Are you going to be here? I <u>HAD huge</u> solidarity from British families,<u> huge</u> (nnh)
635		they think this would affect me. <u>Huge</u>.
636	R	Yeah, you well deserve and like you know.
637	P5	Again,
638	R	I said you err it is good that they look after you, you know.
639	P5	EER, yeah.
640	R	So can I ask, just ask, just kind of mindful of the time. Emm, NICE guideline. Tell me err, a situation
641		where NICE guideline been helpful or constraining in your practice?
642	P5	Emm, it is relate to culture or not?
643	R	Err, yes sorry. Let me get the question right you know. Tell me a situation where NICE guideline been
644		helpful or constraining in your race, ethnicity, cultural practice in your field.
645	P5	Hhh, what can I say? (.4) Well of course we practise you know according to NICE guideline, so I think.
646		No, repeat the question, I don't know if not clear.
647	R	Yeah, err err. Tell me a situation where NICE guideline been helpful or restraining in your race, ethnicity
648		, cultural practice in your field, the eating disorder field.
649	P5	Emm, (.4) Well, we need to talk about weight. I am thinking about families where there was lots of
650		emphasis on the weight. I mean they, they saw on anorexia is only, lost of weight, weight gain and lots
651		of gain. So :: we actually use the guideline in the session, talk about the value of, you know checking
652		the weight within the context of care. So we spoke about different treatment option as such. Oh, we
653		also spoke about you know, not making too much of a big deal of the weight and concentrating on

654		fact of life and regularity of engagement with social activities, and you know the young person having
655		a normal point of life. But that was helpful. Pushing a strong, very culturally determine discourse on
656		weight of lack of weight, or lack of appetite to a more wider contexts. I think urr one of the constraints
657		of NICE guidelines is the one about individual approaches in ehh, at least in young people. I don't
658		know much others were, haven't done much other work. BUT I suppose when we need to think about
659		identity again. The quest of an identity we were thinking about early on. Probably encapsulating
660		patients into very a define manualised approaches doesn't work very much (nnh). For example, I wish
661		there could be more space for psychodynamic work as well. For, for attachment work, or for you know
662		more :: or for schema ↓therapy for example. Like again, that’s an interest I have from, you know
663		my previous life. BUT I wish I could use more eclectic techniques (nnh), where wider range of
664		techniques even though they are not necessarily said where the NICE guideline wants (yeah). You
665		know when working with young people around sixteen, eighteen or they are reaching their adulthood
666		and probably going to find similar approaches into adult services, you know (nnh). I wish I could learn
667		more.
668	R	Yeah .hhh thinking about the multi family group you know. Do you think that a kind of offer a space
669		for race, ethnicity and cultural discussions?
670	P5	Nnn, well I am sure they do even if you don't do like a bespoke err you know, bespoke session on
671		this. I am sure culture can come in the way when you do emm experiential exercises. Or the family
672		meal session or the snack session. Emm.
673	R	I was just thinking does it emm, I was just thinking about when every thing ah like a sort of, like a box,
674		you have family therapy, you got all your phase treatment, different models. .hhh and I was thinking
675		about does it becoming that belongs to that, that belongs to that, and it doesn't happen here, or
676		happen there (nhh). I just wonder how it works actually.
677	P5	What do you mean?
678	R	In terms of race, ethnicity and culture. Does it happen here but not there? But happens everywhere?
679	P5	Well that becomes you know, that does becomes very much on the clinician (right). You may have
680		very culturally aware CBT therapist and the same might not happen for :: I don't know for a

681		psychotherapist. I don't know, again it very much depend on the level of cultural awareness at each
682		clinician has (nhh).
683	R	Okay, emm tell me about your experience of this interview err emm
684	P5	Well, it is a very reflective process. I think it help me point out, look backward and thinks emm. And
685		also , may be help me to consider things that I, I do probably I will do differently today. But I didn't
686		necessarily ( ) two years ago (nhh). Probably help me more thinking with my systemic head on (nhh).
687	R	So, just thinking about you talking to me, someone from a different race, ethncity, culture to you.
688		How does it feel? Does it make it easier to talk about the things we talk about or or does it make a
689		difference?
690	P5	Nnn, well that's probably a discourse I have that. When the having, having a huge interest for culture
691		are people from a diverse background (nnh). And we meet at the conference at the (name of the place)
692		How many people were there from a diverse background? How many people were, although I
693		appreciate background (nhh). That said much of the game, I don't know (nnh). So I think yes, it makes
694		it easier and I think it makes it easier for patients as well. When you are diverse or probably know
695		about diversity (Nnh).
696	R	So, do you have any advice for our white British emm family therapist? You know how might, help
697		them to develop their eye that you mention?
698	P5	Train the eye, I think the advice is very base on err base on life. It is not base on books, or ::
699		conferences you know. Go out, travel, read books, get into a state, emm embrace culture.
700		I remember when I came to London first, I thought that everybody was a phobic you know. I thought
701		you know what this probably two hundred cultural minorities. ( ) English know everything about the
702		kitchen or every restaurant. And what I found was, a very (.2) I mean a population pretty lacking of
703		curiosity (nnh). I would say, go out there, be curious. Because sometimes white British therapist are
704		from upper middle class background. So probably keeps some experience (R cough) of a meaningful
705		If you want to think as a therapist, like I said going to an estate, like a council estate. And you will find,
706		for me for example, it was very sobering when I went. I went there quite a few times. When I went
707		into the Grenfell Tower (nnh). Do a home visit, visiting emm ( ) family of a foster carers where they will

708		look after children that sort of thing. But I will love to say, how many other white British therapist
709		had the same experience (nnh).
710	R	So more experiential [and gather body experience kind of thing]
711	P5	[Go and learn from experience
712		Yes, yes, and be humble to us. You know when you find yourself not knowing what something might
713		mean or the meaning of us, ask questions and read about it (nnh).
714	R	Nnn, so I am going, I am mindful of the time you know. It is ten thirty. I said I will let you go. But I just
715		have one last question. Do you think that I can?
716	P5	Yes, yes.
717		Can you tell me how this interview make you feel about race, ethnicity and culture in your current
718		practice?
719	P5	Well, I feel positive because somebody starting the conversation and probably reminding the general
720		public that these, something we need to work on. Err, you know that I feel it is going to be probably
721		many more thesis like yours. Probably culture is going to be consider like any other tool really (nnh).
722		Like a tool should be in the tool box (nnh). Cultural awareness and culture
723	R	And then what do you think about the biggest challenge in thinking about the cross over between
724		eating disorder and race, ethnicity and culture?
725	P5	Nn, What is that?
726	R	The biggest challenge, you know like when err thinking about eating disorder, err race, ethnicity and
727		culture in eating disorder field. Get people to think about the cross over between this two areas.
728		What do you think might be the biggest challenge for people to begin to think about it, you know.
729	P5	(.4) Going out of their way, especially in eating disorders. Being in a difficult job you know, people
730		sometimes tend to get very attached to their ways of practising.(P5 Skype ring). Oh that's my.
731	R	That's Skype, is it?
732	P5	No, no, no, I am going to send her a text that I will be few minutes late.
733		(P4 writing a text) Okay, I think yes. Err changing the practice going to the biggest challenge because
734		people tend to forget, attach to the way they practise (nhh). I mean I have seen this when you know
735		when we ask clinician to take on new models of working or you know doing care coordination. So I
736		think people were to say, you know what, these the manual we need to read about cultural

737		awareness and you know we need to put into the work. Take some time.
738	R	So, open space in their practice.
739	P5	Yeah.
740	R	Articulate there is a space. Okay then, thank you very much err sorry about running over and you
741		already somebody chasing you. So I won't take too much of your time. So what's going to happen is
742		like I am going to do the transcribe, analysing and then I will send you some of my findings, ideas,
743		tentative draft and you can comment on it. And because I am mindful you know, not having one or
744		two or three more, sort of like keep follow up, sort of conversation. So if you, when you receive it.
745		You, it's a kind of like, basicly what stands out for you.
746	P5	Okay.
747	R	You can disagree and totally fine. And then that would be incorporate as the, in the final analysis
748		before the final thing come through you know. So I like to involve in dialogue, rather than I take
749		some of your idea and write, write it in my own way. Anyway, I let you go. I am mindful somebody
750		like. Do you want to say anything before we finish (name of P5)
751	P5	Emm, thank you for your time. Its been very nice look back on the way, the way I practice.
752		
753		Interview 2
754	R	Okay
755	P5	Do you mind me go and get some water before we start.
756	R	Please do, please do yeah. (Pause)
757		Okay let me turn on the machine, yeah make sure all the switch are buzzing, okay.
758		So emm, where am I, yeah. So err again this is ehh about your experience, about your view and
759		there is no right or wrong you know (nhh). Everything that we talk about will be confidential and
760		anonyms you know. Emm if you okay then we will start, kick start the process (nhh) yeah.
761		Err, do you have any question before I start or.
762	P5	No.
763	R	No, okay, okay. So as you are or were family therapist since we last spoke, err working with
764		children with eating disorders and I like to ask you about your own experience, with food,
765		eating and feeding. Emm so this is the main thing we are going to talk about today (nhh, yep).
766		So err tell me what is your experience with food, eating and feeding, you know.

767	P5	Do you mean my relationship with food or or, what will be helpful for me to think about?
768	R	Ehh :: whatever comes to your mind, you choose where to start yeah, whatever you feel, come
769		to your mind.
770	P5	My experience with food, with, you said feeding?
771	R	Food, eating, feeding yeah.
772	P5	Emm, (.2) well I am thinking you know, my general relationship with food (nhh) which is, we all
773		good, good relationship with food. I would say sometimes I find myself probably like certain food
774		more for what it evokes in it, rather than the taste or the food itself (nhh). And that's probably
775		very much tight up into my family history for sure. As well as my culture being (country of origin) and
776		again I don't want to be stereotypical here but it's true that probably coming from (country of origin)
777		makes you more (P5 hissed), I don't know attached to the affective vlaue of, of food. Yeah,
778		in terms of, may be what matters the most for me when it comes to the food is the variety and
779		the presentation, and that's something be hugely influential by working in eating disorders. Or
780		may be working in eating disorder makes me more conscious about variety. That for example there
781		wouldn't be, like I wouldn't eat the same thing two days in a row, or two meals in a row. Never,
782		might even if I got like forty (P5 laughs) like, I don't know high temper, I am in bed, not even that.
783		Emm
784	R	You mean that's the result of working with eating disorder?
785	P5	Sorry
786	R	You mean that's the result of working with eating disorder, you won't have two meals [the same
787	P5	[I think so
788		yeah, I was really struck by how some people can eat same things over and over again (ahh) and
789		thats probably I tend not to do myself obviously. Not even with my family, emm but, but then again
790		I don't know how much of this is actually influenced by working in eating disorders and again
791		family history, family culture and habits, cause again even back home or live with my partner you
792		know, he is (another european national) but we never tend to eat the same thing on a row again.
793		Emm, and in terms of I mean relationship to food makes me also think about relationship to cooking

794		, know, because I tend to probably cook most things from scratch actually (nnh). I don't like ready
795		meals or even during lockdown we haven't done much, many take aways really. Probably, not even
796		in the order of once a week. But then again, I think thats because we had more time to err be at
797		home and experiment things. We actually had more varieties so I a kind of learn to cook more things.
798		Or like for example, I don't know French things or Asian things, things are, we all like at home. Emm,
799		so yeah, and I think again the relationship with cooking specifically is very much a product of
800		family history, perhaps culture but not so much (nhh). Well, I also think about food and migration,
801		like you know adjusting to a different food when you move in another country and how this actually
802		plays out in the relationship with your clients. Because probably most of my client would be used
803		to English mainstream food which I grab I didn't use to know before I came here. But I was kind of
804		glad to experiment. Sometimes with pleasures and sometimes with disappointment. Emm, I think
805		I think I been very curious about this, like for example I remember one of my patient who, used to
806		binge on, binge on angel delight. I didn't know what it was, so what I did was to go to the
807		supermarket buy a bag and do it myself and try it. So at least I would have the experience of the
808		food in itself but also binge on that type of food, not I didn't binge myself but I think I went through
809		a whole small sachet of it (P5 laughs) and it was disgusting in the end. But at least you know I tried
810		you know (P5 laughs).
811	R	You have an embodied experience of what, what she experienced.
812	P5	Well, at least I knew what it felt. I don’t know, would i do it today probably not, probably not
813		because I am pregnant. But you know, would I do it today, may be. I probably tend to do it, and
814		I am more reluctant I would say. Maybe I was more young enthusiastic (P5 laughs) at that point (ahh)
815		yeah.
816	R	I, I, can I hear a bit when you say the food represent, have got the affective value you know? (YES)
817		can you say a bit more you know like the affective value, yeah what do you mean by that?
818	P5	I don't know if you know the book by Marcel Proust, no, the research of, the the, the search of
819		lost time I think. Its translated like this in English (nhh, nhh) when he is an adult and he is drinking

820		a tea, particularly tea that used to drink as a child and eat some madeleine. Do you know what madeleine
821		is, like a sort of almond favour small pastry that you, you have probably with tea or with breakfast.
822		And it is shape like arr, typical a shell, it's a French sort of pastry. And basically he says that you
823		know the taste of the almond bring, brings him back to his childhood, to his auntie, to the house,
824		that particular place. I am very much like that, again, like for example today I was having lunch with
825		my partner and I made something my grandma used to make, which is like a toast and bread salads.
826		Something so simple, very very poor dish, is nothing sophisticated but again the taste been the
827		same for, I don't know. I probably tasted it for forty years (P5 laughed) of my life, emm but every time I eat, I have
828		that. I can't stop thinking about : grandma or my dad you know. The memory will still bring me
829		there (nnh). Possibly even because I am feeling more homesick at the moment because I can't travel.
830		But you know its sort of automatic reaction you know in a sense, in a way (nhh, yes, yes).
831	R	The food has got a memory function, yeah, I can, [trigger a lot of yeah, yeah.
832	P5	[It is more of a memory than a taste (P5 laughed)
833	R	And you also, kind of mention about food and migration (yeah) I was just wondering what, what
834		is like to, for yourself eating in England you know?
835	P5	Nnn, that's a very good question. Well, I don't know because now my taste is so blended. Well,
836		first of all you know being somebody like cooking, moving to England has been a success because
837		again I got access to many different, I don't know traditions and shops and stuffs. So, see somebody
838		curious, I can experiment more. And I will do it very gladly, like for example nn, the other day we
839		mention ramen and I never cook ramen. So I thought let me go online and see how I can make a
840		ramen. And I made it and now I a kind of, make it almost regularly. So I think I am not particularly
841		fond of British food, maybe I, I like a few things. I know how to cook certain number of things but
842		I think I you know migrating, kind of widen that my horizon when it comes to cooking and eating.
843		Because I have to say I am very curious. So: you know its not uncommon that, I remember I used
844		to play volley ball, not now but I would say few years ago (nnh). After training session, we would

845		have gone with my team, out for a curry or .hhh any other restaurant really. And we kept like a
846		small tradition with two of them actually to go and try and, a new restaurant everytime we go out,
847		like for example last time we went to Iranian and we like it. Arr then of course was lockdown
848		(P5 laughs) so we planning to go again (P5 laughs) in May (nnh) possibly we were kind of thinking
849		okay, where should we go? And we were thinking may be Chillean or polish so again. When, being
850		in (city) is a luxury in a sense. There is a lot of learning that goes on even when you comes to eating.
851		If you are in the right frame of mind to actually you know open yourself to that variety diversity (nhh,
852		yeah).
853	R	I mean you also mention something about, kind of like link to your family, and your culture. Can you
854		say a bit more?
858	P5	Arr, I will say link to my, my family and my culture. But also, marrying into another culture because
856		again we have three cultures as home (country of origin, partner's country) and British. And again
857		how do I relate to my culture when it comes to eating. There is lot of, I mean when you grew up
858		(country of origin) is lot of conversations and sort of sharing of memories, traditions and values that
859		come through. You know it is mediated by food, like for example its not uncommon that. I don't
860		know when you are a child, you kind of look at your grandma, you watch your grandma cooking
861		or making all this, always the same things, more or less and you kind of learn almost instaneously.
862		And you know we have a nice (P5 laughs) <u>say</u> but it is also present in (language from P5's country of origin) that
863		your appetite actually comes and increases by eating, which not just, it doesn't mean only know,
864		just feeding yourself but also means you know being at the table, being a sort of, again these are
865		word that we had it in (own language and partner's language) but we don't have it in English. Err
866		( ) do we have it as a word? [In English? NO
867	R	[Err, I don't know the word but I might not know the word, but what
868		does that mean?
869	P5	.hhh It means that I mean, it's a latin word basically (ahh) con v lis was, the sharing of food being
870		sat at the table even for very long time. Lets say for an hour or two, not being there just there for

871		the food and for eating and feeding. But also for sharing, having a chat, having a nice time,
872		having lots of different experiences whereby probably the food is just a mean that brings you
873		there (nhh) and its not the end (yeh), does this make sense? So that's probably how I view my
874		relationship with food really and therefore brings back to my family is well, having probably good
875		and long family meals where again the food is not the main focus but lots of different messages
876		get mediated and translated into food (nhh). And its pretty much the same when I am in my
877		partner's family. Because again I don't see much distance, much difference between the two
878		cultures and again being with him actually gave me that, you know that strength, that curiosity of
879		learning how to make (country) food enough. I am pretty decent I would say, I mean he doesn't
880		complain so, and I am very happy to you know when I, when we go to his family. They seem to have
881		same tradition, again bringing and sharing, but you are not just sat at the table for eating. But it is
882		more for enjoy the atmosphere.
883	R	The company
884	P5	Yeah, but it is more than that yeah.
885	R	More than that, yeah.
886	P5	More than company yeah.
887	R	Nnn, yeah, I, yeah. So, I was just thinking about emm, how does this kind of, way of doing things
888		like have a meal together and using food as a medium and sit together, everything you just
889		described. How does that ritual, not ritual, that way of eating come about? Is that only unique
890		in your family or in your culture or your partner's culture?
891	P5	With friends as well. With friends yeah (nnh) do you mean how this play out now? What is the
892		question?
893	R	How does this come about? Sounds like you grow up in that sort of way of eating and
894	P5	Well, that's probably a mainstream way of doing things, may be things are changing now, with a
895		more sort of hectic life, nuclear families, people have meals on the go and stuff. But I have to say
896		that being in lockdown is been quite enjoyable because we were able to actually share more time
897		around the table (nhh, nhh). Probably being in lockdown has actually emphasis what it was already
898		a habit or something that I treasure, my partner treasures as well. It certainly is something we

899		want to pass down to our child as well. Because I am sure she is going to be exposed to a different
900		culture, eating culture and all when she goes to school.
901	R	Before she goes to school, its parent shape children's ehh experience. I was thinking about how
902		your parent shape your experience like the day to day, everyday experience you know. How does
903		it works in your own family origin?
904	P5	Nnn, well I think probably my dad, my dad's family shape more, shape my approach to food and
905		cooking more than my mum. Because again my mum would be relax person more or less. Well, my
906		dad likes to have a structure, probably by the time he gets, you know he finishes breakfast, he will
907		say okay, what are we making for lunch and dinner. At least he got, he has got a plan in mind.
908		And my partner is actually the same, I don't know how I pick him but you know. I don't know if he, is
909		oedipal complex or something (P6 laughs) or something that is unconscious, but is worse than me.
910		Because I am pretty organise when it comes to cooking but not as much as him. So yeah, I like that
911		structure. I mean I wouldn't like, especially with kids I wouldn't like you know, to get there, i
912		don't know, to their in front of feed one o'clock and not knowing what to make. Arr, I like having
913		an idea and possibly even changing the statue, for example if the last meal I want to make something
914		else or I fancy something else. I won't have the fix view of changing, but at least I have got something
915		in mind (nnh) and I have to say probably comes to eating and cooking. My dad's family is much
916		more affection and generous in terms of sharing recipes or sharing memory attached to somebody
917		who was cooking, probably was the best, best cook of the family. But for example, if somebody dies
918		in the family. Emm, on that side, on my paternal side they will be remember for the stuff they used
919		to cook or the stuff they used to say when they were cooking and all that. And that sort of knowledge
920		gets pass over and over again. While from my mum side is a bit more sort of mechanical they just
921		eat because they want to feed themself full stop (nnh). So I don't find necessary an affinity with
922		that sort of eating culture if you see what I mean.
923	R	So your mother side eat to, you say mechanical you mean, eat because you are hungry, kind of.
18.3	P5	Yeah, pretty much, just that, because something have to do to survive more of less (okay) but

925		its not, there is no real enthusiasm about it.
926	R	How do you understand the difference then?
927	P5	How do I understand the difference (yeah) nnh (.2) well, I have been felt, straight away, like since
928		the young age when I was most connected you know. So I felt that probably I wanted to be like
929		more, like my grandma was, like my dad is and all that. In that sense may be the difference
930		almost strikes me because I don't find it very nourishing the way they do things, know. The
931		way they relate to food and cooking in that. I don't find it very warm nourishing, willing of
932		sharing, willing to share in a way.
933	R	That's your mum side, is it.
934	P5	It is my mum side, yeah.
935	R	Whereas your dad side is very different, but on a day to day who is doing your, feeding you then?
936	P5	Who was doing my feeding? Well (P5 laughs) when your grow in (country of origin) you got the
937		benefit of having an extended family taking all, taking care of kids (ahh). So I was mainly with
938		my grandma, no actually so when we were living in (city), which was close to my mum's side.
939		There were more, mainly my aunties (ahh) and then, and I probably my mum, but it wasn't
940		something outstanding. Again, something very mechanical say. Emm, yeah. Possibly my dad
941		would have taken over at weekends. So probably doing a bit more sophisticated or or. Lets say
942		apple lay, appetitising stuff.
943	R	So weekend is, when, when your dad is cooking. Is it something you looking forward to or or,
944		on a day to day is more mechanical like you say, weekend is something special.
945	P5	Well, our weekend are tend to be more yeah, spend more time cooking. So I would have like
946		probably couple of things that I want to try if I am making something new or may be something
947		that my husband wants, my partner wants me to do. Like for example, last, last Sunday was my
948		birthday and he made a surprise party for me. And I didn't know anything about it. And he said err
949		yeah make sure you cook a bit more, so at least we got the lunch ready during the week. Something
950		like that and I completely bought into it. I didn't even question why I was cooking for four probably
951		rather than two, and he asked me something he likes (P5 laughs) and I like as well. But you know, err

952	21. 3	and I didn't mind doing it. Actually I was very, very happy about it.
953	R	So you are the cook in your house is that right?
954	P5	Mostly, yeah, yeah. Unless I am tired unless I am tired
955	R	Ahh, so you are responding Yeah, and you are responsible for
956		sorry. You are tired?
957	P5	Unless I am tired.
958	R	All right, okay, so you are the chief.
959	P5	Yeah.
960	R	So what sort of relationship of feeding, you know like you are the chief and, feeding, cooking and
961		feeding the family. Emm, what sort of, what do you they will describe you know this relationship of
962		you cook and they eat or enjoy it, you know, how would you describe that relationship.
963	P5	Ahh (P5 laughs) my (P5 laughs) calls me, it’s a joke actually. So he calls me with an (country) word
964		that I used to describe him, which is ( ) like head chef or chef in charge, something like that. So, emm
965		I am very happy if my partner comes up with something he wants and then I will say okay let me see
966		how is made and you know I can try it. Its like for example, first time I made err beef bourguignon
967		which is quite lengthy, you have to work in certain stages and stuff. So he came up with this and
968		I say okay let me see, you know let me go on the website and see how they make it and possibly
969		I will, I will make it. Problem is that I never stick to the recipe. I like things, I like doing things my
970		way because I got very good cooking skills. Arr, how would I describe it, yeah they will describe me as
971		somebody extremely attached to the variety, willing to try and again. Never having the same meals
972		for too many times in a row. Yeah, maybe they will describe me even as very picky, like I am very
973		picky with ingredients or : like for example, I wouldn't put sauces on top of things that British tend
974		to do. Thats something I kind of stay away for, from, cause it feels that it spoils the taste. So probably
975		they will describe me as either a pain in the neck really sometimes. I have got strong ideas of
976		You are quite precise.
977	P5	what, ehh?
978	R	Precise
979	P5	Precise, yeah.

980	R	So, I was thinking about what is the significance of food, feeding for you then as a person?
981	24.2	Well, nourishment, love, affection, care, celebration as well (nhh) like. I don't call myself relig,
982		very religious person but I know I like for example, on Christmas eve, I will only have (food) and I stick
983		this tradition. Because it was my family tradition as well. If I go to Italy that's what I do. And (nhh) So
984		its mainly love, care, affection, attention, tradition and sharing you know, having a good time.
985	R	So what do think about as a profession working in eating disorders, how do you think about it then?
986	P5	About, about food?
987	R	Yeah, you are talking about the significance of food for you as a person (nhh) and then when you
988		working in eating disorder, and that food, the significance of food and feeding belongs to you as a person.
989		And when you work with that field, how do think about it you know?
990	P5	(.2) well I know I have to be careful because probably the discourse I have around food may
991		come across quite (.), lets say I may give it away. You know in a way, like for example when I do FBT
992		and we know how much FBT and task and treatment on parents. Because they have to take control
993		and do all the feeding and stuff. So when I hear, and I heard it quite a few times actually. When I
994		hear mainly mothers say ↑OH I am so sick of cooking .hhh, my heart sinks more or less and I have to
995		really be careful not to give it away (nhh) Ehh yes, I think I feel quite sad about those families where
996		the meaning of food is been so deprives, so impoverish that again feed feels like, feeding almost
997		feel like a chore. In ( ) , there is no enjoyment, no pleasure nothing.
998	R	So how do you feel and, you know I was just thinking about your thoughts and feelings when
999		family say this to you?
1000	P5	Sorry, how do I feel? (yeah) can you repeat the question Charlotte?
1001	R	How do you feel when you hear they say oh I don't want to, I am tired of cooking?
1002	P5	Nnn (P5 clear her throat), I don't know probably I tend to sympathise and empathise with the child.
1003		Because I guess that may come across as you know I am a burden to my mum (nnh) because in
1004		the end you know if we go with the principle that food is medicine, the parent is actually saying
1005		I am so sick of giving my child the medicine (nn) which you wouldn't hear, I don't know if the child

1006		need an antibiotic treatment. The parent will give them five days of treatment and that's it (nnh).
1007		So I feel very sad, extremely sad and sometimes I don't know how to (P5 hissed) make this
1008		sadness that are therapeutic in a way. Because otherwise perhaps the parent may feel criticise,
1009		or am probably worried that I am projecting my own feelings on the child as well. So I kind of tend
1010		to be very careful. Before I use it, you know before I use my own self-reflexivity, lets say (nnh).
1011	R	And I mean, have you ever been able to put it back, kind of use it, like you say when you
1012		kind of use of very carefully, and have you ever been able to use it with the family to talk about it.
1013	P5	Yeah, perhaps I would be asking what are the alternatives do you see, what else could you do as
1014		parent if you feel so sick of cooking you know. How do you task share your, with the other parent
1015		(yeah) and possibly I will bring the conversation onto the roles and the tasks in the parental
1016		couple, may be I would say yeah, what else can you do, I mean if you feel very tired about doing
1017		something, how can you practise some selfcare and perhaps how can you prioritise other areas
1018		of child if you feel that, cooking is very taxing for you.
1019	R	I just wonder this experience of like, emm sort of like when something bring something that is
1020		quite different to your own experience (nhh) how does that affect you? (.2) I mean impact on you,
1021		may not affect you.
1022	P5	Well, I have to say in pregnancy much more. So may be you catch me in a time, very sensitive time
1023		of my life Charlotte. Because may be when I wasn't pregnant I was much more, I don't want to say
1024		resilience because its not. But, maybe I used to shake it off more easily. Now, I feel you know, I do
1025		feel quite deeply as parent, and you know as future parent as well (nnh). Because I would never have
1026		say to my daughter, oh my God, she is a burden because she has got, have to cook for her, Oh
1027		(P5 laughs) Because there is a lot of parent you see, I mean or maybe I view a lot of parent that,
1028		between a recovery from anorexia and, wean your child as well you know. Helping your child
1029		condition from milk to solid food in a way. But you know you may have to try, you may have to work
1030		for trial and errors in a sense (nhh). You need to help them to regaining some skills I mean.

1031		With weaning of course is a skill they gain from the first time, with anorexia they gain it for a
1032		second time and it may take time. It might have been dishearten for parents (nhh) sometimes
1033		and not all the time hopefully. So yeah, now I feel very sad, probably more than before (nnh).
1034	R	So I am beginning to think that you know like, did the thoughts and feelings ehh when you talking
1035		with the family about food and feeding, you beginning to talk about an example of this family when
1036		they say it is a, its tiring you know.
1037	P5	Did you say tiring?
1038	R	yeah,
1039	P5	Sometimes.
1040	R	And and, I was just thinking about when this go through your mind, how does it, how to you manage
1041		it?
1042	P5	Nnn (.2)
1043	R	Like you say at the moment you are more sensitive than usual.
1044	P5	I will probably (.2) what I tend to do, not sure is the right thing to do is to try and step away from
1045		firefighting mentality, crisis management mentality. Because, of course depend who bring you
1046	32.2	the problem with food. You will have a solution or may be you would be willing to give them a
1047		solution but probably as you say the tiredness and the feelings will come in the way. So what I tend
1048		to do is to actually go on another level and think about relationship between them. How the
1049		relationship between child and parents may affect the feeding process. As well as, you know where,
1050		where is anorexic know this, you know (nn). How was anorexia actually shifting the relationship or
1051		freezing the relationship or perhaps you know affect the relationship itself. I tend to move away
1052		sort of, from the point where I feel that I am getting stuck with. Because potentially if I feel tired,
1053		I feel stuck, I lost my elasticity in way, I lost my plasticity as a therapist.
1054	R	Yes, yes I was just thinking about you know like, just change the context a little bit you know. Its like,
1055		lets say you got you know in the initial stage when family comes in and obviously they are low
1056		weight, what might be the sort of conversation will look like with them?
1057	P5	When the family is low weight?
1058	R	Yes, when they came in, usually low weight. What sort of conversation you might have with them?
1059	P5	About?

1060	R	Food and feeding
1061	P5	Food and feeding. Well, I will find myself giving the standard advice that, you know according to the
1062		FBT model again try to go back into err, err normal eating routine, three meals a day, snacks, make
1063		sure that the food intake is good enough dadadadada. Err, personally I want to give them hope,
1064		of course I don't want the task of feeling to come across as drama, dramatic or taxing or
1065		impossible to achieve. Probably I will be thinking about successful stories as well. Rather than,
1066		the doom and gloom of you got to do this. You got to do this on your own. Because may be that’s
1067		sometimes, these sometimes what families hear, that we are here as therapist but they only see
1068		us once a week. And then .hhh they are left with their mess at home. Emm, I think I am very, I don't
1069		know , possibly I try to convey some enthusiasm, some optimism when comes to doing the
1070		meal session as well. Because that's quite informative for them, the sooner you do it even if they are,
1071		even if the child is low weight, sometimes is better. Emm, yeah.
1072	R	Emm, do you think about your own eating or your, your you know like what goes through your
1073		mind, like, like what they present and you like to give them hope. And do you have, do you think
1074		about your own eating or how you feed your family or your own experience?
1075	P5	May be, but I have to say that. Although it strikes me to realise how much feeding and eating has
1076		become a stranger thing to do for lots of families. All get to the point, like for example emm I don't
1077		know, when I hear that the child been having the meal in their room, ehh for the last six months.
1078		I will be thinking oh my god wow. You know my parent would never let me (P5 laughs) so may be yes
1079		my, my inner discourse come in the scene very much. It maybe I wouldn't let my child to do it, as
1080		a parent. Emm yeah.
1081	R	So what thoughts and feelings when you hear that, that was happening? I mean you won't let that
1082		but if that's happening to them you know. So
1083	P5	Well, there is definitely a sense of stuckness and defeat. Because of course the eating, I mean I am
1084		not just hearing that, I don't know, the child is not having dinner with them anymore but I am hearing
1085		that, there is a sense of loneliness attached to the, to the meal the child is having in their own room.

1086		Its not just you know, not being with your parents but it also being isolated, being lonely and feeling
1087		disconnected (nhh) and perhaps a much more curious about those emotions rather than food intake
1088		yeah (nhh).
1089	R	So, as you are talking about the sort of like when you met them you talk about the meal etc. And then
1090		your mind is also getting in touch of the sadness of this child (nhh) and your, that comes from your
1091		own experience (nhh) and I was just thinking how do you go on from there you know.
1092	P5	Nn, may be at that point I go exploration just to understand whats been lost. And what can be
1093		regain in terms of you know affection, closeness, sense of family, that is related to the meal and to
1094		eating. Because again if you tell them to eat, only just a task. It's a task, the intervention is not going
1095		to be a success, successful (nhh). May be at that point, you need to very much instill the idea of
1096		making meaning around eating or stopping eating, what it is to stop eating, and whats the sense of
1097		purpose this may give to, to the young person (nhh). Emm, may be also I mean, I find myself doing
1098		a lot of err, how example, using a lot of circular question, questions and you know asking the parents
1099		what they think is going on when the child is isolating in the room having the meals. And why did
1100		they let it that way or I try to ask the child what did parents might be thinking when you know
1101		there is an empty chair at the, at the dinner table and all that. And that takes on another level
1102		hopefully.
1103	R	I am hearing, you call it these are a kind of the initial stage FBT (nhh) and its not just refeeding, actually
1104		a lot of interventions happening in all, am I hearing that?
1105	P5	Yeah, yeah, may be again, may be its because I am, you know being a family therapist, may be takes
1106		me to another level when I do FBT, its not just again I give a meal plan you follow that. I give you
1107		the meal increase and see you next week but. Its probably more exploration than, than it is really.
1108	R	Nnn, so i am thinking about sometimes people mention that, about stage one because they are low
1109		weight , parents are anxious and ehh family therapist get anxious as well. Does that happen to
1110		you or not?
1111	P5	Yes, it does, it does. Especially when the monitoring is so sparse and unreliable. Because I been in

1112		teams where there wasn't a great medical coverage. And paediatric team input almost close to
1113		zero. So I felt very much the anxiety of the process in itself. And also because in that method, in
1114		that approach, not as a therapist. If you are the leading therapist, you are task with a lot of other
1115		interventions that are not necessarily psychotherapeutic interventions, like for example, and you
1116		have to do that dietetic psychoeducation or when you have to talk about bone density, menstrual
1117		periods and that, you know. Our will be probably if that was hold by the paediatrician or :: dietitians
1118		as such.
1119	R	Nnn, the reality is like as clinician you have to do all these things isn't it?
1120	P5	Yes, I will do it.
1121	R	How do you juggle (R laughs) all the balls, when you have to do food, feeding, being there at the
1122		beginning as well as all these other things.
1123	P5	Possibly, I say to parents don't panic cause you know I am a psychologist and family therapist, may
1124		be first stage you are going to hear me talk about loads of other stuff. But don't necessarily come
1125		across as therapeutic or psychotherapeutic interventions. But you probably notice when the
1126		intervention changes stage because when we go to stage two, stage three, you will almost notice
1127		spontaneously that the content of the session is changing, it is no longer food, food, food, eat, eat,
1128		eat but it also I don't know. Problems with peers or family problems or social, social media, lots of
1129		other stuff that may come into play. And might be you know that the, the growing ground for
1130		anorexia you see what I mean.
1131	R	Nn, I mean
1132	P5	I have to say I enjoy much more when I get to that stage
1133	R	Enjoy much more when you get to that stage
1134	P5	Definitely, definitely.
1135	R	when you have to less worry about the, the weight.
1136	P5	In the weight and the medical stuff.
1137	R	So yeah at the beginning has got a lot of things to juggle.
1138	P5	Too many may be.
1139	R	Too many.
1140	P5	Too many, that is probably one of the short comings of FBT and I wish may be (.1) as you know
1141		eating disorders professionals, I wish we had the luxury to actually say it more openly. Because

1142		the thing we were very much into fire fighting modes sometimes, we start to go with knowing
1143		what we have to do, sticking to the schedule and we lost the therapeutic strength. Because it gets
1141		lost, it get side line a bit.
1145	R	Nnn, when you have a lot (at stage one) of things to juggle.
1146	P5	Yeah.
1147	R	Because early on when you converse about just do that and that, is not enough to get them to do
1148		it.
1149	P5	Exactly, I guess some parents also may use this, as an excuse not to go into more therapeutic talk.
1150		That for example, for a family where there is a huge conflict avoidance between parents and
1151		possibly marital problems. Its much more comfortable to go and talk about bone density rather
1152		than thinking about communication style in the family (nn). So may be with thats being one of the,
1153		has to be intervention, you know, with this patient the lies and structurally being more avoidant.
1154	R	Nnn, yeah. Early on you say induce hope you know like, one of the thing. I was just thinking about
1155		can you say a bit more you know like hope for you, or for them, or you know.
1156	P5	May be both? (P5 laughs) may be both. Emm, well I like to talk about success stories as well, like
1157		for example patients are treated previously of course. I don't go into sensitive detail but you know
1158		I like to say to them that people do recover, as long as everybody does their job, as long as this is
1159		taken seriously and you know everybody work as a team (nn), in a way not one against the other (nnh)
1160		So yeah, I a kind of bring almost instantaneously this type of topics in the sessions yeah.
1161	R	So you bring your own clinical
1162	P5	and I tend to, yeah both I tend to do psychoeducation but may be I get like, the odd piece of story
1163		of somebody else in here and there. Like when I need to talk about exercise or anything, at least
1164		they know this problem is real. They are not the only one with this. They know that you know they
1165		are in safe hands really (nhh). Because probably what they are bringing, is something that I have seen
1166		before.
1167	R	Yeah, right. I think for family from a slightly visible, visible difference of race, ethnicity and culture.
1168		Would you do anything, kind of different in your interventions or
1169	P5	Sorry, what is the question? For a family where there is a visible difference

1170	R	Yeah, where visible difference like race, ethnicity and culture, or other things. Would your, would
1171		you have more things come to your mind, in terms of how you will work with the family?
1172	P5	Oh definitely, I probably do more research and reading about their eating habits. Like for example
1173		when I was working with in (area) where there is a huge Indian community. Well, I got to the point
1174		where I was able to work a meal plan like base on Indian foods. Like this easily. I mean if you asked
1175		me the names and the recipes and all the homemade. I am a open, I am a text book (P6 laughs) so
1176		yes.
1177	R	You gain a lot of knowledge for that ethnicity, of that group of family.
1178	P5	Yeah, and I think parents like it because I think one of the main criticism to inpatient actually
1179		that. They give mainstream British food, even though it is not what they found at home. Well that's
1180		very much of a cultural sensitivity when it comes to eating habits. But I am sure I would experience
1181		the same if I don't know, tomorrow I get an eating disorder, I get admitted. And I am sure I will have
1182		I don't know jelly and I don't know beans on toast which is something I will never have for
1183		breakfast.
1184	R	Nn, yes its very different situation you know.
1185	P5	Nnn
1186	R	So I think that’s more or less what I would like to ask, you been very generous in share about your
1187		relationship with food, how it show in your work and how the work affect you, and how the sort of
1188		like the moment with the family. Do you have anything to add to, anything you like to add, come to
1189		your mind.
1190	P5	I don't think so, not for the moment.
1191	R	And any thoughts about this conversation?
1192	P5	At some point, it almost felt as supervision (P6 laughs) so I really like it. Thank you. I think you did
1193		more for me than I did for you.
1194	R	(R laughs with P6) so I think this is more or less I like to cover today. Emm yeah, on that note, than
1195		I will stop the recording.
1196	P5	Okay.

Appendix 1f: Transcript for participant 6- Fiona

1		Transcript 6
2		R : Researcher P6: Participant six- Fiona
3		
4		
5	R	All the switches are going, bear with me. (.8)
6	P 6	Yeah, I can see it showing as recording at this end.
7	R	Yeah, good. So the light is glowing, its ur. Ah, so (yeah) it's a sort of like researcher disaster. You
8		know you think you recorded it and then it didn't (R laugh)
9	P 6	Exactly, that will be researcher's nightmare, isn't it?
10	R	Yep. So, okay, its all ready. Emm, so emm yeah. Before we start perhaps I just go through few things.
11	P 6	Sure
12	R	First of all, thank you and then, and just to, important to say this research is about your view, it is
13		about your experience, and your stories. So there is no right and wrong. So it is completely
14		confidential. Everything will be anonymised you know. Emm (nnh) so that, you know where you
15		stand. So don't feel that because I asked question, then it feels like an interview. So it is not like
16		that, it is completely you are the expert here. Yeah.
17	P 6	Sure.
18	R	And urr, also the second thing. I am aware of my background in working in eating disorder. So I am
19		a sort of insider, so but (nhh) for the sake of this research perhaps you can treat me as at, just
20		intelligent laymen, explain and describe for you want to say it, if it is okay (okay).
21		And so the interview will last about an hour and a hour, so hopefully will, will be within the
22		boundary. But if for whatever reason then we may have to negotiate what happen, at the end
23		(R laugh). And you know, so I have about eight questions. So it is quite a lot of things to go through,
24		to just explore what your views about it, you know (nnh). And err so, in the process I might be
25		rambling on you know. I am just as nervous, I am not saying you are nervous. I am saying I am
26		nervous (R laugh). Just to try to get the information I am looking for (nnh). So err if I am rambling,

27		it is not because of you. Emm more from my contexts you know.
28	P 6	Yeah, no problem
29	R	Okay, so that's more of less I like to explain and set the context. And at any stage you want to ask
30		why and you know all that sort of thing, you can pause anything, anytime.
31	P 6	Yeah, it will do.
32	R	Okay, I have about eight questions. So it is not like set in stone, its more like explorative it can go
33		round a little bit, and semi structure , etc you know (okay) And so the first question I like to ask is
34		that.↑Can you talk about how you feel about this research title? And the research title is err race,
35		ethnicity and culture (nhh) in family therapy with children with eating disorders.
36	P 6	Emm, intrigue and interested is probably my first response (nnh). Ye:ss, so :: I am sure that the
37		question that we go into will unpick this in more detail but when I:: you know obviously you gave a
38		bit of explanation at our AFT ED meeting last year. So, we had that focus emm on culture. And that
39		, on that day and I think emm :: for ME you know if I am thinking about culture, then may be some
40		overlaps with race and ethnicity as well. So I was emm, ↑yes, I just saw it as an opportunity to, err
41		think about it and make connections really. So yeah definitely interested. And interested to see err
42		emm what other peoples, when you actually complete your research which can be some time off
43		(P6 laugh) being realistic, not to be negative (P6 laugh again). Emm, I am interested to see what,
44		what emerges as well. I think that emm for me when we did the day :: last year. It is ashamed that
45		you couldn't be there for the emm (P6 tutted) err the slot that I did I found it re::ally interesting and ↑quite
46		emm :: I felt that quite quickly it - obviously we were talking about our own social graces as well as
47		families, and felt a bit, people, it felt quite personal very quickly. And that there were some defensiveness
48		and all sorts went on which was really, really interesting. So I think that's emm :: I :: guess that the
49		connection. Emm if I can be more clear about it. For me, I am interested in talking about things that
50		people find, seem to find difficult to talk about (P6 laugh) (nnh) and I am interested in making the
51		implicit explicit, which is, can be very, really really challenging of course. Because I think that’s emm,

52		(P6 tutted). Err a connection when we talk about culture particularly when we think about race.
53		I think people .hhh that's quite a lot of emm ::: ↑well I will say it :: my experience quite a lot of
54		avoidance from people talking about it. Emm in a clinical sense, so yeah. I think those are some of my
55		connections and what came to mind in thinking about, emm you know the research questions and the, and the topic.
56	R	Nnh, I, I apologise I didn't make the afternoon. You, I understand you were presenting a piece of work
57		that you did, weren't you? It would be really interested to hear but you mention about once you
58		presented. You:: you you get a sense of defensive, the word that I heard.
59	P 6	Yeah, yeah because it was about a white British family. Emm a kind of did a bit of a emm ::: what I was
60		highlighting in my emm piece was that emm :: I use two families. And one was a Muslim Pakistani family emm
61		British Asian and err my team err, ↑not always but yeah reasonably often, I find it happens a lot and
62		this is what I highlighted in the presentation, which they say what about, are there any cultural issues?
63		And err this happen so often when there is visible difference that people say. ↑Are there cultural issues?
64		and they don't ask them that about, that about, a white British families (nhh). And what I was highlighting
65		in this work that I was presented, the real challenge I had emm working with the family and there
66		emm some of what I saw that were cultural issues. Emm around their beliefs, of course and, and
67		some of the, what made it err the work quite, emm difficult and you know ↑we make in progress
68		and it was okay and we got to a good place. But suddenly, for me it felt like, like a a real .hhh emm ::
69		yeah was a challenging piece of work. And when I TA::LK about some of this and talk about you know
70		my own graces and some of the interactions. And of course put myself there as well. Emm, the
71		defensiveness was about people thinking that I had, was a kind of othering the family. Emm which I
72		thought was really interesting (P6 laugh) not everyone. Emm but there was some of that. And yeah.
73	R	And when you say other people think you are othering. You mean the audience that listening to your ..
74	P 6	Yeah, some of them. Some of them, yeah. Yeah.
75	R	And they say othering, what do they mean?
76	P 6	They mean that I was :: emm what I took it to mean was that I was emm criticising the family, really

77		in a way (hhn). Yeah, yeah. And :: that was really interesting because (.2) you ↑know what it is like
78		with those presentations, with the time is short, you want to be succinct. You are not going to every
79		detail but where there is a particular focus you want to home into those bits. So, I talk about my own
80		You know, social graces. And I think in a way, I felt like somebody interpreted that as. Yeah, therefore
81		I :: talk about the family being upper middle class and it was like, they thought I couldn't connect with
82		the family. Emm, and that I was focusing on the difference between ourselves. And I thought that's
83		interesting because I:: actually did emm form a good working relationship with the family.
84		Some of the thing I didn't explain were that we had err, we did connect even though I think some
85		people interpreted my comments as oh, class wise we were on a very different scale but (.2) I didn't.
86		I couldn't be bother explaining that. That were things like talking about ruby and cricket, and (P6 laughed)
87		things like that, that very, were culturally for me very, kind of part of what I grown up with and I am
88		very comfortable with emm, whereas in this, in the UK context that would often be a very middle class
89		thing, and IT IS. Emm that, therefore it was almost like, they were assuming that I wouldn't be
90		comfortable with some of thing, aspects of the family I was emm, their identity that I was, was
91		talking about. And yeah that I was the othering was, was really like <u>contrasting</u> them with myself, and
92		therefore it was like, kind of lack of connection, or lack of emm (P6 tutted) kind of a, I guess sounds
93		a bit extreme but it was yeah the othering yeah, alienating in a way because we are not looking into
94		detail so much, where er othering were thinking about difference emm, and noting difference without
95		being able to use it effectively if that make sense. Or somehow make sense of that. So. I wasn't saying
96		you know, I wasn't able to work with the family or, so it was really, yeah was really interesting. Emm,
97		I thought GOSH, it really, once you start talking about clinical stuff (P6 laugh) because I have done it.
98		Perhaps not in that forum, I done it in another forum but perhaps not in that forum, was very specific
99		you know. Eating Disorders and that was the the emm, the emphasis on culture and eveyone there
100		was emm you know had gone for that reason. Gone, you know attended the day for that reason. Yeah,

101		it was an interesting experience. Emm, so yeah I think emm err :: I would like to er er I
102		think it would be interested today about the breath of you know, ethnicity, race, culture
103		because that's what I am interested in. Not just, not just visible difference (yeah). How do we think about
104		race, ethnicity, culture (yeah) in, in the work, because often what people. I think, would tend to think
105		about, and talk about which is important as well. But not only is you know, what about Black, Asian,
106		Minority, Ethnic people when they are starting to talk about a kind of culture and race that often
107		what's talk about, talking about dominant emm (P6 tutted) you know err white dominants. Emm, and
108		therefore minorities, which is important. And that it is important to think about the models that we use
109		being ethnocentric. And you know things like that, and there is also its, I think many more layers
110		than that we need to, we need to think about.
111	R	Am I hearing something when, when talking about emm (R tutted) whiteness, you know white, white
112		culture there is air of defensiveness, even in a professional group discussion?
113	P6	Yeah, yeah. [I really felt it
114	R	[Do you have any hypothesis, sorry
115	P6	I really felt it, and and it was interesting because and I don't know for sure what everyone's ethnicities
116		are (yeah) but I know that (P6 laugh) two
117	R	What do you describe yourself to the group then?
118	P6	I described myself as mix race,(ethnicity), European, you know my (ethnicity) upbringing etc (yeah). Emm, so yeah
119		and then there are couple of people in the group rr someone was Irish, someone was Scottish, you
120		know. Two people I know. And they won't, that's where I notice, I don't think they weren't, they, I felt
121		like they almost. I didn't talk to them afterwards about it. But, emm I thought, I felt they were almost
122		a bit defensive of me because they could see this thing was going on as well. It was really fascinating
123		because I think the people who emm, who were err, yeah who I felt was defensive were the people
124		who I THINK are white British, I could be wrong about that you see. That's the other thing, you
125		never know for sure. But, that's what, that's what seem to be going on. It was like, by questioning

126		some of this, I was like criticising their culture or :: yeah↑.
127	R	So the conversation is it creating something about them and us. You are talking about them?
128	P 6	Yeah, yeah.
129	R	And it creates this? Sense of defensive
130	P 6	And that was they was almost what I was doing was creating, they were saying I was
131		creating a them and us. What I thought that I was, my intent was to really to talk in detail about this
132		piece of work which had been challenging where there had been a lot of unspoken and I was really
133		trying to, with the family draw out, you know, make explicit some of their values, and beliefs↑ not to criticise them.
134	R	I am hearing your hope to create a with them, together (nnh) but somehow it become a defensive atmosphere.
135	P 6	And I work, I don't think the family would think and talk about it like that. In terms of being, I know
136		that when I finish the piece of work with them, and .hhh they, they you know gave the feedback about
137		how non judgemental, I was and that was really important to them. Because ^you know I could see
138		this, this sensitivities (nnh) yeah concern :: about being criticised to all. Because the mum was say emm
139		er (P6 tutted) health professional, quite emm a professor, you know quite, em quite a position of power
140		and. Emm yeah↑. But also I could see, felt very and err, I try to talk about that but she didn't really want
141		to talk about that, in er, in the sessions. You know, acknowledging (P6 smiled) what it might be like for
142		her to come. And she said oh :: no:: it is fine, its fine. But I could see that it wasn't so this was
143	R	So you are referring to the white upper class family?
144	P 6	Nn, yeah, yep, yep. Emm, so yeah very interesting.
145	R	What hypothesis you made about they don't want to talk about it then?
146	P 6	I ::
147	R	If any, if any thing
148	P 6	.hhh Yeah, I mean my hypothesis was that so, so the mother's family of origin. She said we, we never,
149		we never argue. We never had an argument in my family (nnh). So my hypothesis was that they don't
150		talk (P6 laughed, R join the laugh). Yeah, talk about emotions at all. Just (yeah) probably simmering

151		under the surface. They said its not but I could feel it in the room. I mean that was, that would be what
152		would be happened at times (nnh). I could see people faces go red you know, and I would asked some
153		of this stuff about, you know. How it is for you > and ^you know obviously relational. ↑Being
154		relationally, using relational reflexivity that kind of thing. They would be like err >, no, no, so they really
155		struggle to unpick and it felt I was interrogating them. So I had to be really careful about, not asking too
156		many question at once (P6 laughed) because er er, them, they felt like. I :: could see they felt like, you
157		know they are not giving the right answers or they are not able to answers. So, it made them you know,
158		made them uncomfortable (nnh) which of course, not what I was trying to do.
159	R	No, not at all, yeah. I am beginning, hearing something about how can one talk about race, ethnicity
160		and culture without getting defensive you know. In the setting you were talking about, and in err
161		workshop (nhh). Emm, yeah or people don't want to talk about it, but its there.
162	P6	yeah, yeah.
163	R	That's very helpful. Can I? if I may just expand that a little bit more. Its like err, you talking about this
164		research title make you feel intrigued and interested you know. So I was just thinking about how does
165		it connect with you professionally and personally?
166	P6	Em (P6 tutted), I will start with the personal (nnh) connects with me personally because one of the thing
167		that happens to me is that err, understandably people assume that I am white (nnh) and so I have been
168		in :: training things in different contexts where people say. Oh US, so oh people, you know like US. And
169		they include me in their group of like white British people. And I am like (P6 laughed) no I am not
170		one of you. So (P6 laughing continued) I don't like you but I am er, er, we are not the same. So don't,
171		don't put me in your group (P6 laughed) (nnh) So :: that does feel personal. That's only part of it, but
172		that's you know obviously I am talking about visible difference, emm and assumption being made
173		about that. So err you know some people picked up on the I don't have a completely British accent
174		and other time some people think I do, which I , I don't think I do, but anyway. Emm and so its, its like

175		that yeah, the visibility or invisibility, and the assumptions that are made around that. I find :: yeah
176		really interesting. And that's why I am interested in culture BEING err unpicked for everyone (P6 laughed)
(19.17)177		you know because we don't know and you know. I am marking assignments and people are talking
178		about, you know the trainees are talking about ::: they keep going to visible difference and I want
179		to say hey:: I want you to be as interested, in people's culture even when they are not visibly different
180		to YOU. Because you are making an assumptions that you are the same as these people you know
181		as your clients (nnh). Because you both white and working class or whatever, you know. Emm, .hhh, plus
182		personally I think another layer to that is that, because of my appearance. I think some people ::
183		struggle ::: to ::, to really kind of imagine emm, the depth of you like my cultural values and what I
184		Yeah, what I grown up with, what I exposed to, my experience :: putting it, yeah. Emm, another way
185		:: so:: yeah, I think it is interesting because emm I think I oscillate between making that explicit and
186		other times because I am using, you know myself, making those connections all the time. I think that's,
187		that's the hightest context to me. And other time, I think oh no, may be I need to be more transparent
188		about it. Err, emm may be that's part of how I can help others. I say help, you know support trainees or
189		you know, other people in learning contexts and things. That's to really emm. Yeah, be more explicit about
190		that. Emm, so that they are you know, are able to yeah, connect with ways of doing things emm for
191		themselves. Whether or not there is visible difference or not. Emm, that they really get into that way
192		of thinking about things.↑ And, I mean the, obviously there is the, the personal as a professional
193		(R coughed). In terms of, you know professional connections. I am talking about, I am talking about
194		myself, that's what I am using everyday. Emm, but I suppose there are little things like emm, you know.
195		Saying the family are white British, rather than some people only say oh, emm you know, the family
196		are British Asian. So they might only :: note something about ethnicity when the family are not white.
197		(P6 laughed) so I think that's a really important thing to, to state it for, for all err either patient or

198		young people, families, just to, its to think about emm identities and name them. Emm, so you know,
199		it varies but I do find that quite a lot. Emm, yeah as I said it goes back to my early comment about, are
200		there cultural issues? (P6 laughed). You probably tell the kind of irritates me that (P6 continue to laugh).
201		I don't want to be critical but I just, I find it like err, I don't know it feels like an add on, like shorthand
202		thing that people do yeah (yeah).
203	R	So I mean, you mention about the trainees you know like. I was just thinking about when they do
204		shorthand, how do you approach them, to, to emm?
205	P 6	I think it depends but you know trying to model. I think :: is one thing. Emm, and also to, I mean if by hand,
206		I can't think of an example emm, trying to think of an example emm, if I had to be more. ^No, I can't
207		think of an example where I felt that its important to be really emm (P6 tutted) err ::: directive. Err, I
208		can't think of a situation with trainees. I am thinking about my last trainee, emm (.2) Yeah, I think its
209		giving them feedback. Emm, has been a way it happens, either after the sessions or feedback on their
210		writing you know on things like that, to do case read (yeah) and err , yeah, trying to emm, emm
211		trying to bring themselves in more, which is one of things for psychology trainee is a common kind of
212		challenge. Because you know, they have CBT as their first model, its all about emm keeping themselves
213		to themselves, and so when they start doing systemic training they have to really, quite a jump for them
214		to, to have to emm, think about themselves. SO what I am saying, what I am linking it to a training
215		context. Yeah, really encouraging people to make, make that link to themselves, and others, not just
216		(P6 laughed) the family this, the family that, you know emm (P6 tutted) disconnection is the word I was
217		thinking of. Because .hhh when we just make statements about you know, this :: this person is this
218		emm, yeah I think its, that's a bit err limited. And so I am looking for someone to make the next step.
219		Emm you know, I give the example I say the family is white British sure. I wouldn't then launch into,
220		and I am not you know, not not in the five piece formulation for example. That emm I would certainly
221		be thinking of. Emm you know centering some of those, you know try to bring out some of those
222		values or beliefs or you know what does that actually mean, to the family and what does that

223		mean :: you know, to::the presenting problem or does that mean do our working relationship, trying to
224		add on the layers rather than its just to a statement (yeah, yeah) you like yeah, yeah.
225(25.55	R	So I was just thinking about emm just thinking about in the eating disorder field, emm I am just thinking
226		about, do you have any memorable moments about err race, ethnicity, cultural work. Emm in, in
227		your practice.
228	P 6	Emm, .hhh memorable moments. I think (P6 tutted) the two families I spoke about emm for the
229		presentation do stand out. Because, because for two reasons, one is that emm the work with emm with
230		Pakistani family emm went very well. Emm, and I think and I felt I had a emm a very good working
231		relationship. I HAD to use an interpreter and with the mum who spoke Urdu. Emm, she didn't come
232		to the assessment, I remember the father did but then the mum, pick it up. What, what, that was
233		why I use the family in this, in this presentation (P6 laughed) because I :: you know, as I said the
234		piece of work went really well. Emm and there was a good,↑ I don't know, what do you use the
235		word coherence? It felt like there was a good, emm alignment with the family and the, and yeah. It was a
236		kind of coordinated well and it went well. Emm, and I think ss, I think (.4) the reason it stand out is
237		because I can think of subsequent examples when emm you know, there might be a family who are
238		muslim, non English speaking, of one of the parent non-English speaking where the team might be
239		a bit, OH::: this is going to be difficult, might assume it is going to be difficult. Emm, yeah I think
240		that would, that :: has happened and I :: think it was really important, and I, you know that is just one
241		example but families, the work with the families can be difficult for some many reasons (P6 laughed)
242		(R laughed with P6) that was you know
243	R	that's why it is quite helpful to think about this err, err family that you are
(28.19)244		saying went well with coherence and alignment, and I was just thinking about, few things come to
245		my mind. I am going to ask one thing at a time, rather than kind of bombard you. Is, why do you
246		think it makes a good coherence and alignment with them?

247		(P6 tutted) I err , I wonder that and I thought, I thought about power and I thought err. Are they being ::
248		emm err compliance, for one or a better word. Is that, is that a factor? Emm, yeah what's going on?
249		Emm and then I thought about the family functioning and the structure and values, and how emm
250		you know, there was a good, there were good relationships in the family. So, there were closeness,
251		one of the thing that happened was, there is a real shame that the daughter, emm who was the you know, the index patient
252		of you like, she emm, because she got unwell, emm she didn't have any energy, she had anorexia.
253		She emm, she wasn't able to get up early and pray. Emm and then, emm the parents didn't
254		allow her err to observe Ramadan and emm, so I think what I felt went well is that they:: were able
255		to take the :: information we gave and the rationale and. Because I am always transparent about
256		the model emm, and YEAH use that in a, in a way that work. I did wonder that part of that, is because
257		in terms of the family structure, you know if you think structurally and of course (nnh) we are using
258		that. Emm in emm single family therapy for anorexia. We are asking the parent to be in charge, so is
259		that something that quite a fitted, because they had quite a traditional, if you like model of parenting
260		whereby parents were emm:: would set out how things went. BUT↑they weren't, I mean don't get
261		me wrong I don't feel in anyway they were dictatorial parents. They were just yeah::they, they seem
262		to have a good balance between thinking about their daughter's need AND listening to what we were
263		suggesting (P6 laughed) and I was asking them to do, and actually going with it. Emm, yeah. I hadn't.
264		I was lucky because I had a, mostly I had one interpreter and I had another one. I think I had a
265		couple during the time, <u>but</u> there was a bit of continuity. So I think that help. Obviously I did a bit of
266		preparatory work with the interpreter as well. Just to set the context and :: you know of what I was
267		doing and why and, because it might have seen quite odd you know to her. And obviously I am not,
268		wasn't asking her to be involve clinically. But, I thought it was important to just. Yeah, to help her
269		understand (nnh) what a piece of work was about and emm yeah.
270	R	Depr
271		(P6 tutted) and also what might you see the race, ethnicity, cultural issues for this family?

272	P 6	Yeah, what do I see as>. I:: if I had to break it down like that, I think you know that are overlaps for
273		all families because that was about their family functioning and their relationship with their daughter.
274		(nhh) And their daughter's health was there, you know was their key concerns. Emm I think that
275		you know as I said it had some :: the young persons emm diagnosis had an impact on how they emm kind of
276		function as a family. Because she became very withdrawn and, and was in her room a lot, and they
277		found that very difficult. Emm, but they did make, as I said they did make appropriate kind of
278		adaptations like, with the Ramadan, err for example emm yeah. Yeah, they centred, although I felt what,
279		they centred their daughter's well being , whether or not anyone would see that as a, a cultural norm
280		you know. It is debatable, isn't it? (|P6 laughed) because lots of people would say, well we, we all,
281		you know all parent's want their best for their children. That's not just something that unique to, you know
282		a particular cultural ethnicity. Emm :: but I think for me, what I felt err. What I work with was I can
283		see that willingness and that good will. Emm from the parents.
284	R	So both parents don't speak English or just one parent?
285	P 6	Just the mother but actually the father didn't come to the sessions (P6 laughed)
286	R	Right
287	P 6	So it was quite interesting the way he started and then, cause one of the thing that we do are, sent
288		emm, you know some psycho-education and some website that has links about anorexia when we
289		give the diagnosis. So I sent those to the father and then, I don't know if I err, not sure if I understood
290		at that point. I did, he must have said about the mum, not speaking English. So, or very little. And that
291		she (inaudible) a little bit but, emm. Then I said well, emm sorry we don't emm have this in any other
292		language you know Urdu. But you know, can you please make sure that you and your wife discuss
293		this. So emm, so that she is up :: emm informed and has an idea what we are trying to, you know.
294		It is not hire to, so the speak. Er in terms of what we are trying to achieve and discuss (nhh). So emm,
295		yeah I mean they were. That they are for me, they are not, they weren't a big deal. Emm but (.2) I think
296		err what hhh, what it makes me think about is :: emm:: (P6 hissed) It is a kind of middle ground or what

297		we create between, you know we got this model. And some people might say well it is not you know.
298		It is not going to fit every culture. And its like well what, what do you see as being you know adapted.
299		How would you adapt it to different cultures (P6 laughed). What do you see as being appropriate?
300		And I think that's, you know there isn't the one size fit all. I think that, you know you got the model
301		and then within that you have to have a sense of the, you have to guess the sense of the families
302		functioning and their priority, and whatever so. Some of :: it may have really not much to do them
303		being er you know British Asian Muslim family (P6 laughed) might assume that. You don't want to be
304		emm dismissive but you don't. For me I don't want to centre everything around that either, if that
305		make sense. It is like, just a bit of err, yeah looking at what, what fit, what fits together. Because you
306		can't completely abandon what you are doing either. And so (nnh) its its this model is not, you know
307		its just doesn't work. The model doesn't work for lots of families, I don't think that's just always
308		going to be about
309	R	You mean the eating disorders model, service model
(36.39)310	P6	Yeah, eating disorder model in terms we use you know Maudsley basically (nnh). Maudsley stroke emm
311		family based treatment. Emm so yeah, I think emm we have to be really ADAPTABLE and I think that's
312		a challenge anyway in my team for people saying. OH, this, this, this doesn't seem to be working you
313		know. And its like oh gosh, how rigid should we be. Are we go back to the model and, and try to do
314		an even more you know rigidly (P6 laughed) emm or should we be more adaptive, you know? You got
315		first month, nothing happening or parents don't seem to be on board. Emm you know that would
316		happen, I think about it in my team. Not only but majority of families where that's been the case.
317		A lot of them are white British and people don't go OH this isn't culturally you know. This isn't fitting
318		for family (P6 laughed) kind of looking at other factor. Whereas I think if the family, if the family is
319		non-white then I think that would often come into that, that would be a question? Emm
320	R	Okay, in some way, in some way if you are white British you lost out in your area? Because people
321		just assume this model will fit the white, when white can be very different

322	P 6	Yeah, I think it can
323		Yeah, yeah I think there is that sense of yeah homogeneity that, that people revert to, which is yeah.
324		It's about and with any family, its about unpicking you know. Trying to understand the formulation or
325		what's, what it is about, the way this family function their values, their beliefs emm relationship to
326		help, all those things which are, which are having an impact on you know. How the treatment are
327		going? emm.
328	R	So in some way, this family that you are talking about. Because they are, have a visible difference
329		you know. The er the thinking about race, ethnicity, culture thinking difference is straight away
330		flash up (yeah, yeah) Like you mention interpreter, err the meaning you give to just the mother
331		attending not the father (nhhh) and so on so forth you know.
332	P 6	Yeah, because some people you know some, of course those with a really, RIGID F B T model would
333		say you would need both parents etc. But we don't tend to subscribe to that (nnh) and there are
334		time that I :: emm :: really. I know when I do supervision, complex case discussion or FBT supervision . Emm,
335		urr the times when I wonder about the absent parent is when. Yeah, it feels like they are completely
336		absent and not involve, and I really didn't feel that with, with this situation that Dad is working and
337		stuff. But I didn't, yeah, I would ask about his ↑view and, and difference. I wasn't concern about
338		his lack of being in the room. I didn't see that as just the sign of he is not involve. Emm, and some
339		family and other family that would be the case as well. The parent might not be there but you can
340		see that they are there, they are involved. Emm (nnh) yeah.
341	R	.hhh So just thinking about the, the ED issues in this case, and the race ethnicity culture of this case.
342		I just wonder :: do you think there is a cross over specifically for, for this case. What we been talking
343		about? May be easier because you can think about other cases as well. The cross over between
344		eating disorder and race, ethnicity culture you know, emm. How does it show if you were to
345		describing a family with this issue of cross over.
346	P 6	(P6 hissed) I think in:: I think for any family but I mean you are asking me to think about this family
347		specifically. I think the issues that I would consider are :: about emm things like the meaning of the

348		eating disorder within the family. Does it raise issues of shame or blame or but. I don't, yeah. And again I just
349		don't (P6 laughed). I wouldn't just assume that, that was the case for this family more than others.
350		Emm (nnh) those would be the kinds of things that I would link, in terms of embeddedness if you like.
351		Emm because I could think more widely about, and people might say things about you know emm,
352		the meaning of mental health act, diagnosis within particular population. They may say OH well, no.
353		Emm, err in the ::: you know, in the emm Muslim Pakistani community in (area name) there is not a very good
354		err acceptance of mental health difficulties and there is stigma and shame, and whatever. So that
355		might be one of the discourses and (nnh) it is about, does that fit for this family? You know (P6 laughed).
(41.) 356		Is that relevant or not↑? And so :: , yeah ::, I think emm. We start going into cross over links about gender, and yeah.
357		I remember the father actually talking about emm, I can't remember if it is because I asked. This is
358		gosh, few years ago now, must be couple years ago. And I remember the Dad, whether I brought it up
359		or he said something about you know, his daughter having opportunities and what he wanted for them.
360		In terms of education and things like that. So you know, those would be the kind of things I would
361		asked because I am thinking about future, I am thinking about identity so emm. I think it is both and
362		in terms of some of the questions that I would asked, or do ask, emm. That I think they are emm, see
363		me asking them, lots of families and what I would be looking out for, as I said is that kind of that link.
364		In terms of err, cultural values, identity. Emm. Ethnicity. I mean race, emm you know the other aspect
365		of ur, the you know, the one of the key thing that's important there for young people would be
366		about racism and prejudices, and those kind of experiences you know quite a few young people we
367		work with had been bullied. Emm, but you might get things like young person just feeling different
368		or included or::. So I be asking about their you know, their identity around friendship, friendship groups,
369		emm inclusion in things. Emm yeah. Because I would wanted, want to :: see if there are any, you know
370		if there are any particular experience. That are connected with your race, ethnicity and, and you know
371		culture. Emm, yeah. I mean I asked families about religion of course, and get a sense of what their

372		involvement is, with the community and yeah. What, and that could be in this :: urr I mean in this family
373		were, this family were connected, emm with Mosque, with the Mosque and emm, attenders emm
374		and yet other families you know they pray, emm they are quite you know. They are observing emm,
375		urr you know aspect, most aspects of, of emm Muslim religion but they are not necessarily going to
376		Mosque or connect with, you know wider, I just think of family I work with, mother I spoke to the other
377		day (P6 laughed) emm, it is not actually eating disorders case. But, I said urr urr are you religious? And
378		da emm the, she was explaining that emm they are not actually very very you know connected with
379		emm extended family and, and that kind of things so emm, its is realy about Yeah. Getting a picture
380		for me of how the family is functioning and what links there might be with eating disorder, in terms of
381		as I said what it means to the family, so the family, what resources they have to <u>support</u> the young
382		person. As I said kinds of stigma and shame, emm identity stuff, emm ↑AND you know, the bit I know
383		was also, also refer to earlier was, how that family configuration if you like, will or won't work with
384		the family based treatment model (P6 laughed) (yeah). Something going to, seem to fit for them or
385		does that seem really alien (nnh) emm is it like gosh, we are not, we can't tell our child what to do.
386		And we don't want to be in that you know, in that crisis, having to be quite directive, preparing
387		meals and, and things like that.
388	R	I just wondering what the family response when you kind of thinking with all this contexts you
389		describing, when you working with them, so is it usually easier to, to think about the piece of work
390		when you spoke to the white British family and the muslim family. If we home onto one of them,
391		whichever you chose or any other example that you might, cross your mind. So if we, if its possible,
392		then kind of think about this case, or recent case, or a case that you working on, past case or whatever.
393		So we can just hear a bit about, kind of what might be the issues around this family. Would that be
394		okay?
395	P6	Yeah, yeah.
396	R	Em, so. Is there any case that you work on recently or in the past? That race, ethnicity, culture

397		obviously eating disorder are, are connected, cross over or relevant?
398	P 6	Yeah (.2), I could choose any family. I think the , the thing is important about my work context is
399		that emm you know in (a county) where I am working. The, the you know, the proportions of emm
400		black, asian, minority, ethnic people is much lower than you know, the London boroughs you know
401		(nnh). Emm, so I would say yeah, three quarters of the families will be white British at least (nnh),
402		yeah. Emm, so that's why emm, in terms of thinking about a case. There are many more family who are
403		are white British than the not. Emm, yeah. But, there was another family I worked with are Sikh
404		family actually who had a boy, who had anorexia. Emm, that was quite interesting. Because the
405		other issue there was he was probably autistic, but they didn't really want him to have that
406		diagnosis. Or didn't want to see the significance of that. Emm, yeah.
407	R	How old is the boy?
408	P 6	He was thirteen.
409	R	Thirteen.
410	P 6	Yeah, yeah. Emm, but again that was quite a common (P6 laughed) you know they are not the only
411		family who, who don't want a diagnosis of err autistic spectrum disorder you know (P6 laughed again).
412	R	Yeah
413	P 6	(P6 continue to laugh) It just interesting in terms of, I think I was going back to them because I was
414		thinking about how emm in the end he didn't want any individual work. We would have offered it.
415		We used the family based treatment model. And they came to multi-family therapy. Emm, but got
416		pretty fraud in that we got to the point err. Possibly to have to admit him, emm because his weight
417		chart was just like (P6 making a blowing sound). For the first six months basically, it was really (P6 laughed)
418		really difficult. I remember occasion, we emm had asked them to go to the paediatric clinic. And they
419		did get assess actually. They got assess through inpatient admission and then they were emm, against
420		it and we were on the CUST of having to think about you know using the mental health act. And
421		having to displace the parent. It was quite yeah.
422	R	You mean the parents are not keen for him to engage in treatment.

423	P 6	Yeah, they were like concern with them. They were like OH NO. We couldn't possibly have him
424		admitted. Its like okay (P6 laughed). I am not sure what we meant to do, it was like carrying this
425		in the community. And its really untenable.
426	R	Are the parent worry about him losing weight then?
427	P 6	Yeah, but :: not. It is like one of those, yes but situation (nnh) you know. Err, it just like, this is really
428		concerning and serious. I think with them, I think I did, I did wonder. I mean at the time. You know
429		in the midst of that. I wasn't asking question them about stigma or whatever. Emm, it was much more
430		emm base on making things happen and make decision, deciding you know what the medics were
431		going to push with and what we would push with. It was interesting emm, but it is interesting, he
432		never got, he never get admitted. Emm, he did get better. Emm, that :: yeah. I am just thinking (.2) about
433		unpicking cultural, ethnicity, religious aspect of that. Because I think, as I said then religion comes
434		into that as well. When she start talking about yeah, cultural, ethnicity emm (.2) yeah, I am not
435		saying anything more concrete. I am just trying to think emm.
436	R	Where the family upset with the service when the idea of mental health act being considered?
437	P 6	Yeah, of course. When they, when it was. I mean i seen this before. It's like parents are unhappy, they
438		are concern about their child and then you, you get to the point, and you think admission is necessary.
439		And they seem to kind of back track and say well. As I said yes, but. (P6 laughed) couldn't possibly
440		have our child admitted. And you think, oor what's the alternative. He is not eating, he is like you know seriously
441		ill and just can't keep going, doing what we are doing. Emm, yeah, yeah emm. You know, as I said,
442		he got better. There wasn't a, a rupture in the relationship, they didn't fire me. Emm, unlike some
443		families you know (P6 laughed). Up and recently, emm, yeah :: so ::
444	R	But, somehow the family manage to feed this boy enough to keep him away from the hospital.
445	P 6	Yeah, yeah. It was like a kind of turning point. And I am sure you have seen that in your practice as well.
446		Where you kind of reach this crisis point, and you are like okay. Looking at admission, yeah actually
447		have to go and get assessed at the inpatient unit. And I have to go to paeds and all the rest of it. And
448		then somehow from there started to turn around. So yeah, quite interesting, quite HARD to pin point.

449		I mean I can say that, that was turning point, but in terms of (P6 hissed) why? Or or you know the
450		family view on that which I would have asked. I don't remember them, particularly pin pointing anything.
451		But I think my own view was that, it was something about their, its not that they weren't taking it
452		seriously. I am not accusing of that. But somehow galvanised them in a different way emm (nnh). So
453		yeah interesting.
454	R	So is this boy discharged or::
455	P6	Yeah, yeah.
456	R	Parent feeding him successfully.
457	P6	Yeah, yeah and they didn't wait
458	R	Did he get his autistic diagnosis or something?
459	P6	No, he didn't and they didn't want it.
460	R	They didn't want it. So there is suspicion.
461	P6	They didn't want him to be assessed. They didn't want him to be assessed, this is what I mean. That,
462		the err because, you know in terms of maintaining factors. I a kind of thought, nnh something quite
463		important (nnh) emm yeah. He was very emm (P6 tutted) kept himself to himself. Emm yeah, non
464		communicative and emm yeah. Interesting boy (P6 laughed)
465	R	Is he in mainstream school?
466	P6	Yeah, you know they have grammar school in emm (county name). That's the whole other layer
467		So he was in grammar school. So yeah (nnh) (.2) So yeah, mainstream and (inaudible).
468	R	So just thinking about the specific eating issues for this family, what might you say what's the
469		specific eating disorder issue for them.
470	P6	(P6 hissed) yeah, I mean it was emm you know we gave them the diagnosis of anorexia (nnh). Emm
471		(.2)I just think, thinking back to (.2) emm :: either relationship between emm the parents and the
472		young person. Because in my experience that often, this is parent don't want to err upset you know
473		their child. They feel their highest context is maintaining the relationship. Emm and so if they push
474		too much, will eating or boundaries or stuff, then that upsets that closeness and that you know emotional emm.
475		They see as a relationship between them, so there is a bit of that. Emm in the mix, there is a younger
476		brother emm, and interestingly he was bigger. Even though he was younger, you know he was bigger

477		(nnh), which cause you get, emm yeah. (.2) So emm they weren't, there didn't seem to be issues of
478		emm, shame or er hiding you know eating disorder. They spoke to the wider family, they had a lot
479		of extended family involvement and cross over and things. You know, there will be stuff going on,
480		emm weddings and parties and family events, I remember. Emm, yeah. But emm that yeah, that
481		element of being protective of the son was definitely a factor. Although they recognised the
482		problem, they also felt that they were doing the best thing for him by not letting him to go to
483		hospital or emm (nnh)yeah.
484	R	Are they first generation or second generation in this family?
485	P 6	Second, yeah.
48	R	The parents are second generation.
487	P 6	Yeah, yeah.
488	R	Err Are they okay, fluent in English, kind of?
489	P 6	yeah, yeah, both are professional, middle class family. Err yeah, emm quite committed to coming
490		to the sessions. Like either have both parents or mum:: more mum but Dad, Dad was committed to
491		be involved as well. So emm, yeah, yeah.
(57.5)492	R	And their views about emm, about eating disorders in their culture. How, how do they, what's the
493		meaning they give to it?
494	P 6	(P6 hissed) yes, good question. Emm, I think it was so unusual for them initially. I think it was like (nnh)
495		er, yeah. Emm, I think they, they spoke about emm, because when they went to multi family therapy.
496		He was the only boy, so that was quite a big (nnh) a big emm that yeah. And I think there were, there
497		can be you know difference of course between emm, (P6 clear her throat) young man and young
498		woman, and boys and girls. Emm when it comes to, just as they, they can be between any young
499		people as well. And in terms of the formulation and how it comes about and you know what's the kind
500		of err, emm what are their driver you know, when we unpick that. So I think they, they emm makes
501		some link with academic pressure. They were able to (nnh) kind of recognise the role that, that might
502		have play and THAT was basically that was my hypothesis, was that it was about err big part of the,
503		this is where I thought about ASD was the transitions to school (nnh) because that brings in, got into

504		difficult. It was following the transition to the school, emm that the eating disorder emm yeah, came
505		along. Emm but in terms of how they thought about yeah, the eating disorders diagnosis, in terms of
506		culture and, and fitting in, and (.2) I think you know there wasn't, there hadn't been anyone in the family
507		(P6 tutted) emm with similar difficulties. And I think, it was quite, I think it was quite new emm, quite
508		new and different. And you know as we do with all the families, we really emphasis the lack of
509		blaming, and trying not to, yeah, for people not to feel ashamed or, or you know at fault. Emm (nnh)
510		because you know that difficulty is, is in the family. So, emm (nnh) yeah.
511	R	I just wonder if this family ring any bells to your own contexts you know, err your own race, ethnicity,
512		culture. Thinking about few things you mention academic pressure, transitional to secondary
513		school, shame and blame, all these things or whatever this family emm tap into you?
514	P6	Yeah, I mean I think my contexts was very different to a lot of what I work with emm (nnh). In terms
515		of, I actually find the emm, the grammar school scenario quite odd. Emm, for example, not what I
516		grew up with or had (nnh) any experience of, so emm, yeah. Probably quite if you like, sensitive
517		(P6 laughed) to seeing academic pressure and thinking Oh::: no (P6 laughed) and having to not emm (P6 hissed)
518		::: put those views on the parent or or be critical of them or . And I don't think that, that comes
519		across but there is a real disconnect between my own experience, real difference I should say, not
520		disconnect difference between my own experience and what I see. Luckily for young people
521		around the academic pressure and and (nnh) and so yeah I had a very different. I went to a state
522		school and it is quite achieving but emm, just I in a very different way. We didn't have the same level of pressure
523		around eleven plus, and tutors and (P6 laughed) exams and stuffs. I think culturally I don't know
524		what is like now but for, for teenagers in (country) that certainly when I grow up there was a real
525		emphasis on emm extra curricular as well as academic. So we do a lot eye wise, making I statement,
526		we had opportunity for sport. And I do a lot of sport emm that's for sure. That was the big thing, so
527		it wasn't just focus on yeah exams and that kind of stuff. So, emm. I think a lot of emm, yeah definitely

528		lot of the family I work with. I think there is a huge, huge difference between my experience and
529		the kind of the norms. Emm, yeah. I say more generally British culture and then you could you know
530		narrow that down to, to different families. But, I think yeah, very very different. So I think I try to
531		yeah be curious about that but be very careful about. Emm, yeah questioning what people take for
532		granted. They might feel, feel that, that is you know, experience that as criticism (P6 laughed).
533		Obviously there are times when I need to do that, cause it is important to, yeah perturb the system
534		a bit (nnh) and get people to think about even though they are not. Emm, intending pressure is that
535		in the mix (P6 laughed) (nnh). Obviously can be wider than the family, it is not just talking about the
536		family context, talking about the you know the school, the societal contexts (yeah, yeah) around
537		all that. Its ↑huge. (yeah). So it's not just the parents. Yeah, yeah, might have very good intention
538		and we can see that how impact on young people.
539	R	.hhh I was just thinking about emm, if I just change, not changing but just build on. Can you tell me
540		about your experience of working in the field of eating disorders service. How does that shape you
541		as a family therapist on race, ethnicity, cultural issues? It is a very long question. I am happy to
542		repeat it (R laughed)
543	P6	Ahh.
544	R	Yeah, your experience of working in the field of eating disorder, how does it develop your practice
545		as a family therapist in race, ethnicity and culture issues?
546	P6	Nnn, (.4) (P6 tutted) First thing come to mind was just thinking about starting to work with eating
547		disorders. Emm how that was a shift for me emm anyway. So in the past, I didn't emm work in a
548		specialist team or anything. And then when I came into my post in 2014, I had to start working with
549		eating disorders. That was just an expectation, that was part of the, part of the role, so that was the
550		first bit I suppose was kind of finding some framework. Emm, to do the work. And so I think the link
551		there was that, emm luckily at that time I was able to emm, go on training. Emm, for single family
552		therapy for anorexia Maudsley model. And multi-family therapy training. So, was quite interesting
553		because I already emm yes, I think I started emm doing the work, working with families and using

554		systemic, obviously systemic ideas and systemic principles and then that practice deepened because
555		I was then you know, using, as I said the models emm, and there was more of overlaps in that. So
556		I think emm::. Yeah ::: it makes sense. Because I could relate to the theory. Emm and the ideas, so
557		that was that. In terms of how that's. Did, did, was the question deepen or what's the interaction between?
558	R	How did that develop?
559	P 6	Yeah, develop
560	R	Develop your, your race, ethnicity and cultural practice in Eating Disorder
561	P 6	Nnn, (P6 hissed)
562	R	Because you already doing race, ethnicity, cultural before you come into Eating Disorders
563	P 6	Yeah, exactly, exactly. That was what I was thinking. So I was thinking what's different or emm,
564		what's been the development. Emm, that was what your question is. I think it goes back to what I
565		was talking about earlier really. Er in terms of using that lens, err all those lenses, singular, those lenses
567		for every family (nnh) and really trying to :: ascertain with the family. You know, what's important to
567		them. What influence, do these aspects tag on. If I think about systemic formulation you know. One
568		of the basic question is, what is, what is the problem? (P6 laughed) what are people's perception of
569		of, of the problem. And so when I am doing F B T supervision for example, you know we would look
570		at that question of you know. Do people actually say that there is an eating disorder? (nnh)
571		fundamentally. And sometimes people don't see that (P6 laughed). Here I am given them the diagnosis.
572		But, there is denial or avoidance of that. Emm so, I think emm, yeah. Keep going back to framework
573		which sounds a bit clinical, but you know those are the things that I am, using for consistent. I use
574		for consistency, emm and trying to make sense of the complexity of, of whats been presented.
575		And I think race, culture and ethnicity are, emm:: err really important aspect of the whole formulation.
576		Emm, and sometimes I think they are more central than others and so. I hope this is answering your
577		question about how its develop. I think (.2) I don't think I see it as.
578	R	Do you have an example that you see yourself, yeah I am using my race, ethnicity, cultural lens on this
579		family who has got an eating disorder?

580	P 6	(.4) (P6 tutted) I think I, its emm probably more evident when its emm the work might not be
581		going so well. Emm, I might think about it in terms of strength or abilities, or what the parent agrees
582		or what the young person bringing or, yeah making sure again this, that a kind of emm:: coherence
583		between what we are asking them to do and what they, what are their norms if you like. And you
584		don't want to be at odds emm too much, emm I think sometimes that you know, that can cau::se
585		conflict anyway. So for example, you know with the white British family I spoke about right at the
586		beginning emm one of the things that was difficult to them is that, they said wow we have never
587		really had to :: emm nothing ever kind of gone <u>wrong</u> in the family (P6 laughed) always been perfect.
588		(P6 continue laughing) so emm, to have to be more :: (P6 hissed) authoritative, for example, which is
589		we are asking them to do (R coughed) leading on the :: meals and stuff like that. They found it really
590		difficult. Emm, so yeah I think that was an example of what I saw you know. FAMILY culture yeah,
(1.11)591		how we do things. Emm, our implicit kind of beliefs about what we should do, to be good parents,
592		and then thinking oh, we are going to have to CHANGE this oh↑. Someone asking us to do something
593		different that doesn't you know, doesn't really fit for us. HENCE, my questions about what is, what
594		are your norms? And you know (R clear her throat) we need to look at that which they found really
595		really difficult. And they (nnh) and because they are you know very (.2) what in my view, conflict
596		adverse (nnh). Emm, then that part of the difficulty because it did create conflict emm. But then, they
597		would say oh no, its, that kind of <u>minimise</u> it and say oh no. It's not that, not that problematic. So in
598		terms of going back to your question how it develop. I don't see this as separate kind of thing. Emm, i
599		see it more as :: (.2) emm as I said in terms of formulating and working with the families. Bringing in
600		lots of different threads and they are some of the threads, and sometimes its much more important
601		aspect to look at than the other. I am not saying it can be ignored or. I think its important to yeah,
602		think about it for all families. Emm certainly so that we are being, emm you know meeting their
603		needs. And you know sensitive, so to speak to, their ↑needs and their ↑contexts, and being aware of,

604		what you know going on for them. Emm, I mean that as a wider sense and who their extended
605		family connection are and you know FAITH and spiritual practices and all of those things. Are we all,
(1.13)606		I think for ME, that's key to understanding how the family function and then you think about, and there
607		is an eating disorders. So how does that (P6 laughed) how does all the strands, all the connections
608		between, having an eating disorder and all these things that previously existed. Emm, in terms of their
609		functioning and their beliefs system and their ways of doing things.
610	R	Coming back to this family you talk about err being authoritative, more authoritative in feeding is
611		not their norm because they don't have problems. And err (nnh) I was wondering how do they response
612		if the recommendation is :: asking the parent to feed their child? Which obviously :: is a problem in the
613		first place, that's why they use the service? So how do they response to your comment or suggestions?
614	P 6	P6 tutted. They are a kind of did it but then park where along they just did their own things. So that's
615		what ended up happening. So emm, they seem to be going quite well, but then they didn't listen to us in
616		terms of advice around em sport and things. So we had cut out sport and then emm, we got to the
617		point where we said okay. We are going to experiment, we are going to let him do one err practice
618		this week. Err they just let him do everything, like, think like eight sessions of sport in one week.
619		(P6 laughed) And then it just went (P6 make a deflate sound). You know disaster. Emm, and then
620	R	This is a family that can not take the recommendation, that, if you like the expert
621	P 6	Yes, that was interesting.
622	R	They come up with their own resolution that (yeah) did put the boy back on track. Is it a boy or girl?
623	P 6	Boy, yeah a boy. Yeah, yeah.
624	R	How old is the boy?
625	P 6	Yeah, he is thirteen as well.
626	R	Thirteen as well.
627	P 6	Yeah (P6 laughed) that's my specialty. I am joking.
628	R	(Both P6 and R laughed) but thirteen years old boy has got their own developmental challenge, isn't it?

629	P6	Indeed. Yeah
630	R	And, so what happens, just get my curiosity going now. What happen to this boy, thirteen years old?
631		and parent can, can not do authoritative or firm or whatever?
632	P6	They did eventually emm, they went back to doing more of the emm. They eventually listen to us in
633		terms of the exercise stuff. And quite hard to unpick from them, the challenges with them is (P6 laughed)
634		getting concrete answers for things. They just have this style of emm :: (P6 laughed) minimal, MINIMAL
635		reflection on things. So emm, yeah in terms of unpicking something like that is actually, really like.
636		I was (P6 laughed) you couldn't get hold of it.
(16.45)637	R	It sound like, I was just thinking what might be white British culture influencing the way they talk,
638		the way they live, the way how they do parenting.
639	P6	Yeah.
640	R	There is nothing to discuss there (yeah) I heard. And and you only see the behaviour but not, why they
641		are doing what they are doing
642	P6	No, no, getting the emotions or intent. Or that stuff really really difficult to get hold of. Because it is
643		all minimised, its all like everything is fine. There's nothing more to say. So yeah.
644	R	Did you get a chance to do a genogram with them?
645	P6	Oh yeah, yeah. Absolutely I mean we did that. And when er (P6 hissed) I am just trying to think of an
646		example when er, Oh we did like a, I remember doing a ::: a family shield emm you know, you might
647		do a MFT and yeah, that was really interesting. So there is a style of not talking about things. They
648		thought they were talking about things. So when you were asking them questions, and about it er er.
649		You could see that they felt, they are being attacked. So I have to be very sensitive about it. So its like,
650		so you know how you know. Emm, there was one example once, the mother was in Cuba or something,
651		and boy rang, skype her all something, and he was really anxious about this test and, and stuff. I
652		remember you know, try to talk about it. And it was just like play down, so an example was then, when
653		we asked them to do the mid-term routine outcome measures. Of they got nothing for anxiety, yet
654		there were these really concrete examples where he was clearly highly anxious (nnh, nnh) and yet
655		sort of this mismatch, there is always this mismatch between what was said and what was, what

656		was manifested (nnh) and it was very difficult to get anything verbalise about those things. Because
657		it happened and there was like it hasn't happened. They just gross over it, it was really (P6 laughed).
658		challenging.
659	R	Very Challenging you know. (P6 name) I just notice the time, eleven twenty six. We only ring fence for
660		an hour and a half (nnh). We got to an hour and a half, I am afraid I have to say I only get to ending
661		question three (Three, P6 laughed). I got few more questions.
662	P 6	I thought you ring all the questions (both laughed)
663	R	Well, I am a kind of inter-loop them a little bit. I just wondering how you doing with time. Do you need
664		to go because an hour and a half, you know, our concentration is a little bit stressed (yeah). I can
665		make another time to finish the other part Or how do you like to do this?
666	P 6	What would you like prefer to do?
667	R	I, I really enjoy the conversation. I say if you are okay, I can give you a ring next Sat to finish the other
668		four questions. And er (yeah). I don't want to just like push for it, and we just trying to get through
669		the questions (sure) it is like we don't work, three hours session, family therapy session. You know
670		the data, what we speak about is very important. So my preference is emm, if its okay with you, we
671		book another time.
672	P 6	Yeah, I am fine with that.
673	R	And then we finish the other half. So we get the gist of the data (sure). Because one thing I am dying
(1.20)674		to ask earlier on when we started. I am trying to ask that before we lost them, because
675		if I come back next time. And it will be very difficult to capture that bit. It was related when you
676		first started, you talked about emm you presented your, did a presentation to a group of family
677		therapists (nnh) and then you find them, they responded a bit defensive (nnh) and I was thinking
678		about err. I might hear you wrong. But I heard you, something about, can we talk about race, ethnicity
679		and culture together. Is that what I heard? So that's why I have this big red mark. YES I would like to
680		elaborate that. So have you got more thoughts since then, you know?
681	P 6	I think I was really surprised, Charlotte about the experience. Because I had yeah, it felt like a real

682		miss match. This is so strange, almost like people got the perception that I didn't like this family or
683		that, it is a kind of us and them. Yeah, either or thing created WOW↑. How did that happen?
684	R	You mean they felt that you are criticising this family that you are presenting.
685	P 6	Yeah,
686	R	What was your intention when you share your piece of work, chosing that family?
687	P 6	And I felt a bit exposed you know. Because I am sharing this clinical work and I brought it. My intent
688		err was to really, (inaudible) the challenges of working and talking about culture, in any family (nhh).
689		And to not, do the what I think is the stereotypical emm, you know err visible difference type of idea
690		(yeah) emm, so I really want to highlight that. Both are important and that actually this family
691		presented a lot of challenges. And a lot of people's assumption might be that perhaps we are quite
692		similar, which in some ways you know, have some similarities emm but, yeah. Emm (so, yeah) just,
693		just, how to, really goes back to that something I said at the beginning in my interest of, of making
694		the explicit, the implicit. Emm, in order to use it, not just for the sake of it, its not about exposing
695		people, or:: or:: opening things up for the sake of it. It's really like what might be emm (P6 tutted)
696		making this piece of work difficult and how can we really you know unpick it and look at it.
697		Yeah and it felt, as I said like, they thought I was being, its like isomorphic thing, you know. They
698		thought I was being critical of the family. I felt they ended up criticising me (P6 laughed loudly). Wow.
699	R	That's really helpful to think about because you know, whats go on, after getting understanding of
700		how family therapist's work. But also, how do we bring about the challenge of talking about culture.
(1.24) 701	P 6	Nnn, I have seen it. I think I have seen it in other situation where someone bring something clinically
702		and it does feel like people are asking a lot of question, feel like they are really questioning why
703		someone did that, in a bit of critical way (nhh). And I don't know, when someone is bringing their
704		work, is not that we must just :: not asking any question or whatever. I think we have to be a bit
705		sensitive to yeah.
706	R	To whoever presenting.

707	P 6	Yeah, and think that they (P6 laughed) hopefully they have done pretty good job. Done their best,
708		they are not bringing it to emm (P6 hissed) asked for critique of it. I didn't go there, to say that I
709		shouldn't be questioned. I am not saying that. But it felt like there is a mismatch. I been very open
710		about some of the challenges of this. Yeah, I.
711	R	Was it talk about the emotions in the room when you were :: doing that presentation
712		with each other? Or
713	P 6	Did we talk about the emotions in the family or the emotions that were
714	R	Emotions in the room, like you did a presentation, there was er (NO) something happen in the
715		room in the presentation?
716	P 6	NO, we didn't. And I er, I was in two minds about it. I thought should I say something about
717		(yeah, yeah) how that felt for me. And then I felt a bit exposed, no I just need to give it time to go
718		away and think about it.
719	R	Yeah, yeah.
720	P 6	Nn, I thought no, rather than I didn't want to just yeah.
721	R	Yeah.
722	P 6	Launch into it, so to speak.
723	R	That's really helpful (P6' name). Emm explain and elaborate that a little bit more. I think this is very
724		important. Okay then, I am going to stop because it gone over eleven thirty. So perhaps, you can
725		enjoy your weekend. Is it okay, if we meet again next Sat 10oclock.
726	P 6	Pretty sure that time is fine. Emm, I double check while you are here.
727	R	If not, we can find another time.
728	P 6	No, no. that's fine. The 8th, that's cool Charlotte. Put it in my calender.
729	R	Lovely. So thank you for everything and have a nice weekend.
730	P 6	You too. Have a good weekend and see you next week.
731	R	Bye.
732		
733		Transcript 6b (Interview continued a week later)
734	R	Okay, so all the machines are, seems to be working, with flash lights. Okay, where were we. Emm,
735		first of all you know, are there anything from last time you like to pick up before we go any further?

736	P 6	No, no, er that's fine. I am, I am happy to see what the next questions are and if there are anything
737		at the end, go back to it yeah. Nothing I felt compel (okay) to go back to, thank you.
738	R	Thank you, so err the question I have in mind is like, to continue from last time is like, can you
739		think of a time when race, ethnicity, cultural issue err might be hindering your work with the family
740		with ED issues?
741	P 6	(.2) (P6 tutted) Emm, (.8) I am sure there are in terms of, I am thinking about, I am trying to think
742		some specific formulations whereby when we did emm, when we were looking at the family is like
743		yeah, barriers. I am trying to be more specific, thinking about my own cases rather than the teams.
744		Emm, (.2) yeah, I am trying to start with the last year and work backwards (.4) and I was also trying
745		to think whether or not the family would see it like that, whether there are any examples, so you
746		know the example I use last time with the white British family (nnh). Emm, yeah that's the one
747		that comes to mind the most to be honest. Emm, the most strongly. Emm, and then if I ask my own
748		question again. Would the family have seen it like that then? I don't think so, I think emm yeah.
749	R	Why do you think this family come into the mind more? In terms of race, ethnicity and cultural issues.
(2.38)750	P 6	(P6 hissed) I think its to do with the embedded of their beliefs and ways of doing things that they
751		found very hard to examine or be question about.
752	R	Okay.
753	P 6	Yeah, I think that's why. Emm :: yeah because the other I can't, I am struggling to think about other
754		example that would stand out .hhh as thinking about .hhh where I would think that race, ethnicity and
755		culture had a big bearing on the, on their ED treatment, I mean of course it will always play some
756		part. I am not saying that but in terms of being err, .hhh difficulty or barrier or err, emm, yeah :: big
757		factor. Emm, (. 8)
758	R	So, in some way I was thinking about, may be the issues that you mention about, this family might
759		happen in any family, that may not have race, ethnicity, cultural issues?
760	P 6	Yeah, they, they might because I mean I guess what I was thinking of, in terms of the most
761		challenging families, is ::: hard to :: with other families link it specifically to race, ethnicity and

762		culture (nnh). In terms of the difficulty of engaging, of trusting, the emm, approach that we are using. Emm, yeah (.4) I am
763		just laughing because I am actually thinking that, er thinking of the last (P6 hissed). The family, the
764		couple where they haven't wanted to work with me. Emm, have, have been white British (P6 laughed)
765		So I can't you know actually recall emm:: yeah other families where, of course there is, there are often
766		the difficulties of being slow to get the weight restoration going, and you know, as I said. The belief
(5.01)767		in the emm, you know the treatment approach and yeah. Emm, that often links to things like
768		relationship to help, it could be stuff around. Emm, yeah professional identity. Emm, shames and
769		stigma, those kinds of things (nnh). I can't say that I would have, that I can make err , as, as specific
770		link to race, ethnicity and culture with those factors. Emm, so only for my examples. I would say they
771		are the more common factors. As I say, shame, stigma, perhaps the professional identity, kind of
772		family identity emm, I would say the theme is more around those kinds of things. And well, we will
773		do what we want to do (P6 laughed). Nnnh, lack of trust, I would say they are really big themes, in
774		terms of being difficult to do the work (Yes). Yes, I was thinking of a family who, (P6 clear her throat),
775		excuse me, in effect fired me last year. And, I think it was last year, emm, after me working with them
776		for a while. And emm, they were white, white British family, and I say that there were lots of issues
777		that I just mention in terms of the engagement. In terms of (nnh) ability to do the work. I ↑work
778		with them for quite a while. And then emm, I was deported. I think you know that, do you know
779		that happened to me?
780	R	Err, no. I am not aware of.
781	P6	Yeah, in 2018. I was deported. So, I won't go into the whole detail. But it was very sudden and you
782		know I had to leave my job, everything at work blah blah blah. And I was due to be away for a year, and in the end
783		it wasn't as long. But it was, you can imagine the upheaval. So I came back, and err one of the family
784		I remember, emm (P6 tutted) the mother, this is where they, they fired me. You know, the mother
785		was really vicious. She said to me, OH, emm you make things worse by coming back. She said to me.
786		(Ohh) Yeah, so its like, yeah↓. So she really, I mean I think that's err, themes with err, not all. Some families

787		were, they were very personal. You know, they don't like, they are unhappy because of the work is
(7.38)788		not progressing and then they kind of, yeah ↑turn on the therapist. I mean I had seen it with
789		colleagues, other experienced it myself (nnh). And, so I am not saying that is, in itself er the whole
790		theme. I am just saying that emm, the dissatisfaction is what I am picking up on, which could happen
791		to me or other people. That dissatisfaction, as I said is often about. Emm, actually from my perspective,
792		be the families emm, difficulties with reflecting, on, on their part and things (nnh). And in terms of,
793		beliefs maintaining factors, those kinds of things that, because the blame and, and shame, stigma emm
794		are so strong (yeah). It feels like they kind of (P6 laughed) keep us in arms length, and they don't, you
795		know, they often want a very individual emm solution. They said yep, yep, we will do the
796		family based treatment, but they are really hoping for the child, the young person to, to turn it around.
797		(yeah). And so they might come to the sessions and they say yep yep. But they don't REALLY kind of
798		see (P6 clear her throat) if you like, what their part is, in changing things, for lots of different reasons.
799		And I wouldn't say that I could identify (P6 tutted) links specificly with race, emm ethnicity and
800		culture. But that's why with my family that I spoke about last time. That it was quite cultural (nnh),
801		in terms of those family culture and intergenerational beliefs about. Because there were lots of
(9.10)802		stuff, about achievement, high achievement and that be the highest context. And emm, not talking,
803		not much communication and they would say they were close. But, you know the interpersonal
804		stuff you could see that quite, for me is stilted (nnh) emm very difficult
805	R	So, so that got me think about, I mean if it is
806		okay can I ask about the meaning of you mention deport. So my assumption is like, you need to
807		have a working visa to work in this country (yeah, yeah) and, and did the family know that you,
808		how do they understand your absence?
809	P6	So I ask my colleague to say that, yeah, to do with immigration issues. I didn't go into (yeah) detail
810		because it was really difficult, because it was really difficult because it was like, I don't want them to
811		think that I died or something terrible has happened (yeah, yeah). I don't (P6 clear her throat), don't

812		want to go into all the details of it. But then, on the other hand, yeah people might make up, you know
813		filling the gap (story), so yeah, and some people might be very unsympathetic and (P6 laughed),
814		and be annoyed about it. You, you never, you just don't know, you can't assume anything. So yeah,
815		it was interesting emm.
816		So they just happy with the explanation of immigration issue? [Without further wanting to know
817	P 6	[Yeah, I think. I think I said. So they
818		would have known that was something to do with visa. They wouldn't know the whole, it was
819		deportation or you know. They didn't, they didn't know everything obviously because I went
820		through emm, that yeah. There would be, obviously they were aware that was very sudden.
821		Because one minute I was there, next minute I wasn't. Emm so
822	R	Yes, yeah, it must be horrific for you.
823	P 6	Oh, it was. It was just yep, yep.
824	R	So I was just thinking about did that anything change, I know they fired you but I am just thinking
825		when you come back. Did any change emm, you know the story that you might carry or the story
826		that they might carry about your absence period? I know there is an explanation on the front.
827	P 6	Yeah, I know I don't, I don't know how much the factor that was. Emm, I think they were already
828		building dissatisfaction. And it was kind of like you know. Yeah, another thing. Emm, because it
829		didn't happen immediately. It was may be, I don't know. Err, five months after that. I think it was.
830	R	All right, okay.
831	P 6	Certainly not immediate but it was emm. Things were becoming difficult, the girl, I actually didn't
832		think that. Because after a while, I started to change my formulation. I thought nnn, I think this is
833		actually more emotional regulation stuff. She was quite young, like thirteen (nnh), and err you know there was
834		stuff like, she would vomit and leave it in, on the carpert you know. She vomit on, leave piles on the
835		carpet or :: in bags and stuff. And there was, was stuff about her presentation that I thought that
836		it looks like an eating disorder but I don't think it is quite as cut and dry as that actually (nnh). It is
837		complicated, so she had inpatient admission and I was part of that. And, and it was during the

838		inpatient admission. She er, that they said oh we don't want you involve (nnh, nnh). And there was,
839		I mean there were a lot of parental stuff, turn out the mother was drinking, middle class family.
840		Mother was drinking and I think there were quite a lot of discord between parents that, yeah was
841		there. But then, as often happens they will then unite (P6 clear her throat) against the professionals
842		type of things. So although the parent were quite emm yeah , desperate in another ways. They
843		would then, have a go at professionals, certainly as I said, it wasn't just me. I just happen to be the
844		care coordinator because once when we went to the paediatric ward. Another colleague from emm,
845		the crisis team and I went, err the parents were really yeah, had a go at us. So emm (nnh) yeah.
856		But , that's why I say I am configured the meaning of help, and being in services and their frustration.
847		And emm :: all the things that went along with that are actually parents. For what I could see,
848		the parents really didn't make changes themselves. There were lot of the aspects of what I mention,
849		they were expecting the child to change and (nnh) actually they didn't. In a way, they didn't, that
850		they didn't really properly follow what we ask them to do (P6 laughed) (Nnh) in terms of, emm
851		family base treatment because the young person came back (nnh). ↑On no, I was just eating on my
852		own and left to my own devices and stuff. Its like, so yeah. Then they kind of complaint that it
853		wasn't working. So, .hhh, yeah. They are pretty harsh because they, they also said that I think,
854		when they, when I finish with them, that something like, ehh my therapy wasn't any good or .hhh
855		you know. Basicly, they said I was useless, you know. There is a way of (nnh) like, just completely dismissing me.
856	R	Quite angry and attacking.
857	P6	YEAH, ↑yeah, as if I didn't have a clue what I was doing, like that was how it kind of came across
858		(nnh) so yeah (nnh) it didn't, yeah ↓so . I ↑mean she still in the service, of course. They still limping >
859		along. So (P6 laughed) no one got a quick :: you know (no, no) solution.
(15.07)860	R	.hhh, so if I may just go back to like last time when we met the first time. You mention about err this
861		invisible difference between yourself and people, your families (nnh) even in professional group that,
862		correct me, how do you, describe your own ethnicity or..

863	P 6	So I said that I am mix race, but I have white privilege because don't SEE that I am mix race. Although
864		very few people do (nnh). Emm, and even when I might open these status. I think because of the way
865		I look. I think some people still don't really kind of :: I think they struggle to see err what that mean
866		or what difference that I might make (nnh). So they would say thing
867	R	In the room you will :: invite, or kind of stating your own:: positions.
868	P 6	With families or professionals?
869	R	With families, one at a time you know like err with families first?
870	P 6	Yeah, no. Its sometimes it comes up and its not something I would always state. I mean (nnh)
871		occassionally people asked about my name :: or:: emm stuff like that. And sometimes it comes up.
872		But its is not something I would always say err, yeah. I am from (country) and I am (people of that country) or yeah.
873	R	Nnh, so that raise the question of what would you make it raise it then? It doesn't normally come up
874		and when will be the time it will come up?
875	P 6	And (.6) I think possibly if the conversation came up about being from (country). Or emm, may
876		be cultural values (nnh). Emm, I may say something about that, because yeah, providing an
877		explanation for why I do something or emm. Yeah. And even then, not always, so for example you know if I ending
878		a piece of work. This is not unique to me, but emm, I might say something about what I learn from
879		the family or there will be an element of reciprocity. I might try and bring in, or that might happen
880		during the work (nnh). That's a very strong cultural value, from emm, because when I worked in
881		culturally specific services. Emm, like (name of the service) in (country). The expectation there is that
882		you, err say where you are from (P6 laughed) you have to be explicit about that(nhh). Because, that
883		(ethnic name) families aren't going to tell you about themselves without knowing, without knowing a bit about ↑you (Yes, yeah).
884		That's the expectation (nnh) so a bit of power sharing exercise really. Emm, one of the reasons I
885		don't do it with families in the UK, is that I think that some people aren't really, they kind of want
886		that distance (nnh). (P6 laughed) don't really want to yeah, hear about you or. They were just a kind of want
887		to get on with it. So, yeah. That's that's, you know one of the, I think its not err realistic or helpful

888		to just kind of transplant that practice, thats normal (nnh) in that context to hear because I think it
889		just wouldn't fit, people would think OH. Why we are talking about her, we are here to talk about
890		↑ME. Emm, whereas that's very much, just expectant the (ethnic) context, emm Yeah. That's all
891		sort of things about confidentiality and trust, and you know. Whereas I think, in the UK, in this
892		context, its very much people have the professional confidentiality umbrella. Its like that, like a, very widely accepted, you
893		know, taking it as given (nnh). Emm, you know when I mention working with the Urdu speaking
894		family, and with the interpreter. I mean that obviously we talked about confidentiality then, because
895		the interpreter was, was emm clear that she doesn't cross over with them. But, she made it, she was,
896		she and I spoke about it, and then she said that to the family in terms of really, reinforcing their
897		confidentiality. So I think where there is that question, that might come up when it's a smaller
898		community, that's certainly something I would always address.
899	R	You respond to it when its there?
900	P 6	Yeah.
901	R	Okay, so emm if I may change and get to the next question, is to wondering, can you tell me a time
902		when you manage risk in your work?
903	P 6	Oh, emm, recent one or?
904	R	Anytime, things that you remember obviously, manage risk in relation to race, ethnicity and
905		cultural issues?
906	P 6	I know we spoke last time about the boy who was emm Sikh family (yeah) and err the family didn't want
907		him admitted. Emm yet, I think that's yeah. That's I think, felt that their desire to, to, and it felt like
(20.5)908		they needed to fix things themselves. And they didn't want him to, yeah, handed over. Because he
909		is quite young for his age as well. He emotionally not very mature. Emm, so I think that, kind of fear
910		and worry about him being in an inpatient unit was about what's going to be like for him (nnh). We
911		are not going to be there as parents. I felt that was a real factor in there. Yeah. LOOK, might
912		look like ambivalent on their part, because obviously the situation was quite con, well was very
913		concerning. We were like, wow this isn't yeah. And this is before our services change, now we have

914		a much better interface with paediatric. At that time, it was much less integrated. And now we had
915		a consultant paediatrician half a day with us in our team. Emm, that makes huge huge difference (nnh)
916		in terms of making those links, whereas emm, I know that when this situation happened you know. My
917		psychiatry consultant colleague contacted the hospital and we make arrangement for him to go.
918		But, it was all very disjointed, compared to what it is now (nnh). So I think it felt like a battle with the
919		parent, and I didn't want it to be a battle. And they were like, yeah the mum. I spoke to the mum, then the
920		Dad call me. And they were like, trying to argue against why he shouldn't be admitted (P6 laughed)
921		and as I said we were getting to the point. We were thinking well, GOSH, we might have to use the
922		mental health act. Emm, so yeah it was interesting that using the emotion and, what I felt that was
923		what was happening. A kind of and, and appeal, like a very personal appeal to me at that time. That
924		was what it felt like. Emm, (nnh) they thought it would be the best. They tried, so emm yeah. I felt
925		that that's, it, you know they, they didn't think, may be not as deeply about it at the time. Obviously,
926		I do think about it quite a bit. Because it was quite a fraud situation. But emm, in terms of you
927		know culture, ethnicity, I think there was. Emm, yeah trying to emm (.2). I think it's a different kind
928		of emm, think it is not that they thought of me as a profession. But something quite kind of quite
929		personal about it, I think. And not in a bad way, I am not saying that. They were feeling desperate, that was clear. I think they
930		thought the only way they could kind of influence things was by, yeah, being using it. Well I am not
931		saying they were deliberately using emotion. But it was what it felt like. Its very much, getting into
932		this, emm, yeah. Emotional way of talking, trying to get things done. So, yeah, that's the one that it
933		stands out, I mean.
934	R	I was just thinking about, has it been a time that you ::well professional would describe as take a
935		child home. Obviously, you are not you know, but in your mind that you may be taking a child
936		home (nnh).Err, is there somebody ring the bell?
937	P6	(.4) (P6 hissed) emmm (.4) yeah, there was a girl who I thought who was going to die (nnh) yeah, who
938		was in the service from about age 11or 12 to 18. And although she only had one inpatient admission.

939		She had emm, she attended emm, day programme at emm :: GOSH. Emm, so yeah :: she was
940		someone I worry about a lot (.) And I think what happen is, one of my ex-patient died, committed
941		suicide and:: and she had an eating, again haa , been treated for an eating disorder but actually it
942		was more in the realm of emotional wreck (nnh), so :: she ended up emm, they fired me, God
943		sounds like I, I, (P6 laughed) can't work with anyone (P6 laugh continued).
944	R	And you are not, because you know like we are doing problem talk perhaps.
945	P 6	Yeah, and also is like I work with the most complex families, so you know its, its going to happen
946		(P6 laughed again) So, any way the, the .hhh the family where the young woman died, who committed
947		suicide. They fired me, I mean they were incredibly (P6 tutted) emm, complicated. The point being
948		that happened and then it, it make me feel very unsettled. So then I started to think about my other
949		patient and whether or not she would live. I didn't think she would kill, kill herself. And emm my ex-patient the
950		one who killed herself, I mean she killed herself on a ward, you know. So like (nnh), .hhh how often
951		does that happen. Emm, she was really, really unwell and the parents were very attacking and awful. Emm,
952		so started to think about my other long term patients. That, oh Gosh, where is she, she is just not,
953		started to feel very hopeless and, emm a kind of like, ↓oh what's going to happen. And I share with
954		the team, and I spoke about it. I took it to you know like supervision and stuff. It was useful, emm
955		in the end, I mean she, I don't know whats happen now. But, we actually discharge her after she
956		turn eighteen. And she turn a ↑corner, it was unbelievable (nnh). I never, yeah, I thought she just, she
957		been so unwell for so long. And I just thought this is not going to happen. ↑YOU know like she
958		fractured her .hhh (P6 hissed) err tibia from, you know because she been exercising and. I mean
959		she had yeah, wasn't that her weight, the height was :: or it was chronicly you know (nnh). That was,
960		that was the issue. Emm (nnh) such a low, and I think she had a, she finally had a period around
961		late age 16 or 17 or something. And then, went back to having to having an amenorrhoea because
962		I think she couldn't tolerate what that meant. Emm, so yeah, she is someone who, throw, definitely
963		occupy my mind for :: a long time.

964	R	How do you think worrying about her life and death you know, you know the issue you just
(28.0)965		mention, err has on your reflexivity?
966	P6	(P6 tutted). It was emm (.4) it was an odd kind of place to be. Because I was trying not to just to
967		brush this off. And go well, you know, don't think about it or emm, because that is not going to be helpful. I am
968		trying to put it into perspective. So I think going back to your question, I think it (nnh), quite hard to do,
969		which is why I, emm, yeah. I needed to talk to other people about it, because it felt like. Reflexivity only
970		got so far. It just felt like it was like, may be back and forth (P6 laughed) back and forth (yes). And perhaps
971		harder to think of anything. Emm different, I didn't feel. And the situation is not that I :: family were
972		very :: er nn :: cooperative. Emm, there wasn't an issue there, that they worked. They had no err criticism or
973		complaint about what we done. Emm, there wasn't that element in this situation. Emm, it wasn't that
974		I thought OH I am solely responsible. I didn't feel that. I didn't feel oh, I will fail, you know, haven't done
975		a good job or I didn't have any of those kind of, emm, not that I remember anyway (nnh). That was
976		the dominant, which was more this kind of hopelessness and this, what we have done, we have done
977		(P6 laughed) as much as we can. And what more can we do and it, as I said the hopelessness, I think
978		was very. I think that was where I in terms of reflexivity, I was like OH::, how much of this, is relating
979		to this death and the other patient (nnh). And would I be feeling this. Yeah, worry about it. Emm, if
980		that hadn't happen, so that's why I was grabbling with, emm and why yeah, I spoke to others about it and,
981		emm I think try to err, yeah SEEK outside input as much as possible (nnh). For everybody (nnh), we
982		did a :: emm, I don't know, at away day we did a slot on discharge. And I use couple of cases as
983		an example, she is one of them to, see if we could kind of generate multi-disciplinary ideas to help
984		each other (nnh, nhh), yeah, >to think about those really complex cases where everyone is kind of
985		thrown everything out, at so the speak, yeah.
986	R	Are there any race, ethnicity component, and cultural component to, to this girl that you talked
987		about, described?
988	P6	No, I think the:: umm, yeah:: I think the emm (.2)
989	R	Not that you have to.

990	P 6	No, no. I don't, I think it is more of question of un undiagnosed ASD, was more of a factor there (okay).
		Emm, but I have thought of another family and it is interesting that I have, I thinking oh, am I
(31.2) 992		avoiding talking about them, where I am thinking gosh. This again a very long term piece of work that I haven't,
993		emm, yeah. I am a kind of push to the back of my mind where mum is Chinese, mainland China (nhh)
994		and Dad is white British. And the, yeah I think suddenly in the family there were, the daughters
995		certainly, the DAUGH TERS, this is my patient and then she got an older sister. They both felt that
996		there were culturally issues, in terms of the mum's err (nnh) (P6 hissed) reluctant to consider ehh
997		autistic spectrum disorder diagnosis (nnh). So I didn't work from the family from the outset. But I
998		think, yeah there was very difficult engagement with the service. And I think some of that was, was a
999		service issues as well, to be fair. Not putting it all on the family, I think there were things could have
1000		been better from our end. But I think, emm, yeah, certainly when I did, a kind of more phrase three
1001		work with them. Emm, family therapy sessions, I think there was a lot of avoidance around the
1002		diagnosis. The stigma of, of autistic spectrum disorder. So they could kind of tolerate the eating
1003		disorder diagnosis but the older daughter. Emm, said specificly oh, you know this is because mum you know.
1004		Mum's family and you know, mum's background. They don't really, you know emm, emm believe as
1005		much in diagnosis, although they don't like that, they find it stigmatising, and they want to avoid it.
1006		And, so there was quite strong, quite a strong narrative. Emm, you know we spoke about it. Mum,
1007		mum did not agree. She is like very, err professionally, she is a professor in, emm (P6 tutted) you
1008		know in science round, a quite a prestige university. So yeah, she didn't see it like that. But you
1009		know, the family (P6 laughed) the daughter raised it. She just didn't, didn't want to go there interestingly.
1010	R	And the father?
1011	P 6	He was quite avoidance as well. And they are divorced, emm they did work together very well.
1012		So that wasn't err, that was good. I had both parents involved, but err, yeah he was a bit like. So
1013		although again culturally they were coming from very different background. The commonality
1014		there was still this element of avoidance and denial about the daughter's ASD diagnosis. They didn't

1015		want it, they didn't want it.
1016	R	Nnn, and they are okay with the eating disorder?
1017	P 6	Interestingly yeah, yeah. So. So.
1018	R	In terms of risk, are there any risk in this family, this mix race family?
1019	P 6	Are they recent?
1020	R	Are there any risk?
1021	P 6	Oh, risk, sorry. Emm, there were for a long time, I became involved emm, after emm she had her
1022		inpatient admission. I mean AGAIN, she probably like the second longest patient we ever had (P6
1023		laughed), so yeah, there were. There were risks, I mean I had to do, you know paediatric review.
1024		Because she had amenorrhoea forever and a day. So you know, we did dexa scans and all of that.
1025		Emm ultra sound (nnh) and endocrinology referral and all the rest of it. And actually she ended up,
1026		emm making progress and, and starting her period, restarting her, I should say, her period. But, there,
1027		the risks were physical risk, there was risk around she was self-harming as well. Emm, so my
1028		formulation of her was that. She have the eating disorder but she also had emm, on the autistic
1029		spectrum and there was emotional regulation, quite a mix bag.
1030	R	Nn, so how do you manage like all the risks that you need to manage? And the sort of like therapeutic
1031		aspect or I just thinking about how the kind of this like influence reflexivity and the whole process?
1032		doing everything.
1033	P 6	Emm, I think it varies. I think sometimes there will be a medic involved. So emm, some of it would
1034		be joint and sometimes the discussion that need to take place. And then some of it, I will follow up
1035		myself. I, I guess in my mind, I emm, yeah. I can figure it. I think about different strands, under one
1036		umbrella if you like, probably the best way of putting it. Emm, each need to be address (P6 laughed)
1037		and sometimes, you know some come to the fore more than others. So its making sure that, you,
1038		know that there is a all, those aspects of all being discussed and, its make clear to the family, that
1039		this needs to happen and these bits. You know, something like take president emm, temporary but
1040		in general it, it all needs to be thought about (nnh, nnh). Emm, yeah. It is where can put it.
1041	R	Emm, if I just carry on, asking the last question is like. Can you tell me the dominant about race,

1042		ethnicity and culture you hold professionally? [For eating disorder
1043	P 6	[Dominant discourse that I hold professionally?
1044	R	Yeah
1045	P 6	(.4) Probably goes back to some of the stuff that I said last :: time was that, I think its really central.
1046		It is very, organising because people's belief which is a lot of what we are, emm, working with
1047		(P6 laughed). Absolutely TIE in to their experiences (nnh). Emm, in the, you know in the role, in their identity of you know their
1048		ethnicity. Emm, their culture, I think emm, I see that the task as differentiating whether or not,
1049		the beliefs err support or hinder (P6 laughed) the recovery and I wouldn't assume anything either way.
1050		So I see that as part of the task really, to, to try and understand families, where the families coming
1051		from. And (nnh) how much those beliefs. Emm yeah. Act in a ways that influence emm, the family
1052		and their way of doing things, in way that might be helpful or might be you know barriers. So, emm.
1053	R	Do you think that it has evolves since you enter ehh eating disorder field or?
1054	P 6	My narrative?
1055	R	Yeah, your discourse about beliefs
1056	P 6	Was my discourse (.2) emm :: I am sure it has, emm (.12, long pause) I think probably emm:: this
1057		might not be immediate answering the question about evolution. Emm, possibly connect with what
1058		I said before the different strands and how I might see them (nnh). So I think over time, emm, as a
1059		clinician, as a practitioner. Emm, (.4) I think I am more, probably more confident about emm, rather
1060		than kind of going through, say we, if we think about, if we think about social graces, rather than
1061		kind of going, going through everything systematically (P6 laughed) and try and looking for, it is like
1062		noticing what stands out, and then at some point going. But have you miss other err other aspect,
1063		that are important in terms of about, thinking about the families functioning, in terms of thinking
1064		about their experience. The influences, you know influences of the past on the here and now. And some
1065		of those might be religion, gender, you know geography and and, a merit of things. Emm, so I think,
1066		obviously with the genogram. You know, that’s a place. Emm when I do a genogram, emm, that
1067		would be a place to, initially explores some of those emm, those aspects you know social graces.

1068		But particularly ethnicity, culture and race, yeah identity. So because within that, you start to get
1069		stuff around you know immigration, generations, continuity, beliefs, emm, yeah, family identities, difference
1070		between the generations and in terms of, yeah cultural practices, religious practices (nnh). And
1071		things that have been point of continuity, or things as I said that may have changed between the
1072		generations. So yeah in terms of my narrative, emm, yes probably the best way I can describes it.
1073		Emm, I haven't thought about it before specifically as that. So, emm (R cough) yeah, evolution,
1074		changes over time in terms of my emm, way of looking at it. How I explain, and how I understand it,
1075		how I use it and practice, and (.2.). Emm I think, I think it is interesting because I am thinking of my own practice.
1076		But then of course, I :: as I said I do a lot of supervision, other things, so then that would be emm (.2)
1077		be other area where that's another, you know, although I said the team might say, OH there are
1078		cultural issues, is like a kind of default position. So it can happen the opposite way as well, in that
1079		the family aren't (P6 tutted) sorry the team, or clinician aren't always, perhaps thinking about
1080		this specific, always thinking about this specific of the family in terms of their identity and those (nnh)
1081		those aspects, so yeah. I will say, are they religious, you know > oh I don't know or sometimes its like
1082		err information that I would see that as BASIC. Its not necessarily yeah differentiated.↑ I think
1083		you know, people of course would emm, err KNOW something about the ethnicity of the family. But,
1084		I don't know if it always explore in terms of the meaning of it for the family (nhh). I think there was
1085		an example recently. Emm, (P6 tutted) I wasn't, wasn't ethnicity but it was religion, someone said i
1086		didn't know about emm (P6 tutted) you know this, this branch of Mormonism and you know. I took
1087		it up and I said that do you know that, that actually what the family (P6 laughed) the family actually
1088		subscribed to all of these things that has said on wikipedia. Like ↑YES :: nn you know that, that's,
1089		but but this is not (P6 laughed) so that's interesting that err, yeah. I guess perhaps thats emm, yeah.
1090		I am repeating myself. I think it, as I said exploring the meaning for that family more individually.
1091		Not just assuming.
1092	R	Rather than stereotyping from some information written up.

1093	P 6	Yeah, yeah, that every Sikh family does x, y and z. Or that every yeah, Buddist family does yeah,yeah.
1094	R	.hhh okay, Can I ask you something about, err NICE guideline? Emm, can you tell me a situation
1095		where NICE guideline been helpful or constraining in race, ethnicity and cultural practice?
1096	P 6	GOSH.
1097	R	It's a big question, so you can (R laughed) slowly narrow it down. Thinking about NICE
1098		guideline to start with.
1099	P 6	Nnn (.4) yeah, I would say that my team. Err the team I work in err (.2) pretty em :: (.4) pay attention
1100		to evidence base practice. Emm, say that. Its starting point, so em, yeah. I think, I am going to think
1101		about it more generally, and then trying narrow it down to .hhh, race, ethnicity and culture. Emm,
1102		because like all teams, we have the, the discussion is to okay, is this not working because we are not,
1103		you know, there is not enough fidelity to the model. Or is it, this is not working because it doesn't fit
1104		for the family. (P6 laughed) (yeah) Emm, so I think that's the kind of scenario, evokes for me think
1105		about NICE guidance and you know, that, that family base treatment. Emm, we often be the, you
1106		know, the first point of call for working with (nnh) diagnosis of anorexia. So emm, yeah. Its harder to
1107		relate to more specifically to race, ethnicity and culture. I think that yeah, some families, just, just yeah.
1108		SAY they are sign up to the approach. Emm, and then emm, it is pretty obvious that they just can't
1109		really do it so the speak (P6 laughed) (nnh). Emm, either they find it intolerable because they, they
1110		fear that the relationship with the emm, you know with their child is, emm (P6 tutted) compromise
1111		too much. Emm, that it was too difficult, it was too fraud to have to take that position of, of being
1112		firm and yeah. And they find that, the child's, ↑I DON'T you know the child might be attacking or
1113		upset you know, could be either scenario really and it is just, as I said intolerable for them. So, (nnh)
1114		emm I am, I am using that as an example because I think that's a common scenario and it goes back
1115		to the question of, you know NICE, what NICE would say, what we would try and start with, where
1116		it might not work and then we will be in the position of going well. Okay, what next (P6 laughed).,
1117		Emm so yeah, in, certainly in my team what I would be thinking about then. Because we are talking

1118		about phrase one engagement is you know, is that someone brings that scenario of, of I have that scenario
1119		and we bring it for team discussion, will be thinking about things like emm, you know sharing
1120		formulation with the family (R coughed) and really joining to join emm, the family. Emm, at that
1121		stage, keep joining to join to see if anybody, emm you know, this is how we see it. This is the direction
1122		we want to go and then why, you know. I mean we wouldn't, obviously kind of quote NICE, throw
1123		that in their face but we would talk about evidence base and why we were. Emm, you know, and
1124		using our clinical judgement, putting that in there why we want to, you know pursue that avenue,
1125		so the speak. Emm, so (R coughed). What was the, was it emm, using NICE in relation to,
1126		or was the interface between race, ethnicity and culture and NICE.
1127	R	Yeh, situation where NICE guideline been helpful or constraining, both and, in (R coughed)
1128		in the practice of race, ethnicity and culture.
1129	P 6	It is a difficult one because emm, if I think about the family where the mum is Chinese and the Dad
1130		white British. Emm, you know I might think theoretically she is a scientist. She is going to want, you
1131		know, ehh could look like evidence based, err I can use (P6 laughed) use (P6 continue laughing)
1132		NICE as a kind of ally. But it didn't work like that of course. (R coughed) so yeah.
1133	R	It is a kind of NICE, doesn't fit with the family which you mention?
1134	P 6	Yeah, but I don't think that is just about race, ethnicity and culture (nnh) that would be how I would.
1135		I think it was very hard to (R clear her throat) make that link specifically because I can think of a
1136		number of families where that's you know, being the case and I think its more you know, comes
1137		down to the fact that I said earlier about, relationship to help and beliefs (nnh) and stigma and all of that.
1138		So, I find it harder to relate that specifically to race, ethnicity and culture (nhh). Culture may be, I think
1139		there is a kind of family culture, but emm, yeah, and then you know I gave the example of the Sikh
1140		family and I, my sense, my:: yeah, the way I saw that in terms of emm, their wish to have their child at home.
1141		And may be their sense of emm, worry about failure and duty and those things. But emm, I think
1142		that was link to ethnicity and race, and culture and in a way. Emm, they are not the only family

1143		where that would be an issue (P6 laughed). Emm, I would relate that to, yeah. That, other people's
1144		family culture. So (nnh), emm, I find it hard to emm, (.2) yeah make that, make that more specific
1145		link I have to say. Emm, (.4) (R clear her throat).
1146	R	I am hearing sometimes like, sometimes it fit the model, some family don't.
1147	P 6	Yeah, yeah, yeah. I think that's part of the skill is, is recognising that, and recognising when to
1148		persevere with adaptations or go in a different direction. And that, there is that really difficult
1149		balance of, have we done ENOUGH? (nnh) Emm, have we tried hard enough? This is fidelity to the model or
1150		whatever, or .hhh yeah. Or is it that you need to adapt the version of it. Because this is the, the
1151		other thing of course is like, being in no man's land (P6 laughed). What are we actually doing? Are
1152		we doing:: something that we think fix the family, but is not really FBT or it is not really,
1153		certainly not you know. Emm adolescent focus therapy, its not CBT-E. Its :: this :: err, the term
1154		we often use is you know, formulation driven treatment (nnh) then. You know, that's what you, it
1155		cause to come down to. So yo are trying to adapt, emm, to whatever that is, they are bringing. And
1156		you say okay, these models don't, don't fit at the moment. So we have to be in this kind of safe
1157		uncertainty position of where we go along, with this for a bit and obviously we would be doing the
1158		physical monitoring and stuff like that, trying to find err yeah a path so to speak (nnh, Yeah) so>.
1159	R	Emm, what about your team? Would they be sharing your view, if they hear what you just described?
1160	P 6	In terms of the NICE aspects
1161	R	[Yeah, NICE aspect, of like NICE guideline said ABC and, and I hearing you that
1162		you are sort of like adapt according to the family. (Yeah) I was just wondering what your team might
1163		say?
1164	P 6	I think the difference between us, is that emm, nnh I think more people within the team :: would
1165		want to:: emm, identify race, ethnicity and culture as a, as a emm::. You know, I talk about one of the many
1166		strands. But, I think they would see it as a kind of more <u>separate</u> aspect that they really have to think
1167		about. Emm, its not that I, as it say not that I don't think about it. But I think about it, I think about

1168		it as being very integrated (nnh), whereas I think that. I don't know, that's my fantasy that quite
1169		a few people within the team would go, would kind of revert to that. AH, okay there is visible
1170		difference, we need to think about race, ethnicity, culture. Emm, that it wouldn't really come into
1171		the view, into the frame so much for white British family for sure (nnh). I think it wouldn't be emm,
1172		seem as relevant as yeah.(R clear her throat). So yeah, I think that be that emphasis on, yeah, on
1173		visible difference or, if things aren't going so well and the, in the work. Then, I think people might
1174		question and there is emm, you know the family like Asian minority ethnic, ehh from black, Asian
1175		minority ethnic groups then they would stop, to kind of question it then, I think, so (R clear her
1176		throat) I think like a, yeah seen a bit differently. Emm,
(56.2)1177	R	How does your team response when you talk about invisible difference, in you know the whiteness,
1178		you know the construct of whitenss you know.
1179	P6	I think the team are, ehh open to that and seeing that. But I think they struggle generally to do it
1180		as much themselves (nnh) you might (R clear her throat) yeah, yeah, emm having said that. Emm :::,
1181		TEAM is relatively mixed. Emm :: that :: yeah. I still think there is that emm, default if you like (yeah).
1182	R	Because visible things is in front of you (R laughed)
1183	P6	Yeah, yeah. Seen as more tangible and therefore (concrete) give it attention, make sure its yeah.
1184	R	And you mention the, yourself you know like, although you are mix race have white privilege but its
1185		different (yeh) talking about emm (R clear her throat) as a very good example itself.
1186	P6	Yeah, yeah> yeah.
1187	R	And, so, then we need to think about the experience of this research (R clear her throat). Can you
1188		tell me about the experience of this interview?
(57.2)1189	P6	(P6 tutted), yeah, so I think emm, some of your questions are so specific. Emm, that I struggle to
1190		emm, yeah, there are things I haven't thought about. It, obviously, that specificly so. It was hard to,
1191		I didn't want to, I didn't want to just be blip and you know, make stuff up. Emm, you know, I had to
1192		like, really think in depth:: and for me, always comes back to examples. Because I am thinking of
1193		yeah, try, you know casting my mind back, was interesting actually, thinking about. One idea I had I thought

1194		oh, maybe would have been useful to prepare. I didn't want to over prepare, but then today I was
1195		thinking or maybe it would have been useful to like, go back over my caseload, to like really emm
1196		(P6 hissed) :: reconnect with some of the family. So, I am a kind of left behind a bit (nnh). Emm, so
1197		I notice, I thought gosh, that's interesting that I, you know I didn't even talk about the family, emm
1198		with the Chinese mum and the white British Dad. And that's partly because you know it was such
1199		an intense piece of work. Basicly I haven't seen them for about six months. I been trying to, what
1200		trying I have contacted them a few times .hhh, to say look, emm can we gets, think about discharge
1201		because we are not doing anything now. She is only on an antidepressant, my colleague has contacted the GP.
1202		And they will take it over and its interesting they haven't responded. Any they use to respond to
1203		me really promptly (P6 laughed) (nnh). I now, you know for me another sign, that's go like. We are
1204		not in their minds but I am not. They are not emm, in my mind much now either (nnh). Its interesting the
1205		way that people, a kind of some. I thought about it with, with her how. I thought ahh, now I really
1206		in, was challenging. There are times, I did not enjoy the work because she were like run, screaming
1207		from the room. And it was (P6 laughed) all sorts. You know, and in the end it got to, to a good place.
1208		So that's that kind of satisfaction. So yeah, the preparation was something I wonder about (nnh).
1209		I thought oh, wonder if that would. I think it would have made a difference but I was in two minds
1210		about it (nnh). Emm, so yeah. I think that was propably partly my desire to be ehh helpful. Because
1211		I kind of want to answer as many questions as possible. So that was my thing OH, perhaps that would
1212		have you know, help me, emm (P6 hissed) connect with those family more quickly (nnh). The one I
1213		was a kind of push to the back of my mind. I could have emm brought into the fore a bit more (nnh).
1214		Emm, but ahh something are certainly, well there is many things I will take away. I won't just process
1215		it in a flash. Emm, but I was thinking ahh, be quite, because I did the presentation emm to the team
1216		that I did, did at the AFT day. And about the family. Emm, it would be quite good to er ::: go back
1217		to my team and tell them about yeah the research. Emm, and some of the questions and what is.

1218		Yeah, race to million, and use it as a discussion. Emm, training yeah.
1219	R	So, that's very interesting. That can be an appendix to you know somewhere team use these
1220		questions in, and how they think about it yeah?
1221	P 6	Yeah, yeah, yeah. I think yeah that would be, emm yeah, ↑again a kind of assuming nothing. So I think it is
1222		really useful to emm have that you know. Space for the team to think in depth. Because they
1223		certainly use it when I emm, I did the, the previous session. It did generate a lot of discussions. So
1224		yeah. Good to go back I think.
(1.01)1225	R	And I was just thinking about the, the topic is around race, ethnicity and culture (nnh) and I am just
1226		thinking about what this is like to talk to me who have a different race, ethnicity and culture to yours?
1227	P 6	Emm (.2), I think what I would question more, because you are not white British is what would be
1228		like to speak with someone white British (nhh). Emm, so I guess what I am saying by that Charlotte,
1229		is that I think there is a bit of implicit (P6 hissed) emm bias that I have towards emm, people who
1230		aren't white British and assuming that they had experiences of emm, how do I put, no, something about. It's
1231		not just about the experiences, it is about the way that :: you might think because:: I think when ::
1232		for myself being a, kind of almost, well we said it, an invisible kind of minority ethnic person. It's
1233		like I think a lot of people wouldn't understand. Pretty lots, yeah lot of people, not not, wouldn't,
1234		wouldn't know, wouldn't understand that I am, often thinking about difference and about emm.
1235		And yeah, the impact of arr culture and ethnicity and emm (P6 hissed) race. In terms of err, people's
1236		experiences, identities emm so. Emm, yeah, what I think I am saying in that there is probably level of
1237		comfort if you like that, that brings for me that's the implicit bias. Does it make sense?
1238	R	Yes, the assumptions that
1239	P 6	Yeah, yeah, yeah.
1240	R	Or I might ??? Your mind
1241	P 6	yes, it is not that I think OH, we share exactly the same experiences or but I probably have a bias
1242		that it is like ahh. It is something that you will be tune into. That could be completely wrong but
1243		that's, that's I think that there (R clear her throat).
1244	R	Emm, plus the fact that I actually create a research on the subject.

1245	P 6	Yeah, yeah, yeah, so, for sure(nhh) emm.
(1.04)1246	R	So, can I also ask you about how does, can you tell me how this interview makes you feel about
1247		race, ethnicity, culture in your current practice?
1248	P 6	(.4) (P6 hissed). Emm I think it was (.2) you know because it brought, because of the clinical
1249		examples in bringing stuff really under the magnifying glass. Nnn, emm, yeah what I notice about that, emm ::,
1250		its my first bit and then what does it make me think about my practice, is er. Well er er, I think its
1251		really (.2) triggers even more :: desire to be err self-reflexive but not just that, to use it in the team
1252		context. In terms of the, emm that's why I am keen to, to you know to share the research questions
1253		and experience with the team to think about some of that. Emm, because yeah, the questioning
1254		process that :: yeah makes me go back to, err because when you said about how things have changed
1255		over time or you know, my narrative was like yeah. It's cons, it must be constantly evolving emm,
1256		I think it is, I just think its, that sounding yeah, three feels very helpful to have that yeah, to refocus
1257		and to, and to really ask those questions. Emm, because it terms of how it might change my practice.
1258		Emm, I think it, the way I think about it is, having that (.2) you know I talked about the umbrella and
1259		then all these different strands, just keeping that breadth, you know (nnh). That, emm, yeah, that
1260		broadness, not, I am not saying everything its equal but its more about, making sure these different
1261		aspects are considered and that we go back to them (nnh). And that includes race, ethnicity, culture
1262		and others things are important as well. But, emm I think err yeah. I link that to what I said about its,
1263		its for me its so fundamental, in terms of the, .hhh way people do things, their beliefs, their approach
1264		to things (nnh), their relationship, as they I am talking about families and young people. Emm,
1265		relationship to us as professionals. Emm, yeah, and I don't, I don't, I don't emm, yeah I don't think I
1266		, well not, I don't think I don't. I don't :: shine away from asking questions quite earlier on in terms
1267		of people's identities, so I think that wouldn't be a particular change in practice there. Emm, (nnh) yeah.
1268		you know finding out what :: you know, as I said religion, emm think about generations, people are
1269		immigrants yeah. When their parents came, or whether they are born here. And you know, some of

1270		those differences, those are not things that I would ever be :: yeah hesitant about. Although things
1271		that would come to, to mind (nnh) quite quickly to, to think about. Yeah, the families' identity. Emm.
1272	R	So what do you think might be the biggest challenge in, err the cross over between eating
1273		disorders and race, ethnicity and culture?
1274	P 6	I mean i think the emm, some of the challenges of er, er the issues that are. A lot of the challenges
1275		are the issues that had been you know, brought to the fore in, with Black Lives Matter. Because
1276		their, societal, institutional (nnh) so I think, thinking about that is really important with families. In
1277		terms of how you know, I said relationship to help and how you know, they might have been
1278		treated by services and how they feel about engaging in services. I think its er, its an important one. Emm.
1279	R	Can you say a bit more? Err you know you mention Black Lives Matter, the experiences of using
1280		services.
1281	P 6	Yes, I am thinking the ::: where there are service, questions about emm access you know, to the
1282		service. Emm, I saw something recently saying that emm, you know, there is like a slightly disproportionate
1283		you know, access to the service. Are we, because its not a very emm (P6 tutted) err, larger asian
1284		emm, you know south asian population then in, in our emm communities, in our catchment then ::
1285		there are you know black people. Emm, that's yeah African, Caribbean, emm different err people
1286		from different places originally. But, emm, it er you know. I think its emm, what I am saying is what
1287		we can do in the room but there is actually getting people into the service (P6 laughed) (nnh). Yeah, from the
1288		outset and making sure that, there is that. Equal access emm yeah (nhh). And that there is, yeah
1289		proportionate, emm access to service is what I am saying. But then, the next level is yeah, thinking
1290		about as I said, people's experiences of professionals of services of yeah. Have they been listened
1291		to, and and you know that could be education that is not just, just obviously health is important but
1292		thinking about those emm, experiences within society that people have had, and have they, they
1293		influence. So it is a kind of slightly meta conversations (P6 laughed) (nhh). Its where I am thinking of.
1294		Emm, yeah (nnh) and making sure that's yeah :: ss space for those. Some people don't want to, yes,

1295		some people are very keen to kind of say, oh you know. You know, that's not yeah, big deal or,
1296		relevant or you know I had that. Emm, yeah. But for others its like, yeah. I think raising it, it might
1297		not come out immediately but you know I think that's part of ethnical practices. It's like our
1298		responsibility to say, I am thinking about this and so, and perhaps the conversation can evolve. It
1299		might not happen there and then. Because people might be distrustful or, think I am not yeah.
1300		Lay myself on the line and tell you about all these difficult things that are sort of happen (P6 laughed)
1301		to me. Like you know (nnh) would have that reaction, wouldn't they? Emm, yeah, does that
1302		answer your question.
1303	R	Yeah, yeah it does, you know. Emm, err the last question I have is err, did anything change since
1304		we met last time? The first and second interview?
1305	P6	Emm, in terms of my thinking or you mean?
1306	R	Anything, anything you might notice you now, or you might, there might be nothing as well you know.
1307		Yeah, yeah. (.2) .hhh yeah, I think that's just that slight shift which, you know was enhanced even
1308		more today, by you asking question about, which we did touch on the team last time. But emm, the
1309		questions today and there are something about the whole configuration which is making me. Emm,
1310		yeah, think team. But it is not like, a massive, wasn't like some epiphany or anything between
1311		last week and now. But it is like err, probably the beginning of that shift. Emm, around yeah just
1312		revisiting, revisiting really. Emm, being more explicit with some of the ideas. And (emm) thinking
1313		about our practices as a team. And what my part is and that. Emm, in terms of leading some of the
1314		you know the supervision and the discussion and. So I am thinking about that, yeah, yeah.
1315	R	Okay, thank you very much. Then, that brings us to the end of our interview. And for that I will just
1316		pause the recording.
1319-1564		DISCUSSION about deportation (exclude from the transcript)
1565		Interview 2
1566	P6	Yeah, I can see that recording.
1567	R	Good, good, good, so its all happening. So err, so just wants to say that you know the interview

1568		is about your experience, your view and there is no right or wrong as usual. So please feel free,
1569		don't think that there is an expected (R laughed) answers to it (okay). So everything is
1570		confidential and anonymised (yeah). So err, err shall I, let me start by asking you, can you tell
1571		me your experience of food and eating and feeding.
1572	P 6	MY experience (nnh) of
1573	R	personal experience of food, eating, feeding.
1574	P 6	My personal experience, okay. Emm, I was talking about this a little bit the other day in terms of
1575		emm body image and growing up without my biological mother, and wondering what difference
1576		that made. Err to me as a woman and as a girl what influences that, which have more lastly
1577		influence. My mother was around, not sure if I explain this. But for the first four years of my life,
1578		emm, before she left. She left my sisters and I with our father. And so I had a step mother for
1579		four years and, and I didn't, yeah I didn't have a, you know my mother err around. So, yeah, I
1580		think food was quite emm (P6 hissed) err I learn to cook at a young age. Err because we had
1581		to, and I think that were lots of gender, nnn demarcations I guess. Err in my upbringing around
1582		: because my father didn't cook. So, think that was quite a emm, was a bit of gender division.
1583		My father couldn't, couldn't cook really. Emm, so when my mother left he had to get someone
1584		to cook for us. Emm, so yeah. I think that was quite a big influencing factor. And I grew up
1585		arr, we had quite :: when I look at it now I would say quite boring food (P6 laughed). Emm,
1586		Compared with the way I cook in my attitude to eating, I would say I am a lot more expansive.
1587		Emm, I was always interested in cooking more varied things. Err so I cook quite young age, and
1588		I always err been into food. So quite wide, I guess European emm dominated (country of origin)
1589		food is a bit like :: an amalgamation of european, english, scottish type, some type influences.
1590		Emm and then things like quite a lot of lambs, so you know, influence by the geography the type
1591		of thing. Emm, and I was, I say a ( ), linking back to what I was saying but my mother a kind of
1592		lucky that I, I didn't have any difficulties around food myself. In terms of eating, in terms of

1593		attitude to food, in terms of worries about, I am comparing myself as an adolescence and a
1594		young, a child to my patients, and the young people I work with who have a lot of, fear of food
1595		who get a lot of messages around. Emm, through social media and other means, body image
1596		and lots of insecurity and those kinds of things. I, I don't really don't remember anything like
1597		that being, a feature. Food was something I enjoy, something I like. We celebrate occasions with
1598		food. All those kinds of things really. Emm, later on I have more of an influence from my (mother)
1599		side and that wasn't there when I was young. Emm, because my mother wasn't around. So, later
1600		on that, that, that was different because in terms of ritual, err and special occasions, sad occasions,
1601		deaths emm things like that was a whole. There is a whole lot of ritual emm around food, that is
1602		very yeah prescribed I would say. Emm compares with how I grew up and I didn't have those.
1603		Yeah, it wasn't as I said, really was when I went to university. Emm, or just before I went to
1604		university in fact. Emm, what I started to having emm, more exposure, to different, emm from
1605		that side of my culture, my mother side. Emm, yeah. hhh SO (P6 hissed) yeah I think that's the
1606		best way to emm. I mean I always been active. So food is quite functional to some extends
1607		as well. I always had to eat well for the sports that I undertake. Err err I been involved in sports,
1608		quite, at different levels you know high school I competed in athletic to national level, things
1609		like that. So, there is always err that kind of link with food, having to eat properly, having to eat
1610		well. Emm, have enough energy and that type of thing. So I always been an high energy person
1611		and always had to eat, quite a lot and to keep yeah. Keep me going really (P6 laughed). So its
1612		that's been since a young age right through to still the case, yeah.
1613	R	Nnn, would that be part of a team belief that if you do sports then you have to, everybody
1614		have to eat healthily kind of thing
1715	P6	I think so, I think its like a cultural, err part of sport emm. So I did a lot of team sport, that's why
1616		as well as individual stuff later on. But yeah, definitely team, team sports were, emm I mean
1617		I say team, won't bore you with so many sports. And things like for example cricket, where

1618		you have afternoon tea (nnh) and (P6 laughed) you eat quite a lot (P6 continues to laugh). I used
1691		to love that because you would took turn to make food. And, emm I, that's always been part of
1620		it, just taking food to share. So culturally that's like a massive err, its not unusual, many cultures
1621		are like that where you take food to share (nnh). And that's part of it, with a group of people.
1622		Emm, yeah, whether it is a social thing or a sports thing. Obviously in the sport things is a bit
1623		different because you are eating to fuel yourself for the activity. Emm yeah, [that's always been
1624	R	[So, if I
1625		sorry carry on. I interrupted you.
1626	P 6	No, that’s always been part of that. I was finishing
1627	R	Nn, so I was thinking about what is it like to eat. If I go back slowly, the last thing you mention is
1628		team, so I was just thinking about taking food to share, how that feels like to, to be eating with
1629		your team you know.
1630	P 6	Because I enjoy food, and I enjoy sharing food. And that’s always been part of it. I didn't say
1631		that growing up we had a family meals, you know every night. Every meal was like together, emm
1632		and we sat down at the table. We didn't have a television growing up. Emm, so we sat down at the
1633		table, we finish the meal, emm and then you had to sit there for I don't know how long (P6 laughs)
1634		it was. But this was like a thing in my family. You didn't get down from the table straight after
1635		eating. So then, we play games. Emm, often compare (P6 laughs) to things, all sorts of different
1636		board games, stuff like that. When my sister were, left home and it was just my father and I.
1637		Then I would read. So we would sit at the table and <u>read</u> for half an hour (nnh). Emm so it was
1638		just like a quiet time basicly. That's what I grew up with yeah.
1639	R	So whats the atmosphere and how it feels like to eat and then sit with each other.
1640	P 6	Ahh, it was always. I mean when my sisters and I were all there. Five of us, it was pretty lively.
1641		Emm, (P6 laughs) we had lot of energy. So, <u>yeah</u> mostly, I mean sometimes it wasn't very good
1642	9	because my father was a tyrant and his moods would ehh, you know cast a shadow on the
1643		whole family meal which was <u>not</u> good of course. Emm, so that was that. But, the other time

1644		I have a lot of happy memories like sister and I just laughing joking. One of my sister ehh, would
1645		eat anything we didn't want to eat. That was quite handy. So we had to eat everything, you had
1646		to finish the food. Emm that was you know, it was plated up. You didn't help yourself, you got
1647		given a plate of food and you eat it. Always have pudding, emm so we had a main meal and we
1648		had a sweet always, every night for the evening meals. So, that might be just ice-cream and fruit,
1649		or in winter some kind of cooked fruit pudding or whatever. Emm, we always had a you know,
1650		quite a substantial meal. And and yeah, as I said my sister, we would just say yeah, please. We
1651		didn't want things. We just were allow to give it to her. And she just ate it all, emm yeah and
1652		food, was quite often, as I said quite, quite positive. Certainly when there are all of us, I enjoyed
1653		a lot more. I enjoy it less when it was just my father and I left at home. Emm, yeah. Its very
1654		different that I remember we used to make emm ginger beer. And so we used to open it and
1655		it exposed out of the bottle (P6 laughs) and finally our father got angry with it. He said no more,
1656		you have to open it up on the lawn. Because, of course we knew what was going to happen.
1657		And we were just like, literally hit the roof (both R & P6 laughs). You know, we do things like that
1658		just to yeah. We ate outside as well because it was nice weather, summer. So, we ate on the,
1659		we had a veranda along the side of the house. So, you know, in winter as I said it was indoors.
1660		But it was always at lunch time, was always very very much you ate together. There wasn't,
1661		you know (nnh) obviously at school that was different. But at home, it was always emm yeah,
1662		you ate, certainly lunch and evening meal emm together. That was the expectation.
1663	R	So just, sounds like a very pleasant positive experience. I was thinking about who is responsible
1664	11	for for feeding, I mean cooking and feeding. You mention your mother
1665	P 6	Quite gender, yeah it is quite gender specific. So, as we
1666		grew up, basicly it was emm, we had, had someone came to cook for us. And then, emm : I was
1667		cooking from the age of twelve, cooking evening meals. And my sister and I took turns. So basicly

1668		cook evening meals from, from that age, not every night from that age. But, when I was about
1669		fourteen onwards. I cook, I cook it, all the cooking. I cook all the evening meals.
1670	R	So compare with other family, of your age, you are a better cook? I am thinking of the cultural
1671		expectation, girls of that age will start cooking or or
1672	P 6	Some would, some would. But it was more of an occasional thing. So for me to have to cook
1673		every night was, was quite a responsibility. Emm, because I had to plan it of course. So, that’s
1674		what I learnt to do from a young age. I would think it had, about, you know obviously my father
1675		would buy the food. I didn't have to, but my father would buy the food and I would just plan .hhh
1676		the meals (so) and then (carry on, carry on) for, and then for bigger occasions birthdays and things.
1677		Then I will cook special food, emm but I used to, I remember the first meal I ever cooked at age
1678		twelve yeah. So I had all the cook books out. So I like look at these books, and I decided what
1679		to make. It was actually quite a elaborate meal, emm for me at that age. I did, made a steam
1680		pudding, a lemon steam pudding, ahh was the pudding. And I just remember the kitchen was
1681		a bit of a bomb site (P6 laughs). I think you know at that age, I didn't have the experience of
1682		judging time as well. Or things like that. I was quite competent but it was just not yet. And
1683		I made this dish called sweet and sour sausages. Emm, so yeah.
1684	R	How did that feel when you finish it, when you have a special meal for everybody (R laughs)?
1685	P 6	I don't remember everyone, I don't especially remember everybody eating that. And you
1686		know being like super positive or whatever. I am sure they were grateful and everything. But,
1687		emm I just remember the planning of it, to be honest. More than the, the outcome. It turns out
1688		fine, emm but then when I cook for birthday and things. There were a lot of positive, there was
1689		lot of err appreciation from people for sure. My grandparent used to come, and emm I remember,
1690		this is my paternal grandmother, my paternal grandmother would come and she watched me.
1691		And I hated being watched, I just wanted to be, was like my own thing. But she was kind of, from
1692		our perspective it was quite positive. And she was emm, kind of like impress with my planning.

1693		My ability to do all these things. But I just wanted to do it on my own. Not, not have anyone ::
1694		.hhh scrutinising me or. I didn't like that, I remember.
1495	R	Did she scrutinising or, or just watching
1696	P 6	She was just watching and I didn't like it yeah.
1697	R	Yeah, feels like more than that, feels like more than watching.
1698	P 6	She wasn't critical, scrutinising me, might sound it like that. But she wasn't a very good cook
1699		herself. Emm, so she was kind of, she kind of like it. But I just want to get on with it on my own.
1700		(yeah) I just didn't want people watching or. I think yeah, it’s a thing I always had, was like,
1701		used to think just do it yourself, don't watch me (P6 laughs) it’s a kind of the attitude. Yeah, its
1702		different if someone said teach me, showing me how it like, that’s an interactive thing. Someone
1703		just passively, I don't like being passively watch in that, in that sense yeah.
1704	R	Okay, I understand you know. So I was just thinking how it feels like to be a cook at twelve and
1705		being successful and you know and
1706	P 6	I think I was just didn't keeping with a lot with my upbringing Charlotte. It was just kind of
1707		expected to be honest (nnh). Yeah, I think that’s the real family kind of attitude was she just got
1708		on with things. So it wasn't really a big deal. It was just like became part of my identity. I mean
1709		I am a very good cook now. Emm, I cook a lot. I cook very elaborate meals. I love cooking. Emm,
1710		yeah I always have and it’s a luxury to have the time to do it. I would spend the whole day cooking.
1711		Christmas I made a menu :: preparing menu a week in advance. And : do all the preparation and.
1712		So yeah, those skills. You know I have built up over time (nnh). And yeah, which was nice.
1713	R	So, I was thinking about the, what is the significance of food and feeding for you as a person.
1714	P 6	Oh, I love to feed, I love to, its its about hospitality. Emm being together, and being comfortable,
1715		being : having people's needs taking care of, emm yeah. So if people come to my place, then
1716		I will always just offer some, some, even a snack or you know something to drink, something
1717		to eat. And then I basically, with my friends emm, they know that I always, well for many years i
1718		have done Christmas and Easter, and birthdays and other occasions as well. We go out to eat,

1719		on birthdays and things but emm, other times I would, so for example you know lockdown two
1720		started on my, started on my birthday last year. On the fifth, and so the Saturday evening I
1721		planned emm, a dinner. I made dinner and I had a couple of friends came and collected it
1722		from my house. So they came, they had this menu, and so they came, and they got all the
1723		different themes. I made Bini for appetizer, and there is starter, and a main and desert. So they
1724		came and they got all these boxes of, you know all the stuff. And so then, arrh we had this sent
1725		on other people on the call as well. But they were in (area) and (another area). Obviously they
1726		couldn't have the food but emm quite, a few of us were ate the same food (nnh) except for emm
1727		thanksgiving. I have an American friend she wanted to do thanksgiving. I said oh, I, I will cook
1728		a turkey. I cook a big turkey and then I will drop it off to you. Emm, so that's what I have done
1729		over lockdown, to emm its yeah. Those kind of, they have nails on line, emm sometimes with
1730		share food. If I have been able to cook and share it. Did it with another group, yeh done it with
1731		quite a few groups of different friends. Emm, yeah. So, its its definitely about sharing in my
1732		culture is called (name), which is emm, ehh, what it is. It is a kind of like hospitality I guess. It is
1733		just, you share what you have. Emm, you don't keep it to yourself. Emm, but very important to
1734		emm yeah.
1735	R	So, that's if I go to another household in your culture. I would be welcome with hospitality and
1736		that's the cultural thing.
1737	P6	yeah, yeah, there is a term emm, yeah, its terrible. I can't remember the term for it but it literally
1738		translated meaning killing with kindness (P6 laughs). So its like you know, the expectation that
1739		you emm, yeah you really make an effort and make sure people are taking care of and ↑you
1740		know I think in lots of cultures that is the case. Because food was scarce and you know that
1741		was very very important. Obviously we don't have that issue now. And western you know,
1742		western Europe certainly does not, for most many people of course, foodbank exist and : arr
1743		but you know for middle class people. Emm, there is not a shortage of food. The opposite of

1744		course is the issue that are. I didn't, I am grateful that I didn't have, the attitude of :: people
1745		say to me sometimes, like oh oh you, you emm, you exercise so much because you eat a lot
1746		(P6 laughs). I said no, its not because that at all. I don't have a like er check and balance. Oh, you
1747		know I certainly not the other way round. At least in terms of going, like I can eat this because
1748		I exercise, seeing it as counting calories or those kinds of things. I think proper, I just kind of know
1749		what, generally what the balance of energy you know is needed. And when I, you know I have
1750		done all sorts of things like you know marathon and etc, etc. You know when you are doing
1751		long training and stuff. Often it is the next day that you, you actually feel more hungry. So I use
1752		to do a long run on a Sunday. Err would be like anything between two to three and a half hours.
1753		And you know its okay to eat, but then often the next day you feel it. Same as rowing, because
1754		you know I row now, so cause quite energetic and if I have a big competition or something like
1755		that or, been doing a lot of training and stuff, and I would notice. I won't do, automaticly go, oh
1756		I have to eat more today. That might happen because I am hungry but then might happen the
1757		next day or something (nhh), that's just, just, you just find the balance really.
1758	R	Yes, so you notice and balance quite well for yourself. Looking after yourself
1759	P6	Yeah, yeah.
1760	R	I was just thinking about how do you think about food and feeding as a professional in eating
1761	22	disorder, what informs you?
1762	P6	So emm, I : I think I air towards you know normal for the family. Its it's a big thing, so when I am,
1763		make doing an assessment, and trying to gather a, a sense of you know what is the family's
1764		culture, what does the family's ↑norm. And trying to move you know towards that, especially
1765		when there is an eating disorder been diagnosed. Emm, so you know how would the family emm
1766		like to you know work together, to eat together. Emm, yeah to get things back to some kind of
1767		equilibrium, what, what would that look like. Emm, and the family and obviously you know
1768		some families say they may not have an evening meal together. Emm, SO, going like at that

1769		stage, thinking okay so : how : yeah. Is that something they like to, to do a bit more of you know.
1770		Eat together more with this, when you get that real separation and people needing very individual
1771		life’s type thing. And or you know, I have situations where I have fourteen year old cooking their
1772		own meals. Emm, and I just say, for themselves, not for the family, just for themselves. And I was
1773		like is that what you always done. Is that what you know, the parent used to cook or, about
1774		trying to find out whats normal for them and what works for them really. Emm, its its what I
1775		think about a lot emm, when we trying to, yeah : work towards encouraging the parent. Because
1776		things you know. As you know, things get, can get so distorted. Emm, in terms of patterns and
1777		habits and things like that. So, emm trying to encourage the parents, or parents, carers. Emm, yeah
1778		towards something that they feel confident : and comfortable doing (nnh). Emm, and that's not
1779		too unusual or I don't think its helpful to try and expect a young person to do. You know,
1780		completely change their habits, is like when things weren't healthy and in a good place. What do
1781		that look like? What was that like for your own family? So (nnh) I think within the team, emm
1782		yeah, there is quite a lot of feeding. Emm, I think that happens in eating teams is we usually
1783		have snacks around (P6 laughs) and you know, use to bring food to the office a lot, share food
1784		and all of those things. So (P6 hissed) obviously you know, that’s not just, that’s being something
1785		about the pandemic, contact, that difficult yeah.
1786	R	How do you understand the team share food then, I mean?
1787	P6	All I see that is part of looking after each other, that always been. I think its almost like a natural
1788		kind of antidote to being around people who aren't eating (nhh) is that, I have a lot of people
1789		say when they work in inpatient unit. OH, I put on so much weight. Emm (P6 laughs) when
1790		you are around seeing people who don’t eat or won't eat, or can't eat. And its kind of like OHH,
1791		it’s a, yeah. And I, I sometimes think a bit of that like, emm myself that I, know like oh gosh I,
1792		I really emm, yeah wouldn't want to get into any restrictive narrow habits. Emm, I think I am very,
1793		I think it definitely, even though I have very good eating habits, pretty balance I think. There is

1794		still that :: occasionally that creeps in where I would, I almost want to eat more as a, as a
1795		reaction subconsciously to yeah (nnh). Being around with people who restrict.
1796	R	That's outside the room when ehh, I mean after you met the family. I am beginning to think
1797		what's going on when, how you might be thinking or feeling when you are with them in the room
1798		you know?
1799	P 6	(P6 hissed) how I might be thinking or feeling, I mean the thing is talking about food all day. Emm
1800		which we do a lot you know. I am as I say I am quite, I eat quite a lot. So, I feel hungry (P6 laughs)
1801		literally that's the thing. You know by : I will eat my breakfast and I always have like a snack.
1802		Sometimes I eat at nine thirty if I am hungry. Sometimes its ten, sometimes its. When I do an
1803		eating disorders assessment. We go to eleven and then we have the break. And err yeah, often I
1804		am like thinking about my snack, like thinking about the break. But how I feel in the room. I think
1805		it was really variable. I mean there is that, the input they, because as I said that, you know
1806		biological ehh in drive from myself is there. And there is the NNN, ERR empathy for the, you know
1807		the person who is having the difficulties of what torture that must be like. As it often, emm yeah
1808		what I, what I think about. So I don't emm, I don't remember, may be I did. When I, perhaps,
1809		when I first started working with people who HAD eating difficulties, may be there I might have
1810		found it harder to understand or. But I don't, I, its interesting because obviously family members
1811		and other people are just kind of like. Ahh, I just don't, JUST don't understand it, why can't you
1812		eat or why:: I : yeah I, I do. I can see why people can't eat. Emm, what are err, err turmoil they
1813		are in. Emm, so I don't yeah. I think, I think I .hhh I acknowledge that and think about that, can
1814		see that either in their room or when I am doing err, you know a, a digital session. Emm, and
1815		I think, not I think, you know that’s what I bring in. Emm, acknowledging that, that position
1816		that, that person is in. Emm, really trying to hear, emm yeah where they are coming from,
1817		as well as sticky to the task, which is to restore you know we are talking about someone with
1818		anorexia or to emm, yeah, change habit if its someone who, whose got you know more of

1819		bulimic emm type presentation. And so, yeah I think emm, what's it like? I, I, I do feel enormous
1820		ahh empathy as much as I can for people being in that you know. The young people who,
1821		coming are in that horrible, horrible position. Because I, because food is so fundamental, to life
1822		to wellbeing, to you know everyday life : that's I think that’s, yeah : why it is so important to,
1823		to get hold of. Because we can see how, how quicker it takes hold. And, and how much of a
1824		impact it has on every facet of life. Because that's where eating, drinking, sleeping (P6 laughs)
1825		all the basics. Emm, that's how I see it.
1826	R	Do you think about your own eating err or when you talk to family?
1827	P 6	Sometimes yeah, sometimes not so much. I think it depends on how helpful I think it might BE.
1828		And what stage someone at, in terms of their journey. So if we were kind of later on and the
1829		stage of, thinking about emm you know normalising eating and someone going back to sport or
1830		things like that. I might emm, think about it or even say something about it. Emm but you know,
1831		being very careful about not trying to, err you know say this is the best things to do, or ( ).
1832		Trying to normalise it, I mean that’s a big big big part of, emm helping people. Emm, its like, I, I
1833		often say, look I want you to be doing the things your friends are doing. I want you to be able to
1834		go to parties, or birthdays or events. And not have to take your own food you know (nnh). Can
1835		you imagine that. Is that something you want. So it is really about thinking about trying to get
1836		those goals and alignment. You know the phase three stuff, in a, yeah. Emm, as FT-AN. Emm,
1837		quite a lot of emphasis on that. Emm, around the centrality of, of food in life and that,
1838		wanting to be, wanting to get back emm some kind of equilibrium for that young person (nhh).
1839		I thought that would be amazing.
1840	R	You mention about the deciding helpful, whether it is helpful. What might be influencing your
1841		move in terms of its helpful to, to share a bit of you, your experience, whats not helpful?
1842		You can give me an example if it helps.
1842	P 6	Yes, I am thinking of a boy. I worked with who emm (P6 hissed) who is very into rugby. Emm,
1844		that’s one of his big motivators (nhh). Emm, was emm, yeah wanting to get back to eating. Yeah,

1845		obviously the irony was that he was you know a lot more smaller than his peers (P6 laughs) and
1846		wanted to be a very good rugby player. And the eating disorder had meant that actually he
1847		was developmentally he was way behind. So he became a much less effective emm players (nhh).
1848		So, emm yeah. I think that he was receptive to thinking about emm snacks, and having enough
1849		energy for his sport and, emm we talk to him on that level. And you know about emm yeah,
1850		needing that but. I don't think I particularly brought myself in it too much. But I think you know
1851		there are times when I yeah, I would ehh say something about that. About knowing what energy
1852		it takes and, and a team aspect or those things. I think you know going back to your question,
1853		how to judge it. I think that's a, with lots of phases or ( ) in the treatment, and there is that.
1854		Err, judgement that I use which comes with experience is to noticing what people are open to
1855		hearing or not (P6 laughs) and for example emm, recently I use emm my, this girl said to me.
1856		Emm, are you not, you are not listening to me. And I said okay, well, one of the difficulties is that
1857		you know your mum and I are focusing on a weight restoration. And the eating part of that and
1858		you are focusing on some, some different bit. I said how would you feel about emm, hearing
1859		from someone whose been through what you been through. Emm, and I don't know if you
1860		remember ehh (name) : (name) did the, (name) story in the context, few years ago. And I said do
1861		you think you might be. Anyway, I could tell that she was a bit on, on the fence. So, there wasn't
1862		kind of right thing to do at that stage. Although it, she was more receptive to hearing from
1863		someone else. SO the me (nhh) I thought make that might be an angle. So I said, I will send
1864		this, this through to you in case you are interested. But, don’t feel under any obligation to read it.
1865		And, and : she hasn't read it. And I can tell she is just not, you know quite there yet. And I think
1866		its similar emm, in terms of certain thing I would say or I just wouldn't say. Because I can tell
1867		that someone, they might feel that, that they had been told what to do. Or preachy or needs to
1868		be that receptivity. Up to a point, which as we know comes and goes. Emm, but its not about

1869		yeah pushing it on people. Some of the stuff is non-negotiable, in terms of the meal plan and
1870		expectation around that. And you know, I am quite pragmatic about it. I am not, obviously going
1871		to get into negotiation or, whatever and, and yeah. She is hardly restoring and there she is saying
1872		oh, well you know. You told me that my blood pressure and pulse were a bit better so that just,
1873		that gives the message that there is nothing wrong (P6 laughs) nothing wrong. Are there any other
1874		physical things that we are looking that we were looking at. And she said no. And I said what
1875		about periods, she is like ohh, and I say go back to that. You know its its :: the objective stuff
1876		because some of the subjective stuff is just, when someone is not ready to listens yeah.
1877	R	So, coming back to the, the food and feeding. I was just thinking about emm your own feeding,
1878		when you talk to family, does your own feeding, your experience of feed by your family err
1879		come into your mind you know?
1880	P6	(P6 hissed) emm : I wouldn't say a lot consciously I think its more, I think I am more interested
1881		in what they do as a family (nhh) rather than mine. I think that's a lot more influential. Emm,
1882		cause do they have family meals. How would they like things to go, who does the cooking. Those
1883		kinds of things. Emm, are they of family who eats out? Or has take aways or so yeah, I no,
1884		I think have, I have much more of a focus on what the family, yeah the family's norms are. Then,
1885		yeah, quite a thinking of my own or own experience. And yeah.
1886	R	Is there sometimes family trigger your own experience you know like?
1887	P6	(.1) Not so much, I would say. Not that I am aware of.
1888	R	It's okay, you don't have to have. I am only asking.
1889	P6	Yeah, yeah, I know. I don't, I am just thinking. Why don't, I don't think so, so much. Emm,
1890		because I think my : experience you know as I said during the cooking. And its quite unusual,
1891		yeah there wasn't anyone that I knew growing up who did what I did. Emm, in terms of being
1892		responsible for .hhh yeah cooking. I remember having exams emm, like GCSE equivalent. And
1893		I remember, I don't know the beginning or part way through one of these exams. And I
1894		remember that I forgotten to ehh, we have this oven and you, put on a timer. You know, you

1895		put something frozen and then they are there, for example there is a stew something in the
1896		morning and then it like, it would turn on in the afternoon. And then come home, and it would be
1897		hot and cook whatever. And I just remember, being no, no. NO, I forgot to put the, which is
1898		you know completely normal because I was preoccupied with, but I had that. You know I had
1899		that responsibility, like from a very young age, of like ahh, having to be emm, ↑well having that
1900		responsibility and having that ↑yeah. Having to think all the time (nhh), kind of think ahead,
1901		plan ahead, type stuff (nhh).
1902	R	I was just thinking about what might be the, the feelings of eating in a family, like some of the
1903		family bring, what they do like you say finding out whats going on for them, and then the feeling
1904		of eating in that family, you know like, do they talk about those things
1905	P 6	Yeah, I think emm arr I think of many many many recent conversations with families and the
1906		tension (nhh) you know that is often talked about and both of the siblings and the parents
1907		you know, the classic scenario of, the siblings get down, siblings gets down to the table. Emm,
1908		because they don't want to be around, we all with tension and (nhh) their siblings would be
1909		eating disorder, sitting there you know for an hour. How longer, however longer, however longer
1910		it would take. Emm, all of that, so that's yeah. I, I really feel for the families. Emm, when they
1911		describe that and you can see that sometimes of course there is no right or wrong things. Some
1912		obviously, they said that, that the young person will only eat with the mother or you know
1913		you get these separations and, on food becomes just an absolutely loaded in terms of its
1914		meaning and in terms of, just not being simple at tall. Emm, yeah, I am very, I am you know, I am
1915		not a parent but emm, I really, really arr. ↑Well try, try to tune into the parents' experience
1916		around what it must be like for them, not being able to do that, as well as the young persons
1917		of what the guilts and shame, and look, what am I doing to my family and JUST, err the
1918		intersection of all those different experiences and how awful that is. Emm, yeah
1919	R	Does that mean, remind you of some of your experience of eating in your family, that

1920		being responsible to feed or like you have to sit around tables and
1921	P 6	Right, it doesn't really. I don't really tap into that. I have to say (nhh). Emm, yeah. I think : yeah,
1922		doesn't really connect with it. Emm,
1923	R	Its okay you don't have to, I was just wondering you know like in terms of like what family bring,
1924		trigger something
1925	P 6	Yeah, I think in terms of personal connections. The one I make more readily, if you like is it. I like
1926		eating and food to be a happy relax time (nnh). And that's you know what I said I love cook for
1927		people. I love to be the host and all of those things. I very much like to create that relax
1928		atmosphere. Emm, and as I say we had a load of good times but you know the, the, the not
1929		so good time in my family around the table. It might have been associated with sitting down. But
1930		it was all about my father. It wasn't really, if that make sense. It wasn't really about food. Emm,
1931		we didn't have battles around food really. It was more that my father would shout or scream
1932		at the dinner table, type of thing (nnh). There is that little association there which is not pleasant.
1933		He once had a, ehh complete tantrum and smash the, arr (P6 hissed) the table. And broke the
1934		end of the table. We had this massive oak ↑table. Emm and he flew smash things, but he is he is
1935		very very violent .hhh. Those were not yeah, so those. When I didn't emm, I didn't see those
1936		Asian
1937		table but that was just the end of the day. That was just him rather than it being emm, yeah.
1938	R	It could happen else where you mean, not not just
1939	P 6	Yeah, exactly, anytime, yeah, yeah.
1940	R	So just, just thinking about on the line of thoughts and feelings when emm, when family comes
1941		in, when first come in when they are low weight. Err what might be the, the thoughts and feelings
1942		that evokes in you when they first come in you know. In terms of feeding.
1943	P 6	I think, I am often aware of the, the paralysis, that's what I notice. And I can feel that often (nhh)
1944		you know coming off the parents (P6 laughs). Emm yeah, so what does that evoke in me?
1945		I think that evokes in me the sense of right (P6 laughs) this is really contain it, be the, be the

1946		container for the parents really, listen etc. And start to move towards okay, err action and
1947		advocacy. Obviously it doesn't happen straight away but that's what tends, that's what I notice.
1948		Emm, and those first, you know like for example the assessment and then, those assessment
1949		when we give the feedback is really starting to fit with them about action, rather than paralysis.
1950		Emm, yeah. So its, it's a bit, I don't want to sound detach, but it's a bit like noticing it and letting
1951		it kind of wash over but not being swept along with it. Because we know that's not helpful (nhh).
1952		Probably the best way I can describe it. I think that's what happens a lot. Emm
1953	R	And how does the parent or the adolescence response to that?
1954	P 6	Well, I think emm vary. Yeah, its to whether they can really, you know sometimes they a kind
1955		of get it theoretically but emotionally clearly tugging at their heart strings, and they are very
1956		influenced by emm, the relationship their child sometimes it can feel like more the anorexia
1957		that influencing them. Emm its really helping to tease, tease that out, emm so they can do
1958		something useful and not be drown by it I think. Emm, yeah I think some parent they yeah.
1959		They come, and they already done some reading and you can see that they, they have got an
1960		idea but doesn't make it suddenly simple of course. But its, yeah, but started the journey in terms
1961		of having a sense that okay. I am going to have to try and stand back from this to some extend
1962	45	at some junctures. But emm yeah. It's not just about emm, emm its not being cruel (P6 laughs).
1963		You know you would have heard that many times you know, you are being mean, you are cruel
1964		or those kinds of idea come in, yeah. And that's what the anorexia uses, doesn't it?
1965	R	Yeah, yeah and I am beginning to think that your calmness, not letting things wash over, sounds
1966		like very containing, your tools for the family.
1967	P 6	Yeah, that's what I am aiming for and emm yeah I had some nice feedback, the other week from
1968		the family, well the mum said I really yeah, you had the ↑really good balance of like calm but
1969		also emm (P6 hissed) yeah telling, not, not mincing your word. Telling us you know, what we
1970		needed to hear. Emm, I mean it was psycho ed stuff, nothing unusual but emm yeah (nnh),
1971		having to do that, take it seriously nhh.

1972	R	Yeah, sounds a very helpful to them, something that they find it, they appreciate you know.
1973		I just thinking about the enjoyment of eating, because when family come in, being in an
1974		eating disorder, eating disorder become, eating can be challenging (yeah). I am wondering that,
1975		the enjoyment of eating err, how does it (.1) play out or like talk about and think about, feel
1976		about in the sessions.
1977	47	So, I (P6 hissed) think I keep pretty low key. Because you know when the young person is not
1978		enjoying eating. I really don't want to, yeah, I think I leave that to the parent to log, when
1979		we are thinking about. And every now and then, err you know every time I check it out. About
1980		are there any appetite, is there any enjoyment of food, emm that kind of thing but obviously
1981		there is often very, lot of reluctance to acknowledge anything positive about food. It’s like seen
1982		as a real, you know the enemy and those kinds of things. So I try and coordinate with that. Emm,
1983		that the family you know, the rest of the family can enjoy food. And I think is really important
1984		that they feel entitle to do that but not push back on the young person. So, I think emm I very
1985		much emphasis that people being in different places. Emm in terms of their attitude, their
1986		feelings, those kinds of things. And I certainly don't, wouldn't say to young person about my
1987		enjoyment of food or at certainly not in those early stages. I be very very emm reluctant to do
1988		that, wouldn't be appropriate I think (nnh). I try to tune into what they might have like
1989		previously or get the parents to think about that. But you know that can, I don't want to shame
1990		them. Emm because obviously at that, there is there is this, err horrible position they are in
1991		where you know the eating disorder won't let them acknowledge that they used to love,
1992		you know I don't know, ice cream, peanut butter or whatever you know. Emm, so I say I am
1993		very tentative about emm, I, I, I talk about the different needs within the families. So you
1994		might have, we might have an overweight parent who does need to watch what they eat. That's
1995		absolutely you know normal, acceptable (nnh) fine for them, think about this difference. Different
1996		needs and really you know emphasis, obviously the growing needs, and adolescences and all

1997		of that. Just trying to yeah, use more objective type. Emm yeah, think about those objective
1998		type emm needs and things within the family yeah.
1999	R	Nnh, I think eating disorder you know there is the important elements of making sure, refeeding
2000		you know, refeeding, that can turn food into very function, you need to eat (yeah). I am just
2001		thinking about the the symbolic aspect of food and feeding. And at what point that got introduce
2002		into, into the work you know.
2003	P 6	So, at what point the emm, the enjoyment rather than the functional do you mean?
2004	R	Not just enjoyment but the whole symbolic meanings of food, you know like the, there is the
2005		functional like the refeeding bit, you know the health and safety bit (nnh). And I was just thinking
2006		about at what point the symbolic meanings emm it can be many things, emm that got explore
2007		and (.1) and just thinking about yeah, how, when does it come into the conversation or not
2008	P 6	I think it varies hugely because I think some parents would come with, and state very openly
2009		their feelings about I am the parent, I can't even feed my child and what that means to them
2010		(nnh) you know that can be. So I think in my experience, some parents connect with that
2011		immediately (nnh) where is the other don't, emm name it. So I, I wouldn't introduce it or name
2012		that as a thing really early on if its, if its not raise by the parent (nnh) I think it's not a thing err
2013		the thing back to different families that really, really about kind of attuning to where they are at,
2014		with it. Emm yeah, in terms of the relationship to the child, their relationship to parenting,
2015		emm their beliefs or, all those things. Because it could come with things like, so often I would
2016		ask, after session one, after the assessment. And then that, I would often when they come back,
2017		I often say have you spoken to anyone else about what you are going through as a family.
2018		Because I am interested in, in the private you know, public family part of it (nnh). And some
2019		families you know say NO NO, we can't tell grandparents because you know child doesn't want
2020		us to emm, or she didn't want us to but we needed that support so we done it like, starting
2021		to, to think about their identity (nnh) and some of those things. Kind of something yeah. I am

2022		just kind of gathering that I would say early on. Hugely varied, I wouldn't say, have a set time
2023		or place. Emm to bring that in but certainly by you know when I doing phase three stuff. I want
2024		to be exploring if that hasn't already come up. Emm, I would definitely want to, to think about
2025		emm yeah. I think I made that link with yeah, as you said symbolic with you know, the family
2026		norms, the, what does it going to look like in the future, what do you wanted to be, what do
2027		you want, how do you, whats the place of food in your family and how do you wanted it to be.
2028		Emm, and how the young person want wants, to, to fit in with that as well (nnh). Emm, how
2029		much weaning there is to, emm yeah. And you know are they back cooking, are they you know
2030		doing anything independently or is it still very functional yeah.
2031	R	Nnn, thank you for sharing your thoughts and ideas. Emm, I was just thinking about emm, I am
2032		about to bring the conversation to, together (nnh). I was just thinking do you have any comments
2033		or reflection about our conversation or things that you like to say that are, you haven't mention
2034		yet or
2035	P 6	I think what comes to mind that I haven't mention is interesting thinking about emm, going into
2036		the room or into the session. And emm yeah, and or when, when I do or don't consciously
2037		connect, yeah with my own emm experiences. Emm, yeah I am thinking about ideas that
2038		neutrality charlotte (nnh) kind of when I am more emm (.1) that's quite organise err, I would
2039		say yeah. At the beginning that I, I think its emm like all of my, obviously all of my own experience
2040		and other things and all the family I seen before. Its all there but I keep it, a kind of keep that
2041		very much at the background. Because I am really want to centre the family (nnh) and I think
2042		young person just wants that space (P6 laughs) for it to be as it is you know. Not that we would
2043		preach, obviously we do all the psycho ed and those other things. And that's probably quite,
2044		can feel quite you know preachy in itself. And yeah, I want them feel like there is a you know
2045		there is a right or wrong. That I have got all, ( )up, that's my way of thinking and doing things or
2046		that, that person, these personal experiences are, of mine are, you know at the fore. I think that’s
2047		unhelpful. Emm,

2048	R	So, does, does it move away that neutrality at some point you know. Or neutrality continues to
2049		be there
2050	P 6	Yeah, I think so. Ehh some, you know when you were asking me about when I might say something
2051		about you know sports or nutrition, on my own things like. Again when they are more, when
2052		I see that receptivity (nnh). Emm when I think there is an openness to dialogue, then I would,
2053		I think that would be, that would be much more appropriate. I don't want to be pushing stuff
2054		on people that's, just yeah.
2055	R	Anything else, you might like to comment or
2056	P 6	(.2) just interesting in thinking about emm, myself as a teenager and doing all that cooking
2957		(P6 laughs). Revisiting that, I know, obviously I talked about with my friends at times or people
2058		sometimes asked me questions about, oh so, you know how did your, your upbringing, you
2059		know does it help you in anyway. Emm, you know something were difficult, were they helpful
2060		at home. Emm, yeah, highly organised (P6 laughs) and able to yeah. But I didn't see it as, as as
2061		kind of normal to be honest. I, I, I, err it was emm yeah, yeah.
2062	R	Not even within your culture context
2063	P 6	No, I didn't. And sometimes err I think I am, I would go so far as sound ungrateful but it didn't
2064		put me off. Because it could have put me off, because it was you know there was no choice
2065		really (nhh). It really could have put me off. Err because there was that expectation and, and no
2066		choice. But actually went the other way. And it is something I am still you know, I enjoy and
2067		interested in (nnh, nnh) able to use you know.
2068	R	Become er er a strength and, for you, something you benefited
2069	P 6	Yeah, yeah,
2070	R	okay then, if you don't have any question to ask I am going to bring the research question to an
2071		end.
2072	P 6	Sure, thank you
2073	R	But as usual, if anything that stirred up in our conversation you like to have further discussion,
2074		anytime.
2075	P 6	Thank you.
2076	R	Is that okay?

2077	P6	Absolutely fine, thank you.
2078	R	So, so I will stop the recording now
2079	P6	Cool
2080	R	let me turn off all the button, okay.

Appendix 1g: Transcript for Focus Group 1

1		Focus Group 1Transcript
2		
3		R : Researcher
4		Participant 1: FP1 - Amy
5		Participnat 2: FP2 - Bella
6		Participant 3 : FP3 - Cynthia
7		Participant 4: FP4 - Davina
8		Particpant 5 : FP5 - Eleanor
9		
10		Transcript
11		(First 45 seconds blank, R set up the recording)
12	R	Now, we are are live, you know. Emm, so may I just start with the introduction. What I said, if you can
13		share your name, err your, how you would define your own ethnic identity, work optional and how you
14		like to work with the other, in order to be safe. (.5) Who would like to start? (.5)
15	FP1	Okay, I will start. So my name is (name) and err I would consider myself be white British and I am not sure
16		what people would like to know but emm, I work in an eating disorders service in (area). So, emm I live
17		in the (area) area. Emm, what do I need to feel safe. Emm, I am not sure I guess we just have to wait
18		and see. But emm, you know I am sort of coming into this, you know wanting to sort of share my
19		experience and really learn from other people's experience as well. And, and, and hear what other
20		people have to say. Err because I am, I am sort of an, er sole family therapist in the service I work in.
21		So I don't get the benefit of being with other family therapists all the times. So, think this would be
22		really good for me. (Nhh thank you).
23	FP2	My name is (name), I am a currently employed as family therapist. I would, go to my background of,
24		emm, black British of African descent. Emm I currently work across paediatric inpatient and outpatient
25		setting. Err in a tertiary hospital and my experience of eating disorders, is also been in the community
26		as well. Err, I am sort of really keen to participate in this. I think the topic really really key. Emm, I think

27		there is a massive working progress. Emm, though that was my emm plans to be here. Emm, what
28		would make me feel safe, I suppose that emm, when we talk about issues of emm, race, ethnicity it
29		can be quite sensitive topic. And I, is hoping that people can remain curious about the input that they
30		are bringing and curious about the family that they are working with. And I suppose yeah, we are
31		coming from a slightly not knowing position sometime. Rather than being too quick, make judgement.
32		(thank you).
33	FP3	Emm, my name is (name). Emm, I would I guess if my ethnic, emm I am white Scottish and I work
34		in an adolescent inpatient unit. And I guess I think it is emm, a really really interesting and important
35		area. And :: emm, I don't know what I will learn. Echoing what FP2 said we are in a not knowing position.
36		Emm, but I am curious to learn whatever I learn. Emm, and I guess what would make me feel safe is :
37		yeah, curiosity and, and us being respectful, I suppose, thank you.
38	FP4	Shall I go next? Emm, I am (name) err I recently got a job at (name of workplace) community
39		eating disorders unit and err which uses the FT-AN model, Maudsley model basicly. Emm, it is quite
40		a new team there. Err it's mainly psychologists, well it is solely psychologists, and psychiatry. And part
41		of my role is training and supervision, and I like to emm, partly for my own work. Emm, think some
42		more about emm, doing culturally sensitive work, with the family I work with. But also the training
43		part of my role. Emm, I will be very interested in joining this group. My ethnicity err, I am err white
44		British. Emm, err I am a Lesbian err parent. Emm, I don't know what else to say (P4 laughs) about
45		myself. Couple of you know me already. But emm, OH, yes, I told you where I work. I will be very
46		interested in emm, I am currently in (name of a place) so emm I think someone were saying they
47		were working in (place). So be interested in hearing more about that. (P4 laughs)
48	R	Thank you.
49	FP5	I guess it is my turn, emm, so I am (name) emm, I am white Latino I guess from (country name). Emm,
50		I been working in eating disorder for about eleven years. And err cultural awareness, sensitivity and

51		emm self-reflexivity, an area that I am really interested. That was my emm masters research on
52		that as well. Emm, I think I come very much from the premises that we always learning and err,
53		you know the discourse in society is so kind of err embedded, that very often we don't realise a lot
54		of the discrimination discourses. So I think its emm, important to, to be open. I think people said
55		already, be curious and being respectful. I really honour to be here, got Charlotte and look forward
56		to just, err this afternoon.
57	R	Thank you P5. I might be, I may be only fair for me to say, answer to these questions as well.
58		I am Charlotte, and I am Chinese from Hong Kong. In this country about thirty years, so people might
59		describe me as a first generation professional immigrant to this country and, and how to be safe.
60		And I am semi-retired, so have spent a lot of my working life, working with eating disorders. So it is
61		where I am, just focusing on the research and see what happen. Emm in terms of
62	FP5	JUST, just the research (FP5 laughs)
63	R	No, sorry I am being er er (smiles, laughs) thank you. And err, emm yeah so. How to be safe? You know like,
64		I echo the positions of trying to be curious and being reflective, and I am no more expert than
65		any of you here, is just emm kind of curious person and ask the question, try to find out where it goes,
66		where it is going. So perhaps, I should share screen now. Emm, and I wanted to say that if at any point
67		you feel that, you feel uncomfortable, kind of like feel not able to say what you want to say. Perhaps
68		let the group know, so we can pause and think about it. Rather than just gone silence in the background.
69		As I say, race ethnicity and culture can be sensitive, emm yes. And, so if I just share screen and put
70		some contexts to why, what I am looking for, what I am interested, particularly for this focus group.
71		Emm, its. Let me go here. Everybody can see it. Okay, so I am just talk to the diagram, a little bit.
72		So these, three rings representing my question. Race ethnicity culture in family, family with children with
73		eating disorders. So, the orange circle become my area of interest, what is it in there? That's my question.
74		Emm, I wonder how you see what might be in the orange circle there. So, I like to hear what you see

75		that? What might be there and interested to hear your view today? And as we are all family therapists,
76		I think it is good to orientate ourselves from our own position towards race, ethnicity and culture, and
77		with children with eating disorders. So how do we see the two circles, race, ethnicity and culture
78		overlaps with children with eating disorders. How, how, I think this is an open question? How do
79		you think about that? Anybody would like to respond? Do we think of them as separate thing? You
80		know, race, ethnicity and culture on its own, children with eating disorders on its own. Or do we
81		think that they are connected. If they are connected what might be the relationship? (.5)
82	FP4	I am, I am. I think there are probably is a connection. Though with each individual and family, we
83		don't know exactly what the connection is::. But living in a racist society emm it is bound to have
84		an impact on er young people and their sense of themselves. And we can see that as a, a vulnerability.
85		Emm, towards, which might lean you towards having err an eating disorder (nhh).
86	R	So the societal contexts?
87	FP4	Nhh↑
88	FP2	And I think certainly in a, a inpatient I work in. Emm, quite often is about which family are coming
89		through the door, which young people are coming through the door. What's the background? What's
90		the relationship how, and I think very much when I am thinking about eating disorders that whose
91		actually, you know being referred? Emm at what point in a particular journey. Are they being referred
92		to services or not. Emm, and then also thinking about what other family script that informing people
93		actually, turning up to, its support may be. So I find them very complex layer of relationship to
94		eating disorder services and what there is? So I am always very systemicly thinking of the wider
95		contexts of. Yeah, who is coming through the door, who is being sent through the door (nhh) by whom?
96		(yeah) and then what do the team that we are working with look like. And as a black professional lots
97		of time, I have found myself probably one of the minority people. Emm, I say BAME for the sake of ( ), but

98		I am not very comfortable with that word all the time. Emm, yeah I just think there is always
99		conversation to be had. And I as a clinician with them, particularly in eating disorders or an inpatient
100		setting. I err often thinking about what are the conversations that, the affordances and con, constraint
101		around the conversation we can have or can't have. Emm again, sort of thinking about, of you know
102		the Black Lives Matters movement and how we have to sort of RE, configure our service I suppose.
103		Make sure there is good fit for the family that are coming through the door. So how does that position
104		in terms of things like FAITH as main, its an area that I am really curious about (nhh). Emm :: yeah, sorry.
105		I leave it on that for now.
106	R	That's helpful.
107	FP2	Yeah.
108	FP5	I was actually er thinking similar point that PF2 emm, just made now but for the families who don't
109		come through the door. And HOW does services are representative of the community that they serve
110		and what is it about the service, about the workforce, about the discourse, the medical discourses that
111		are emm, perhaps being barriers for these families to emm, to get the support that they need (nhh).
112	R	Thank you
113	FP3	Emm, I don't know if this, if this even fits with the question Charlotte. (nhh). And it’s slightly different
114		I learn I suppose that I am, I am also really curious about the, the lens of patriarchy and that kind of
115		ideas in the dominant culture whatever that is. And how those ideas are kind of internalised by
116		family. Emm, about body image that kind of stuff. And how kind of normative ideas about what people
117		should look like. (yeah) connect to racism, connect to all sorts kind of really narrow thinking. Emm, yeah.
118	R	Can you give me an example PF3?
119	FP3	I ↑guess I am just, I suppose I am thinking about emm (FP3 hiss) the the, the, you know the pressure to
120		be slim (yeah). Like the pressure to look, to be slim, that certain body type are deemed acceptable

121		and other are deem less acceptable, and obviously and I mean I speak from a position of white
122		privilege and you know hair, the kind of :: hair, hair products that, that that hair should be straight or
123		you know that's the story I heard all sorts of ideas about how people should look. And particularly how
124		women should look. Emm, may be that it's a really, may be that's a kind of very limited idea. Because
125		eating disorders do effect boys as well. Emm, yeah.
126	R	That would be how the boys being effect by those
127	FP3	Yeah, yeah and and stuff about sort of gender, gender identity as well. And and young people who
128		might be questioning emm, questioning their gender, just all of that stuff really, kind of normative ideas
129		(nhh) and this link that often is between the idea of kind of perfectionism and eating disorders. And
130		how, where we are getting these ideas about what perfect is (.1) actually? Emm, yeah, I think, yeah.
131	R	Thank you. PF1 would you like to add anything to that? Or or you are okay or
132	FP1	Yeah, I am okay. I think that what I was wondering about was, was how do you, how do you sort of,
133		unpick. Emm, you know just one part, you know because they are interconnected I think. The idea of
134		you know culture, race, gender, all of those things they, they all overlap. And, and you know and I think
135		that something that I found in my work with family in, in eating disorders is finding out about the
136		individual family's culture, you know. So the culture of the actual family, so it might be a culture that
137		base in their race, their faith or or other things. But actually finding out about how they have created
138		their own family culture. I think that's quite an important thing and what that means to them in terms
139		of coming into services. Emm, you know being under the care of services, having to come and get
140		help. And I think all of those things but you know sort of everybody else touches on similar things
141		really, so yeah (nhh) I suppose that's one thing that I always think about.
142	R	Thank you FP1. I guess that is where we start you know. Perhaps we can hold on to what your thinking
143		at the moment. Because you know like anything, when we talk, we, things beginning to shift,
144		kind of thing, you know. Emm, so what I like to do is, my plan is to emm invite you to put on your

145		professional hat, in terms of, I am going to show you some videos and err, some video clips. Not long
146		one. Emm, so when you looking at it, you can put your professional hat on, and thinking about what
147		you see and notice. And what resonates for you and what doesn't resonates for you. And these clips
148		are video clips from different cultures. I am only going to show you two. The first one, is err, family
149		meal on Nepali family, very different from UK. And the one is Taiwanese evening meal. So I am
150		going to show you and then, with that in mind and then we can have a discussion after that. Let me
151		just share screen, bear with me. One of my anxieties about today, is about technical aspect, whether
152		things work for you, you know. Emm, okay let me do the share screen here, maximise all the things, yeah.
153		And share, and then, yeah. Not this one, I want the other one. Yeah, I want this one.
154		(sound come from the video, knocking sound)
155	R	Can you hear it? Or can you see it? (.4) Hello
156	FP4	Yes, I couldn't see it. I am not sure about the sound.
157	R	Let me just maximise all the sound
158	FP5	Yeah, I can hear it, [I can hear, I can hear the pan
159	R	[I must say that the sound, there aren't that many sound, this is slightly ethnographic,
160		a bit like, just watching. I make sure all the sound turn up to 100, yeah. So there is nobody can not hear,
161		or can not see yeah?
162	FP4	I don't know about the sound
163	FP1	Yeah, I am about to say, I am not sure whether how much sound is there.
164	R	There is not a lot of sound, but let me play it (.5)
165	FP4	Yes, I can I can hear that.
166	R	You can hear some knocking noise of the
167	FP4	Yes, don't know about the others.
168	R	(The video clips is running) This is a nineteen minutes clips. Of course I can't show everything,
169		So when I recorded it, I move it on.

170		(the video clip runs about four minutes)
171 (24)	R	This is a clip of a sort of like culture and meal. I am just wondering what do you see and what do you
172		notice? And how you feel? (.10)
173	F P 3	Okay, if I say something? (nhh) I mean I guess my first thought was emm, feeling of intrusiveness (nhh)
174		who film this and why did they film it? And did the people give consent and I don't know just all, a lot of
175		discomfort really (nhh) and about watching :: watching through a western lens. And personally reflecting
176		on how kind of different, lots of it was from my own, my own experience of family meals, as a child
177		and in the here and now. Emm, and the similarity as well, I got really interested in that (nhh).
178	F P 4	It is hard to know what to make of it really without context or emm, just such a short clip. I mean my
179		impression, I , I agree with FP3 and wondering who is watching and who the mother was responding to,
180		and the impact of being filmed, and I felt what a lovely warm emm meal and how relax despite being
181		filmed. But I was, I was curious about emm, what I thought was the oldest boy having his own plate, but
182		the girl who was, may be his age, now I might have got this wrong and maybe I am making assumptions
183		which is what I was curious about as well. That why was the girl sharing with the younger kids and the
184		elder boy having his own plate.
185	F P 5	Yeah, I thought about role expectations as well. Obviously we didn't see the whole clip and err, just
186		have a snapshot of emm, there we don't know how, may be representative for their day to day
187		experience and so and so on. But, I was wondering role expectation. The girl seems to be the one who
188		was helping out to prepare the meals while there was a boy that, probably the same age or even older,
189		that he was like at the beginning of the clip. Yes, he was having his own plate whilst she was sharing with
190		the younger one. I was curious about the err what seem to be the kind of, err they are eating quite
191		independently, so the little one has very little assistance and how :: much was mum paying attention
192		to how much they are eating. Emm, emm, or if there is an expectation that was the girl who was

193		sharing the plate with. Emm, so I think, I guess that was one of my thoughts. Emm, that no wasting food,
194		there, when you know, someone didn't want their food, they kind of giving it to somebody else.
195		That's some of the thing.
196	R	I just wonder, in terms of the context, this is a you tube clip I found from you tube. They are film for
197		westerner, you are quite right. The title of the clip is actually how they cook organic potato curry. So
198		they are film for westerner to watch how they pick the mushroom from the mountain, from a to b,
199		to everything is cook organicly. So it is interesting when we, when I took it and put this in the context
200		in thinking about eating and culture, in their way of culture. So, it that gives you a bit of context. But,
201		I was thinking about, looking at the clip you know what resonates for you, what doesn't resonate for
202		you?
203	FP1	I suppose, I suppose the first thing come to mind was, was just how. For me, just, just how different it
204		is, you know how difference the approach to cooking, being together, and being err with each other at
205		the meal time. You know it is so different to sort of what, what, what I am used to, you know. And that,
206		yeah so. I suppose that is what I really thinking about is, is how this so very different and sometimes
207		when I eat with family. It is, we all asking them to do something very different, you know and its so,
208		to what maybe they are already doing. So I just I suppose that was what I was thinking about. I don't
209		have any answers to it, its just you know, when we see difference and we are asking someone to do
210		something different. How do people feel about that and what does that do to them? So I suppose that
211		was what I am thinking of that.
212	FP2	I was thinking meal being a very joining time for the family. Emm, almost like that was time to come
213		together. Emm, I was, I was thinking of (.1) coming from quite a matriarchal, sort of family line of
214		who did the cooking in our family. Emm, and my brother certainly didn't. Emm, and yeah it stood

215		there for me as well, that boy had been eating his own plate. But then also the sharing of food
216		afterwards. Emm, ( ) over. Emm, (.1) it just felt quite a relax time. It felt like eh, a sort of whatever else
217		has gone on in the day that time for everyone to come together. And, and that, it felt. I was LESS
218		thinking about the group feel about all the filming of it, which in some way felt a bit and let go. But it
219		was almost like okay. Here we go again, you know. Like it might not been the first time. But emm, nhh.
220	FP1	Yeah, I was thinking, I nhh↑.
221	FP2	(.2) I think it was just yeah, but the idea of sort of being really communal and, and quite a nice
222		experience really. Emm, nhh.
223	R	Just thinking about if you were being invited to a meal, to join their meal, what might be the things
224		that might kind of, you will consider?
225	FP5	Having a fork (nhh) and I been in that situation before. Similar when I was in Egypt and, after emm,
226		you know after Ramadan and, and sharing a meal, and I don't mind sharing a plate with other people
227		having the same. But I felt quite uncomfortable eating with my hands, so I wants a fork. And that was
228		a real contrast in terms of culture. That was the first thing came to my mind, in my mind (nhh) (.4)
229	R	That's what I am thinking about, about resonates or not resonates (.3)
230	FP2	And I imagine as a visitor, your food would have come first regardless of whatever else, anyone else
231		have to eat, in that clip. I don't know it’s just my.
232	R	Sorry, FP2, I don't quite hear what you say. Do you mind repeat?
233	FP2	As a visitor, you would probably have your food put there first regardless of whatever, anyone else had.
234		Emm, oh as a visitor, mightn't been some ( ) African carol in that context. (.8)
235		Yeah, I er, I er agree with what FP1 was saying that, the difference I would find hard. That, I think I
236		don't know, I hope I would be able to, to manage that. I mean sound absolutely delicious (FP2 laughs)
237		actually. Emm, but I was just thinking we, we do the family meal and my workplace, and how

238		comfortable would that family from a similar background feel err, re-enacting that in our setting. I should
239		think would be really really exposing and difficult. (.8)
240	FP1	I suppose one of the thing I thought was that, there wasn't in in clip, there wasn't anything that I saw
241		felt uncomfortable (nhh) you know. And and so much of, of what the sort of we doing in our service,
242		when I eat with family. It is, we all asking them to do something very different, you know and its so
243		much of, what : sort of we do in our service, you know when we did family meals. It, it feels really
244		uncomfortable and it feels as though everything you know, you are sort of, you are having to sort of
245		REALLY make sure that you are doing, you are doing things in a very particular way. Emm, where as
246		watching that clip, it just flows. You know, they are sort of all, sort of knew what they were doing and
247		you know everybody knew where they sat, and you know you sat wherever, you use your hands and
248		it just felt, it felt very em, just very comfortable, and it just flow, whereas you know I am thinking at
249		the moment about, sort of my work context, and I was just thinking actually, you know when I am
250		working with families. It SO HARD. You know, you got people that are sitting there and sitting over
251		their children and making them eat. And it's you know, SO HARD. It is really hard work, and that
252		wasn't hard work. It seems really quite you know simple, and easy and straight forward. I suppose that
253		was the thing I was thinking about (nhh)
254	R	When you thinking about it, what does it do to you FP1 I was just thinking?
255	FP1	(FP1hiss) emm, you know (FP1 laugh) I felt I just felt exhausted, well not exhausted I felt like actually
256		
257		and that, and that and watching that just make me felt quite comfortable and quite you know, it is
258		quite nice actually, to watch the family you know having a meal and they are not being a struggle.
259		They are not being sort of like, well has it been forty-five minutes, have we done forty-five minutes,
260		do we need to take the meal away (FP1 laughs) you know. None of that, it was just you know. We are
261		putting this all of this together, there you know, they all had the same thing. Emm, you know there was
262		the sharing and it was, it was really nice. And it was make me feel quite, you know sort of quite

263		comfortable. (nhh) its different but it just felt, just felt quite comfortable which is nice really, in
264		comparison to sort of the conversation that I was having this morning with families (FP1 laughs).
265	R	Okay
266	FP5	I was thinking about, emm well err, two things interconnected really. How probably it is different if we
267		were emm join them for the meal at home. Rather than coming to the clinic and, and I think you know
268		
269		if we asked them to have the meals in the clinic and how different would that be. We wouldn't really
270		GET the experience of them at home and how, now with the corona virus measures and we work
271		remotely that we are getting that experience. So we are doing family meals remotely and watching
272		them at home. Emm, and it also effects how we interviewing, doing much less interventions and and
273		more like, emm participating in them, have conversation afterwards. Emm, so I think its emm touching
274		something that FP1 said earlier on, thinking about the cultural of that family, and how we perhaps have
275		to ask what family meal were like, for that family before the eating disorder came about (nhh).
276	R	Thank you, does anybody want to add anything before I move onto the next clip (.4)
277		So, I am going to share the next clip, the next clip I will give you a bit of context. Apologise I didn't
278		give you the context early on.
279		This is a clip about err a family, it's a movie actually, a clip from a movie which I found from You tube.
280		And its emm, it's a Taiwanese family having a meal together. Taiwanese is the republic part of China,
281		not the communist part, I think. Emm, let me share screen again, find the share screen button. And (.8)
282		Can people hear it or see it? Yeah. And they are in Taiwanese language, perhaps you don't understand
283		but this has got eh translation, transcript at the bottom. Let me get it,:: ehh big on the screen and start
284		at the beginning.
285	R	(The video clip running for about three minutes)
286		I assume you can hear and see it and the transcription, not transcription, the subtitle at the bottom.
287		Again I ask the same question, you know what do you see, notice and feel and anything that resonates
288		or not resonates with you? (.4)

289	FP5	The amount of food for four people, could feed an army. That amount of food, the variety and keep
290		coming. It seems that the father was very much the, the one incharge, in terms of cooking. That, that
291		was like ( ).
292	FP2	I was thinking about gender narratives and about the role of the Dad and lot of my focus was looking
293		at him and what he was doing and how he was managing. How he was, it felt like, where is the other
294		one felt more relax, it felt like there was stress and pressures, and burden might be on his shoulders, and
295		and I was just wondering whether there was like the core part of the family that were, you know be
296		eating on a regular basis where people had come back from ( ) or whatever they had done. And he
297		was just trying to maintain the normality what the family normally, what their normal routine stuff.
298		Emm, that was quite distracted in lots of ways. There was all this food that was saying emm, and first
299		I wonder was a ↑celebration, or festival or something. Then, I thought well might be not. But, it
300		still felt quite a, a stress time, family, and then he got called away. And it was almost like, and whatever
301		his work context was quite a stressful environment where there was a lot of authority and then he was
302		bringing that, and that was sort of quite unresolved. So, yeah I was LEFT with more questions on this
303		one, than the last one. Emm, and just wonder about, yeah, what are the conversation they want to
304		have and won't able to have. Emm, whilst she was, what might have been what they talked about
305		afterwards ( ). So yeah, it was, it felt MORE of an effort to bring everyone together in that sense than
306		the other one.
307	R	SO, I was wondering FP2 what resonates for you then, as as when you heard, when you notice all
308		these things you know.
309	FP2	I think what resonate was, may be the tension and the sort of walking on eggshells (FP2 smile) and
310		and a, I was trying to put myself as a female and we are all females here, and nearly everyone was
311		female in the video. I was trying to put myself in that position. But then I also struggles, I think within

312		that, yeah, I was just thinking about gender narratives and (.1) and whether he position himself as the
313		head of home and needed to be providing, and emm how much he put himself in that role. And how
314		much society put himself in that role, was it, was it a struggle, then on for me. And :: thing.
315	R	I don't want to put you on a spot FP2, but I was thinking why these things resonates for you? And
316		not the other things. Or I er, it can be a similar question for the rest of you.
317	FP2	I think even just people body language in, in that clip for me. It just felt more laboured than it had
318		been the first one. Emm, yeah (.1) (FP2 hiss) (.1) yeah.
319	FP1	And I suppose I think it felt more familiar. Emm, for me. It eh: you know the the fact that they
320		were sitting at a table, and:: emm using knives and forks and sat in the food out. People were
321		helping themselves you know, in a particular way. It just felt a bit familiar. But, but the tension felt
322		familiar as well. If that makes sense, you know, a sort of what you were saying FP2, about that, that
323		sort of tension. And absolutely, I think that was the other thing and that's the difference between
324		the sort of first video and the second video, is that there was that tension and there was, err you know
325		a dynamic and there was something going on within, within the family that we are all sort of wondering about
326		and we are all sort of curious about, that actually you know we did not sort of. Well, I didn't say,
327		I didn't pick up on in the first video. So there is a bit more familiarity in it because you know, that's.
328		If you work in an eating disorder that's what you seeing every day, isn't it really? Emm, but we err, you
329		know sometimes we get tension at home as well. I sometimes you know ↑meal time at ↑home are
330		tense, aren't they? You know for me and my family. So, its its just that familiarity there, I think I just
331		more generally in that video? for me.
332	R	What does this familiarity do to : do to you then? You know, when you see something familiar, familiar.

333	FP1	Emm, .hhh I suppose when you see something well↓ when you see something familiar you are sort of
334		think ahh okay, maybe I know a bit more and I think it might shut down a bit of your curiosity because
335		you think ↑ohh okay I know whats going on here. But emm, we don't necessarily, so er yeah, I wonder if
336		it does, does that sometimes.
337	R	Because,[you think, sorry carry on
338	FP1	[I think that, that, that happens certainly in an eating disorders service is that you think. Right
339		okay, so this is what we got to do and we have to follow this, this path and we have to be doing this,
340		and you know they have to be refed and you know, and there is a lot of medical intervention, isn't there?
341		with an eating disorders. Emm, you know, so its that, oh okay, so you know their blood test is come
342		back like <u>this</u>, so we have to do this, we have to do that. So emm, its sort of familiarity makes you feel
343		like, maybe you know what you are doing but in, in a way that's not necessarily good thing because it
344		might stop you being curious about, may be other things that might be going on. So, yeah, yeah, may be
345		maybe.
346	R	I am curious about when you say the bit we don't know, because I think we talk quite a lot about things
347		that we resonate (PF1 nhh) and I just wonder if there are anything don't resonates for you.
348	FP1	(.2) about that particular clip?
349	R	Or the previous clip as well, you know we start with two clips.
350	FP1	Nhh, nhh, I mean I guess culturally they are very different to me. You know I am, I am white British and you
351		know I have a certain background and you know its different to their backgrounds. So, I guess that
352		doesn't resonate with me.
353	R	Nhh, so what happen when the background of not familiar, not resonate, you know what happens?
354		Err, how do you know, how do you know that (FP1 err) this is not familiar, this is not resonates, and
355		what do we do with that?
356	FP1	Nnn, I am not sure↓

357	R	No, don't, don't say. I am just asking question (FP1 yeah) I don't have answers either you know (FP1 laughs)
358	FP4	For me, it makes it harder to be curious, even though I might be inside, it : I : struggle to ask the
359		question in case I cause offence (FP1 nhh) Emm, (.2)
360	R	Because inevitable, we have something share with the family and something we don't share with the
361		family. What do we do with, I think the share bit and the not share bit, they are equally important.
362	FP3	Yeah, I mean I. I felt really frozen and I kind of fear (FP3 hiss) and I, I , I kind of resonate with what FP2
363		and FP1 are both saying about that, that kind of tension. And the resonace is probably from my own family
364		orignin actually. Emm, I guess it is interesting I think, that, that, it was in my body, the frozeness and it
365		makes me, don't know↓, its information in a way. Emm, but it it it makes me wants to tread quite
366		cautiously. Emm, yeah.
367	FP5	Yeah, I was thinking one of the tensions I saw there was this invitation for feedback but at the same
368		time not quite being open to it. And and how feedback is given, which felt emm, emm, critical to some
369		extend. And err and how other people then try, you know respond, you know to try to manage the tension raise there. And
370		I think that's one thing that we do, deal with quite a lot in eating disorder, not necessarily the meal
371		time. But in, you know meal time all the time, well I think it was quite interesting. And I, I go back to
372		that idea of asking family how (PF5 clears throat) how were their culture around eating before the eating
373		disorder came? Because I was making an assumption about the clip that : emm, which is different, felt
374		from the other clip, that the other clip felt that is a real kind of family time together, quite relax, quite
375		enjoyable whereas this is more like a rule that you have to be sitting around the table, err not
376		necessarily that you, you enjoy, you have choice, choice. Err, and how that creates emm, an atmosphere
377		nhh.
378	FP1	But it is interesting isn't it? Because they were doing the same thing, they were having a meal together

379		as a family. They were doing the same thing. And its, its just left us feeling so different. (PF4 nhh) you
380		know, I suppose that's what I am thinking about as we are talking really.
381	FP2	There is something about the table and the, it is funny because every Sunday night growing up we used
382		to have like meal round the table. We did habit, habitually thinking it was great and it was fun, and it
383		was lovely, that. It was years later talking to like, my brother in law and he was like, oh my God that
384		round table used to really freak him ↑out. And it was like we thought it was a really inviting space, err
385		aside everything else. But, it, for him it was just like the torturous (PF2 laugh) he went through. So
386		there was always lots of emm CONVERSATION and DEBATE and stuff in our emm, family growing up.
387		I was really strike by the silence by this one. And I think emm, yeah, that really resonated with me, about
388		it being quite a quiet emm, not very conversational (FP2 laughs) and it almost like who could get away
389		first. That was what I was looking at. When I saw that I was like, oh my Gosh, where is in ours I just
390		think sometimes the conversation made it (FP2 laughs) part of the meal, part of the meal. Emm, but
391		with this family, was almost like they, conversation has a different place or where it might be.
392	R	Thank you for sharing FP2, I am hearing some contrast in terms of like, this meal, this particular
393		family, this meal clip, and your own experience of tables and Friday meals. I was thinking about one's
394		own experience and what they see. How do they, how do they come together?
395	FP5	Not sure what I understand what you ask, could you say this again?
396	R	Using FP2's example, in terms of like see, the table, the meal that the family come together. Correct me if I am wrong
397		FP2, if I don't rephrase it probably. It is a kind of like, err ones' own experience. FP2 talks about her
398		own experience of her meal, you know like. And then seeing the meal clip which is completely
399		different table, chairs and atmosphere, different rules, different sort of like err meal altogether,

400		a different culture. And I was just thinking about between one's own expectation of what a meal
401		could be like, what is resonates with us, what's familiar with us. To something NOT familiar, don't
402		resonates, how do we manage these two worlds, you know.
403	FP4	Yeah, I err, I agree. Because you are in danger of possibly or mistaking a silent family for I mean,
404		we probably on to something, there was lots of tension and it was about, may be about one of the
405		daughter moving out or something. But I was, just make me think I might be in danger of mistaking
406		silence round the table for tension. Whereas in fact, that might be a cultural norm. Emm :: there is the
407		article, can't remember who is by, it is call the family meal? And I quite like it about the importance
408		of family meal for communication, and bringing people together, etc, etc. But I remember some
409		emm, people critiquing it saying that this is actually a middle class sort of template for how family should
410		behave. Emm, I don't know I gone off the tangent.
411	R	No, no, not at all. I was thinking, the next question I have got, in the kind of, what is the overlap
412		between when we think we know, that we see something resonate, familiar. And when we see
413		something we don't know, because it is all in our head when we met the family. Something we don't
414		know, and something we know, and how do we manage this two spaces? What is happening?
415		What do we see between this two spaces?
516		(FP4 clear her throat)
417	FP5	I don't know it is interesting that we :: emm, using certain aspect to associate with tension, and we
418		mention about the ( ) Because we think, on thing that resonate a lot with my experience of family of
419		origin, origin, is that emm you know. In my family, in my whole life, I am still happening today, everyone
420		( ) have twelve o'clock for lunch, okay. And, and there isn't a lot of conversation, there are some
421		conversation but not a lot of conversation. We do talk about the morning what we are going to do in
422		the afternoon, and sometimes about you know, but it ticks whatever is happening. Emm, and there is a
423		ritual or you know : first course, second course, through the end, dadi dadi dadi dada. Emm, and

424		sometimes there is tension and sometimes there isn't, is, is , very much part of our culture as a family.
425		Emm, so I think there was lots of resonation, resonance with this second clip to me. But, there were,
426		the tension I can't put the finger on that I felt in this family, not necessarily to do with the silence.
427		But, yeah, emm But I think it is emm, what's other people saying how this err a risk that you
428		become less curious and make assumptions.
429	R	When things are more familiar when you feel resonates (FP5 yeah), you lose your, your curiosity
430		(FP5 yeah) and yet I am, I am still a bit unsure about that, looking to you guys to help me to think, to think
431		about it is like, what do you see when you kind of not resonates with something, something that is
432		not familiar, what do you do with that? How do you know it is not familiar to you? And why it is not
433		familiar to you? (.12)
434	FP4	I mean I know in theory when there is something that we are not familiar, we should fall back on, you
435		know systemic principles of err curiosity, etc. But I think when in the context of eating disorders, it is
436		like a double block to curiosity, there might be the cultural issues of difference, but already the family
437		are there in such an expose, tense ↑position because of the eating disorder. So I think that those
438		sort of double exposures might make me more even hesitant. And I sort of know it shouldn't because the
439		therapeutic aim would be to up your curiosity. So this is very helpful to think about actually. How to
440		take risks in this context of super sensitivity.
441	FP1	I think, that's, that's the word for me is the risk, isn't it? You know, because uh uh, I completely sort of
442		connect with you on that, its when you are with the family where they are concern their child is going
443		to die because they are so underweight and they are, you know it is how do you take risk and ask, and
444		ask things about, things they might not necessarily sort of seeing as being connected. You know, sort of
445		they are sitting there and they are sort of saying, well you know our blood pressure is dropping and

446		you know she has lost two ↑kilograms. And you know but they, then we are asking questions
447		about sort of other aspects of their life and, you know so, its how DO you do that in a way that, it
448		sort of make sense. And, and it doesn't feel look, like it doesn't make sense (R nhh) and yeah. I suppose
449		that was, that was the word that you were using FP4 that make me, yeah it is about risk, isn't it?
450		Because you know, we are sort of dealing with different type of risk, it is not just relational risk, its
451		you know physical health risk, ehh things like that.
452	R	Do we have a chance in terms of thinking about cultural practice (R laugh) and I don't take that away
453		you know, the physical risk, threats and health is very big, you know the risk. But, is there any chance
454		for thinking. PF4 talk about the double risk, the first risk is when you are a bit about uncertain about
455		the cultural aspect, how do you think it about it with the family. The second bit is the sort of risk as well,
456		in terms of physical risk you know. So that's, totally agree that it is the challenge. Emm, (.2)
457		So on that note, I suggest we do something slightly different. I suggest we do something slightly different,
458		I am suggesting we are going to do, we do a fish bowl exercise. There are five of you, so arrh, if, I am
459		going to put two questions forward, on the chat. Which is like, How does the consideration of we spoke
460		about resonate, not resonate, where is the space between resonate and the two clips link to the wider
461		eating disorder practice. Which are not just the meal, eating disorder is always more than just the meal,
462		you know, even the meal is very important. How does that resonate or not resonate, the emm kind of
463		like come into consideration. And the second question is like bringing into like the familiar family to, to, to
464		What working with family of similar race ethnicity and cultural background, or white British background
465		if you are, because they are sort of the majority service user. Arr resonates, or not resonates? How do
466		you relate to that? You can give example if you wants to. So I am going to put these questions onto the
467		chat, so you can see. I know it is quite a long questions you know. So if we do kind of fish bowl,

468		ten minutes of like three of us talking and the other two just listening, and then the listener will be talking,
469		and then we will be coming back together, have an open discussion about it. Would that be okay?
470		In that case, I need, I will type the question onto the thing and then, I have FP3, FP2 and FP1 on one line,
471		is that okay for you to go first and FP4 and FP5 you can turn off the camera, so we are in reflecting team
472		mode. And I am just a facilitator. So I am going to type the questions onto the chat.
473		Err let me put the first question. How does the consideration of what resonates, and what doesn't
474		resonates, forgive my typing, bring to wider ED practices such as non-food issues? Give example if you
475		can. The first one is on the screen, is that on your chat box
476	FP3	Nhh
477	R	I am typing the next one in as well, when working with family of similar race, ethnicity and cultural
478		background or white British family whether it resonate or not resonates, how do you relate to that?
479		Give example again if you can. The question is on the chat, you can refer to it.
480	FP5	Charlotte, the first question, is that err resonate or not resonate, is that like or link to the eating
481		disorder practice?
482	R	Link, thank you. I can't change it now (R Laughs) it is all gone, come from my typing.
483	FP5	That's fine, thank you.
484	R	It is LINK to the wider ED practice such as non-food issues, it meant, it is a S not an at. Give example if
485		you can (.8)
486		(Fish bowl conversation between FP1, FP2, FP3.)
487	FP2	For me so far we spoken quite a lot about the family is this emm :: the, the observed, and then may be the team being the
488		observers and, : I think in order to even to start having some of the conversation that needs to be like err, a
489		further fix space. Emm, and that is creating a safe space for this sometimes quite difficult conversation
490		and challenging conversation. So in a sense, it is almost like : responsibility to have, reflexive supervision

491		spaces and : were people can be challenging and feel safe to be challenged as well. And :: it is
492		For me so far we spoken quite a lot about the family is this emm :: the, the observed, and then may be the team being the
493		learning, and those learning spaces. Emm, its almost like you, its very easy to become very insulate our
494		conversation, our thinking, our thought, our, we , we sort of leaving to a stuckness as well. And
495		culturally well it, that's what we are used to doing and all. Talking about unless we are challenged or
496		in an challenging environment, to may be move on our thinking. I think that was the other thing that I
497		was◦ all that.
498	FP3	What do you think that makes an environment, what other the kind of, of the component of being
499		challenged, what helps it to be challenging and safe [OR the opposite. I guess what stop
500	FP2	[well one of the, yeah
501	FP3	that from happening
502	FP2	Yeah, I mean I think at the moment. So I teach on a weekly emm family therapy workshop, which
503		in a sense is locally, it is very multi-disciplinary, people are coming in and out. We can have anywhere
504		from four or five people to may be about twelve fifteen. And almost to me, that's a sort of co-facilitate
505		of that space. It's almost like okay, because we have sort of set the time, you know. You know, its very
506		dependent who is in and out of the room
507	FP3	Right
508	FP2	who is going to come, its almost for me, like a space to trial. Emm, trial new theory, new new systemic
509		concept, and people have sort of. It almost sort of got everyone buy in, that was our space that we
510		can sort of you know, move it and, and hear it, however we want it. So, that feels very very safe. Now,
511		I could be in the same space with the same people, with more people (FP2 yeah) might not that rapidly in that
512		systemic way, in the same way (PF3yeah) and it might feel quite different. But in that particular

513		space (PF3 yeah), one week emm, for me that experimental bit were : it doesn't feel like you are
514		judged or anyone feeling being judged in some way (PF1 yes yeah yeah yeah). But, FORTUNATELY
515		everybody is able to get that, <u>now</u> you know I don't want to say that two of us that are with our
516		systemic hats are facilitating something that feels the safest to most of the people THERE. But I think we
517		do quite a good job at it, and I think we work really really hard at it. Emm, I am very mindful of my
518		own position in that space and how that could change into different spaces. Though I don't know how
519		you create a safe, that safest space in the first place (FP1 nhh, FP2 yeah)
520(1. 11	R	FP2, can you give an example of what you mean?
521	F P 2	The other day for instance, I err, I had particular taken a family were, who was emm, you know the
522		young person had eating disorder and quite complex, atypical anorexia, didaladada, and emm been
523		lots and lots of discussion and I felt that was a really good one to bring to the sort of family therapy
524		workshop. The one we would take in turns to present, emm take the case or dilemma, or where we
525		felt there are some stuckness. That was very instinct because we had the review of the same young
526		person and their family. And and may be some of the split in the team and how different professionals
527		had felt, position. And it was actually quite hard work, because it wasn't a specificly systemic space.
528		But it, its much more psychodynamic team been pull into that dilemma (FP1 nhh) of nnn, safe for me,
529		I am not leading on this, what safe to reveal, what safe isn't, how safe I can go in terms of where I was really
530		struggling in my practice with this one (FP1 nhh). Emm, though it was about holding and remain curious,
531		holding the space but also taking the risk, taking the relational risk of saying what I really struggle at the
532		time. We had not had the chance to reflect on the full MDT on it, but actually as difficult as it was, but
533		it was really useful to go back to that and think, well actually how much my thinking had changed. What
534		are the area of practice that I know that I would like to think and develop. Emm it was quite interesting
535		about the new information that I came out in that discussion in that hour. But for me, there was

536		something about letting go of what was the routinely safe space to can I take a risk in this use space
537		which isn't which feels a bit mo::re yeah trickier yeah
538	FP1	[which is the safe (FP1 laughs) yeah more tricky a bit more vulnerable yeah.
539		I think, I think that's something (FP1 hisses) emm, that I can, can sort of, it was, it was so helpful
540		to hear you say that. Because you know when working as MDT is amazing but actually sort of going into sort of
541		their, into situation into meetings, or into group supervisions where it is not appearly systemic space.
542		And its really really tough, especially when sort of my colleagues will privilege something very
543		different about the family, to what I might privilege you know, emm so my my medical colleagues will
544		privilege the sort of the medical bits you know, emm my you know other sort of therapeutic colleagues will
545		privilege something else. And its really hard to sort of going to those sorts of meetings, and talking
546		about these families, you know the families that were working with, you know we are trying to open
547		stuff up. This, this when I sort of take families, I am trying to open something up and to think about it
548		a bit differently because I know I do get stuck sometimes. Emm, actually they will do potentially is that,
549		you know it, it won't open up. It will close down (FP2 yeah, yeah). It feels really really hard, because I am hoping
550		to go into situation where I am opening something up, you know so that I can go in and be a bit different with
551		the family or think about something, be a bit different, and actually its got, it got a sort of shut down
552		and its really, really hard. The idea of being vulnerable and showing, actually, my colleagues, I don't know
553		what I am doing here or I am no (FP1 laughs), I am feeling stuck, you know. Err it really really hard work,
554		really hard (nnh)
555	R	I am thinking if there is any isomorphism that between colleagues, actually can be similar something
556		like this happen between us and the family, therapist and family? (FP3 yeah) in terms of culture
557	FP2	Yeah, that's very interesting because it ended that where, two team members felt that the family
558		therapists were privileged, in the good cop bad cop scenario. And the, not necessarily their experience,
559		the experience about doing the family therapy was really really hard work and really tough. And I am

560		, all of us at some point in the team are mentioned that, it felt not good enough. (FP3 yeah) emm
561		it was very interesting to come together to hear those stories what haven't been, the untold isn't it.
562	FP3	Yeah, and I suppose in a, in the context we worked in, humble story as well. Emm, the kind, like you said
563		that when people feel not good enough. I don't know if I am going off topic but (FP2 nhh) are other
564		discipline allow to say that? (FP1 nhh) I don't know, emm I guess we all don't we, we all have our own
565		kind of our family story about that and the matrix of culture, culture lens we bring to that. The culture
566		of our family, the wider and all of that kind of stuff.
567	FP1	But also I think that fear of being vulnerable and, and and looking as though we don't know what we
568		are doing
569	FP3	Yeah, yes
570	FP1	And you know, and I wonder whether you know like, you were saying FP3, may be other sort of colleague
571		from other professional background whether they are able to connect with doing that. You know, I am
572		fairly sure that, one of my colleagues, you know who is a medical colleague would, would
573		not be ↑comfortable saying, I don't know, I am not sure (FP2 nhh). OR I just wonder may be, you know
574		because of our training, and because of experiences, we are sort of maybe we feel a bit of, OR
575		(FP3 deep breathe in)
576	FP1	we are suppose to feel a bit more comfortable (FP3 yeah) with being vulnerable, or asking the tricky,
577		you know saying the tricky things, I don't, I don't know.
578	FP3	I think it is a culture, may be this this is (FP1 nhh) going to make a bit of statement here. I think I
579		sometimes I think it’s a bit of a privilege in a way. Like we are thinking, to to to have a training,

580		or a supervision structure that allows you, that you are permitted to do that (both FP1, FP2 nhh). I feel
581		really that's, I feel really fortunate (FP1 nhh) to be allow that in a way. Emm, but YES, there is also
582		that question about how, how is that seen, how might that be seen, how might that be perceived
583	FP2	It was also, look, probably got five minutes to get your point across in that setting
584	FP3	YES SS (FP1 laugh)
585	FP2	with no set agenda there
586	FP3	YES, YES, YES
587	FP2	with no set of agenda, so it's a sort of like, almost like you are in, you are out, talk to the wall in
588		some sense.
589	FP1	The hot seat (laugh)
590	FP2	How can you respectfully, cross your point in your five minutes slot without marginalising (FP1 yeah yeah)
591		or ( ) But, actually you know when you hear the, I don't know, the pathologising of the parent (FP2 nhh), or
592		or whatever, which sometime are really great (FP1 yeah,yeah) with, without actually saying no. We are
593		not been, been taken, not terribly effective but we are trying to be emm respectful of the family
594		members in a different way.
595	FP3	I know
596	FP1	Yeah, yeah, yeah
597	R	I am afraid I am going to err intervene that, because we are done our ten minutes, we need to give emm
598		FP4 and FP5, their response to what we had talked about.

599		Perhaps, FP1, FP2 & FP3 can turn off the camera, so FP4 & FP5 can turn on their camera.
600	FP5	Yeah, I think you know the dilemma that err they share are so familiar and so emm resonates a lot to
601		me, in a way. And I was thinking, for example FP2 saying that the responsibility to have supervision and
602		and, er to be part of, to create reflective space, and I am thinking emm being in a position,
603		like me and you FP4, very much in a kind of supervising in the team, not just of having supervision
604		but how can we support the team to support the team to develop that culture, and that understanding
605		and how hard it is. I had experience with someone who I supervise many years ago and she err, was
606		employed as a family therapist even though she is not systemic train family therapist. And er, when I
607		brought conversation about culture, and said what is culture has to do with it. It should be the same
608		for everyone. Emm, and er and I am thinking you said about your services, having lots of psychologist
609		and err, and my experience of some psychologists, not all of them. Some psychologists that they
610		have this, they think they are very systemic, they think they know it all. And actually when they come
611		from this position of emm expertise, certainty which is the other point that the group was saying how
612		emm, how difficult it is to introduce the idea, even the idea of curiosity and, and emm you know and
613		being vulnerable, I think, err not knowing, not emm you know. I don't necessarily relate, not knowing
614		with vulnerability but you know. So, all all very very relevance, I guess.
615	FP4	Nnh, yes, yes. I completely agree. That question I think FP2 first raised about how, how do we make
616		it safe for us to be able to take these relational risk and cultural risks. Emm, but we the team, what
617		are the factors in the team that can make that more or less easy. And I think we have a responsibility
618		, be it for a training role to sort of lead by examples I suppose. Emm, so to, to may be, be brave. When
619		we say when we feel out of our depth, when we don't know. And I liked, who was it, err FP3 was

620		saying emm, it was err a privilege in a way, to be able to talk to the not knowing position. And I haven't
621		thought of it like that, and err how much more difficult for other disciplines to be in that position and
622		OR if you are the consultant responsible for everything to be in that position. Though I think the
623		not knowing position, can mask how difficult it is (FP1 nhh) personally to be in a not knowing position.
624		you see what I mean.
625	R	I wonder if this not knowing position is when we are with the family, when we are not, when we know,
626		we are familiar and resonates with them. Or when we are in a place when we are not quite sure. How
627		do we go on with that.
628	FP4	That might be a helpful middle position, in between knowing and not knowing, not quite knowing. Yeah,
629		I like that.
630	R	And I wonder what that space might be, when we know, when we don't know you know. How might
631		we present ourselves to the family, or, we talk about risk and safety. I was just thinking about when
632		we do work with err cultural work with the families, when we not knowing and when we know what
633		happen? (.1) How do we manage that relationally with them.
634	FP4	I had an example, I don't want to take up all the space FP5, am I cutting it.
635	FP5	No, no, no, go for it.
636(1.24	FP4	Emm, I think it is so important to feel safe in your team. And I had an example recently emm, working
637		with a Bengali family, and and the girl did not have a straightforward eating disorders. It was
638		overlapping OCD and our hypothesis <u>was</u> that emm, she been in hospital couple years ago. Sudden
639		leg injury that had gone <u>horribly</u> wrong. And emm she been really frightened about the future and it still is.
640		But at the same time, her father was in the referral, but never spoken about with the family was in
641		prison, and suddenly had gone into the prison. The father was actually the person the girl was closest
642		to in the family. And, it took me :: ages to (FP4 clear her throat) ask about that time or make a link with

643		that time. But, and, it's a family I use an interpreter with, and I, I deliberately asked the question when
644		the interpreter had finished at the end of the session. That maybe difficult and I asked the
645		family if it was all right to talk about. They said yes, but then emm, few days later. I got an email from
646		the girl's older sister who hadn't been in any of these sessions, saying (FP4 hiss) how dare we talk about
647		these painful issues that had nothing to do with the eating disorders, and why were you making it worse
648		sort of things. And emm, I just felt without a safe team, or a team where I felt supported that would felt
649		terrible. I mean it did still feel terrible, because it did make me think that I hadn't engaged the family enough
650		before asking that question which cause I know it was hugely shaming, but I still think that it needed
651		to be ask.
652	FP5	Yeah, and and I think that way be an isomorphic, emm with that, was saying emm really to do with the
653		agendas I guess. Or the, the, the medical model taking very much, kind of priority in, in front of err
654		of, of the questions or what we need to attend to, and and some of those emm dynamic or, or
655		experiences or or aspects like, you know like cultural and, and ethnicity and so on might emm not
656		have the ↑time. Because of, err I think one of things I first say was you ONLY have few minutes to
657		to you know, either to discuss a case sometimes and you just need to, to get to the, to the
658	FP4	POINT
659	FP5	point (FP4, FP5 both laugh) or or you know, get a, a, answer for what you need and not really time
660		to reflect or explore. And think a bit more about the family in a, in a more systemic way.
661	FP4	And don't you find it the, the, where you are now FP5?
662	FP5	I have been at (name of service) for almost (number) years, not for very long because I am, I resigned.
663	FP4	Yeah

664	FP5	Emm, but it it it is very challenging, and I think the challenge, eh we are here today, we all systemic
665		family therapists, train systemic therapist and we find this work challenging. Emm now
666	FP4	=Huge
667	FP5	Imagine someone who : emm isn't, or has a different theoretical background or even not therapist.
668		And are doing this job, and how we are supporting them.
669	FP4	And I was yeah, I was asking where you are at now. Because I was wondering, like us we had a massive
670		increase in referral, and people are :: so overloaded and like you say this work is so challenging. If you
671		see four or five families a day, err your brain is just shredded and you, how you can think about these
672		complexity. I am, I am quite worried about my team really. I fortunately they are all really young↓. I can see
673		them getting more and more miserable and BURNOUT. Emm I think at the moment is really really
674		difficult. And to, to be : sensitive to the cultural differences and the engagement and all that just, I think
675		probably takes more time, but whats been really really squeezed at the moment is time and thinking
676		space. So I am quite worry really.
677	R	On that note FP4, sorry to ::
678	FP4	=Sorry.
679	R	= I think we need to mindful of the time. Shall we bring FP1, FP2 and FP3, so we can have our last part
680		minutes, and I also want to give you a break and we need to finish 4.30 and we still got one more
681		exercise to do, to bring the whole things together. So shall we do about ten minutes. Then, we can
682		have a quick comfort break, five minutes, and then, I think we are tired (nhh) after zooming, staring at
683		the screen for a bit. So, shall we come back together to just thinking about what we heard, what we
684		spoke to each other (.4).
685	FP3	I guess I just feel quite emm, kind of emotional listening to FP4 & FP5 speaking, and .hhh I guess some

686		wider point I suppose about the, the impact of COVID, on relationships. What that means, you know
687		what that means globally, what that means in our communities, what that means emm in our
688		public services. Emm, and I actually I feel like :: this kind of challenge to attachment if you like. It means
689		that. Yeah the, the, the need to be building secure relationship and doing that work. Emm, is never more necessary
690		at the moment and harder at the moment I guess. That's what I am, I know this is not related to eating
691		disorders per se. But, yeah. (.1) And curious about why, well may be, may be not curious, may be it
692		make sense but kind of curious about why such an increase in eating distress at this time. But it also, yeah,
693		I got some my hypothesis and ideas about that.
694	R	If I change the subject like, I just mindful I post the question when working with family of similar
695		race, ethnicity background or white British family and I notice we haven't kind of discuss about this. I
696		wonder if its err, because my question is not very clear or actually the, the context are so big like COVID,
697		team, tired and everything become quite difficult to think about emm, the details in what happen in
698		race, ethnicity and culture? (.8)
699	FP2	I :: must admit I drove over the question a bit, because I, on the one hand I read if you are working with
700		a someone with similar cultural background, whatever that might mean but then I also saw on the other
701		side of that, emm, if they are from a white British background. And I thought right I am not from a
702		white British background. Emm, then I was wondering if there was a part two part question or, or how
703		that could be. Emm, I just remember speaking to someone during coffee saying that, that the clinical
704		lead was saying, no, no we haven't got time for reflecting space (FP2 giggled) and I am like oh my God,
705		it is like time that we really need to have, and even when they are limited, its like bloody prioritise
706		your time. So, yeah, some conversation I can't remember when it was, its like you saying about,
707		if the team, five families a day, and how joining it is. I think, we just like have a big thing around like,
708		Black Lives Matters and you know black history month emm. But also thinking about self-care as clinicians and all of that.
709		and I thinking them, and I think everybody here it has mentioned something to do with where
710		self-care gets position or doesn't get positioned and I think during COVID. It, it's the fact that demand

711		and capacity issue (FP2 laughs) just keeps, almost like its like the, the balloon gets bigger, bigger and
712		bigger, until its ready to burst. And at what point, then I know, for me I just thinking, with all of this,
713		none of this is sustainable I suppose. Unless issue of self-care and whether a meaning look through all
714		of that. Emm, apology I might gone off track a bit and I am trying to remember, what the initial
715		conversation was, though for me, I just think again the safe space or reflective space is, the supportive
716		space is. And its time and the boundary, initially for me at the beginning of COVID, it was like well you
717		know, twenty three webinars to go to every week. Well, (FP2 laugh) that was fun for a while, and then
718		after while I had to find myself in saying no. I need to stop some of this, its too much activities.
719		Because at some point, you need to be able to switch off and just be, spending time with love one or
720		whatever. So, for me I am sort of thinking a:bout, what is the learning from this second lockdown, from
721		the first one. And some of it, we, we might be looking through our institution and whatever to help
722		with that. But I think, with some of it we need to just really really be boundary to ourselves. And I think its
723		that, that dilemma emm really. Because I think at the end of the day, issues of race and culture, ethnicity
724		they were talking about, we are here to talk about today. If they are already taken a back seat role
725		at the beginning of COVID, my worry is that it become even more (FP3 nhh) of a thing. Yeah, because
726		you still hear conversation saying ↑well, we haven't got time to do that now. Its like oh my God, are we
727		so, are we further away from meeting emm meeting these needs
728	FP4	I think, I think we might be. And that's a big risk. Because I was thinking I, you know I, sometimes I say
729		this in : the team. But it, it is quite a: a risky thing to say. Part of me feels I can't do family therapy emm
730		on screen, on line. I can do parent work, I can work with some family, individual fine. But a very
731		conflictual:: er whole family I can't do very effectively. And then thinking about putting cultural issues

732		into the mix (.)where one has to be slower and more sensitive and pick up cues you know. I, I don't know what
733		all the difficulties are. I, I just, I just sort of feel I can't do it actually. But that, that emm. I don't know
734		whether you know we were allowed to say that (FP4 laugh). I mean in our service, we prioritise err
735		certain families, may be about risk or how long they have been in the service. We still doing some
736		face to face work. A lot, well fair amount, but I, I worry that, it will increase, increasingly become online
737		because of the numbers. And I think that will impact the, the more challenging work which I think
738		working with difference.
739	FP5	Thinking about again the isomorphic, emm, emm parallel with err supervising people. Because I
740		supervise all the family therapists () almost half of the team and still is. Emm, and how I can have
741		a lot of work conversations about culture and ethnicity and how that impact the work and their
742		own commissions. Emm, you know graces, emm so on. And how much harder it is to do with the, the
743		rest of the team who don't come from, from that background. So that's kind of we don't share that
744		err, err that experience, in that : you know the live story as well. Emm, and because there are other
745		emergent issues. It will take a lot of time to actually create those conversations that in a way that
746		make them meaningful. So, I am wondering if part of us not doing as much, is to do with that. And
747		because the model is quite a medical model and its still is. And if it's a family therapy model, that's
748		deliver by non-family therapist.
749	R	We got one more minute, I need to stop so that you can have a break you know. Is anyone have
750		something very different from whats been said so far? We make sure you have the space to say it.
751		Otherwise, we take a quick comfort quick, come back and look at the next task, if you like. Is that okay.
752		So stay online, put yourself on mute and stop the camera, and see you in, five past. Yeah
753		(Comfort break and I put some questions on the chat)
754	FP5	I think this, the way that you reframe the question is much easy to answer I think. Is that the same as
755		for the second question that you post before, or it is a completely different question?

756	R	It's a kind of summary because we kind of open it all up to meal, culture, resonance, difference, not
757		difference. So we open the conversation into a very big things
758	FP3	Oh sorry
759	R	and it depends on what we take from it you know, what difference, how we feel, how we think about
760(1.45		things. I think in some way this. Thank you everybody, everybody has come back. So it try to emm
761		stick to time. Emm, FP5 asked the question whether these are sort of reframe from the previous
762		question. And I think it is, I think the previous questions is about opening up. This one is almost like
763		bringing it together, very wide, breadth and depth of conversations we just had. It can be a sort of like
764		confusing and this is bringing it back together. I have put it on the chat, is your chat open? Is thinking about how do
765		we reflect our race, ethnicity and culture in our practice? Given the contexts we just spoke about.
766		Em, the environment we are in really tough. And we are exhaust, exhausted. How do we reflect our
767		race, ethnicity and cultural practice, like pre-COVID, during COVID or post-COVID. Emm, is there anything
768		in ED or ED services make it difficult to consider race, ethnicity and culture. And how do we know, how
769		do you know when assumptions happen you know, in our work?
770		So, I think emm. Would you like to do a fishbowl or an open discussion. So we will do it for about
771		twenty five minutes before we can have a sort of five minutes feedback. (.4) If you have no preference,
772		shall we do a fishbowl of different combination. So that, its about ten, ten, ten. (Yeah). So ehh, you
773		want to work with somebody different. I have FP3, there are five of you, so you will bound to talk to
774		someone again. You know, FP1, FP3 and FP4 on this side of my screen, and then I have FP2 & FP5 on this
775		side. Shall we have, do you want to go first or go second FP3.
776	FP3	I am happy to go whatever, happy to go first.
777	R	Let go first, let me make executive decision. FP3, FP1 and FP4 you go first, then FP2& FP5. And the question are
778		on your chat side. How do we reflect race, ethnicity and culture in our practice? Is there anything in ED
779		or ED services make it difficult to consider race, ethnicity and culture? How do you know when
780		assumptions happen in your work?

781	FP4	.hhh, nhh
782	FP3	Yeah, yeah
783	FP1	There is something I was thinking about when sort of, when I was looking at those questions. And the
784		the question that really stood out for me is there anything in ED or Eds make it difficult to consider
785		(FP3 yeah) race, you know I suppose that was, that was the question that stands out to me.
786	FP3	YES.
787	FP4	Nhh, me too
788	FP3	ME,TOO.
789	FP1	Okay, so why does that stand out to all three of us then (FP1 laughs)?
790		Well, there must be something then.
791	FP1	Yeah, yeah, yeah. I suppose I suppose something for me is that, emm, I work, I work you know, where I
792		live in (area). Its is a predominantly emm white British (FP3 british) the young people come into the
793		service is white British. Emm and emm, you know, so I don't, I don't know whether that, that does
794		something? You know that does something to sort of, you know, do we do I make an assumption that
795		because they are predominantly white British that you know that you know there is, I know something,
796		and that I, I sort of have some privilege in terms of my knowledge of them and their background. And
797		where they come from. So maybe you know emm, I don't , may be ask as many as questions or I
798		am not as, as curious, may be as round as race, ethnicity and culture as maybe I should be? I don't know.
799		Emm, so (FP3 nhh) yeah I am not sure.

800	FP3	I, I, I, :: I like you both it, it was the question that the question that kind of niggles with me too. And I
801		am not, I am, i can't give a really coherent answer I think. But there is something, I don't know what
802		connection it is. I wonder if there is something about the medical model.
803	FP1	Right okay.
804	FP3	I don't know, I don't know quite what that is (FP1 nhh). Emm,
805	FP1	When you say the medical model, do you mean just sort of held
806	FP3	The medical model in eating disorders specificly
807	FP1	Yeah, and how position
808	FP3	How it positions, something about that
809	FP1	Nhh, okay.
810	FP3	Something about that.
811	FP4	A difficult illness, more than a bundle of psychological or racial, not racial, relational issues. Though
812		in my team, its very systemic. I think there is a number of factors. I just think I am in (area) (FP1 nhh)
813		and yet the majority of ours. I was going to say patient (FP3 yeah) young people are, I don't know◦
814		a, I haven't been there long enough to know. But, but seems a ponderous of white middle class. Yeah
815		, young women and that, is that the stereotype of err a person with anorexia, or are they being err
816		being referred to the services, more than another group. Because it is stereotype.
817	FP3	These, these are the questions that are so interesting really.

818	FP4	But I also know our team demographic, is a very err white team.
819	FP1	Oh, oh okay, I was thinking, I was thinking, our isn't.nhh
820	FP4	Right
821	FP1	So we have got a mixture in terms of our team, sort of people from different racial backgrounds, from
822		different cultural emm backgrounds. Emm, err you know so, actually we are quite lucky as a team.
823		Emm, because we, we have a sort of a real, sort of range of people from lots of different backgrounds,
824		so we get lots of different voices but emm
825	FP4	But would that make it easier to raise these issues then. But are you saying that, that the client group
826(1.52	FP1	Yeah, its it's its it's the young people, you know they are predominantly white middle class, you know,
827		err females. Emm, so yeah, I don't know what that does. I don't know what that does, when, when there are families emm, that are
828		referred that are from a different backgrounds as well. I don't know whether that means we sort of
829		, we think about them slightly differently. I , I am not sure we do. Emm, but yeah. I am sort of, I am
830		not, I am not sure whether that particular to ED. I think it is particular to ED services actually. I think
831		its you know (FP3 nhh) emm, because it is you know something very particular. You know, I think that
832		its sort of may be invite that particular that stereotype as you are saying FP4. So you know, certain
833		certain family will be referred, or certain young people will be referred (FP3 nhh)
834	R	Do you mean there are some, some sort of certainty that we know what's happening to the white kids that
835		are referred to the eating disorders?
836	FP1	Not at all, I don't think there is any certainty in it. I think it is, its just that sort of may be, they, they
837		eh present in a certain way when they go and see their doctor (FP3 yeah) or you know with their

838		parents or you know and, and so, and you know the people around them will put those things
839		together. And make assumptions you know, thinking about your last questions about what that means?
840		(FP4 yeah). Emm, what that showing, emm, and you know, and then they sort of come to us. Emm,
841		you know and but it, it doesn't necessarily mean :: what, may be the medical profession's or the
842		psychiatrist or the doctors think it means. You know, err there is something that happens within our
843		services is when we, when we sort of assess young people. Emm, they come in and then we have to have a consultation
844		with the doctor, with the doctor. So we can put a diagnosis to the young people. Emm, and I, I, I find
845		that really really difficult, especially if you only met somebody for one, you know one session, one
846		assessment (FP3 yeah). Emm, but, but we have to do that for, for other reasons, for figures and things like that. And, and I
847		find that really really troubling because I think that, actually you know we met somebody once and
848		where we are portioning of this diagnosis to them. Emm, and, and actually what does that really mean? What
849		is that going to mean for the rest of their life. And what is that going to mean for them, for the rest
850		of their life. And what is that going to mean in terms of how people talk to them, how family members
851		talk to them, and how, and how we sort of go forward in terms what we are doing with them (FP3 yeah).
852		How we work with the family, so I find that, I find that really, really tricky (FP3 yeah), and really
853		quite troubling. I don't know what other people experience that, but.
854	FP3	Yeah, and I suppose it's the whole thing about care pathways isn't it, what what do they, what do they
855		help us with and what do they stop us seeing? (FP1, FP4 nhh) What do we, what do we yeah, what is
856		admitted in the process and not explored.
857	R	That's so interesting but FP3 sorry to interrupt you but I think arr, arr its time for FP2 & FP5. You know like,
858		yeah.
859	FP3	Okay.
860	FP5	Hi, I was quite emm curious about the question that err they all kind of related to most, was to do with
861		err you know. If there is anything to do with eating disorder, eating disorders services that makes it

862		more difficult and I am, I was thinking how, the context in a way is a strong influences factors. Emm,
863		yeah, its strong influence in our thinking here. Because I think you are, probably be much easier, emm
864		to talk about how you reflect about race, ethnicity and culture in our own practice. I am sure that
865		would have lots of examples to give. Emm, and I and I made that connection earlier that it is much easier for me to talk
866		about this things when I am supervising someone who is emm from the systemic ground that, it is from
867		other disciplines. Err, so it is much more part of what we do. But there is something about the context
868		of eating disorders services and and how an eating disorders get expressed, in terms of physical ↑illness
869		and the risk around this, that has, you know a huge impact on how, how we work. And that was
870		kind of the question that they connected with most with. (FP2 nhh)
871	FP2	Yeah, I think there were some really interesting discussions. Emm, which I think we could run (FP2 laugh) for a long
872		time thinking about emm. And certainly thinking about eating disorders and some of the services that
873		I worked in, and I can't remember who had mentioned about emm, there were something about one
874		of the team. PF1 was talking about err, it was very diverse team. I, I make an assumption that was a
875		community team, it might not have been. But, then the emm, the majority of the young people were
876		white British, whereas the team weren't. And I worked in services where a lot of the young people
877		coming in, or are actually having an inpatient admission from, by a, I don't know, private service, (name of
878		private hospital) whatever. Emm, very sort of high functioning, academically young people whose parents
879		be fair, knew how to beat the system a lot, if I am sort of saying, the white middle class families. I am not making
880		a generalisation, there in some sense, didn't mean there wasn't cross cultural emm lens to the young
881		people that came through the door. But certainly about how voices were expressed. How different
882		narratives were put into, yeah what service provision look like. Emm, yeah and its almost like, like
883		just something about it doesn't mean that anorexia or different eating disorders don't cross culture.
884		But they do, and everybody knows that. It isn't discriminate against emm, you know different

885		communities or culture. But there is something around why other conversations still difficult to have
886		within team. Emm, some of that might be about medical model, some of it might be about emm, I
887		think the make up of the teams I think. I think for ME, right now I am very focus about race indicators
888		and, who are we recruiting, services. Emm, the race indicators you know on every level. They were
889		development recruitment retention, about development, about all of that stuff, put the stuff in the
890		services. And its about how the services develop culturally, in, in all forms of cultural means. Emm, in
891		order to meet needs of wide ranging of different communities group within eating disorders.
892		There is a curiosity about it because on the one, there is time I thought yeah, it would be really really
893		easy to just walk away. But actually, our families of every culture that actually need the service,
894		require the service. Emm, there is a lot more round , there is a lot more somatising conditions that emm,
895		you know young people are coming to the door with. But at the same time, I am not, I never quite sure
896		why it is so difficult to have the conversation about sort of race, culture and ethnicity. Emm.
897	R	so FP2, I am just wondering. Emm, you mention its difficult with team. I am just wondering if you find
898		it easier with the family then, or or other people find it easier to work with the families than with the team?
899	FP2	I think it goes back to something that FP4 was saying about before about you know, its almost like that
900		:: emm balloon again. It's about burst, its almost like, we just put into too much pressure on ourselves
901		about what what we are supposed to be achieving on a day to day. We, it is some of it about being
902		kinder to ourselves, about actually stripping back what our role and purpose going to back to that
903		basic. And really, must starting from scratch from, you know what is the normative routine and
904		boundary with the families. What are their scripts, just asking those questions, rather than this
905		expectations with we are supposed to be performing on all the levels. Have all the answers, cause we

906		can't. Then, may be if we are able to be kind with ourselves in that respect then. The issues of race and
907		cultural come out more organicly. Rather than we can't, may be putting ourselves in this where we
908		are supposed to have all the answers and and. I think it's a bit of both but I just think again, its about
909		how we prioritise our time, and what conversation we are able to have. Whether we are
910		developing our stuff, whether it like on an individual or team basis, depending what the level we are in.
911		Emm, but yeah I just think emm, if some of that is about having emm, consultation or team
912		consultations for external people to come in and help some of the thinking. I think that's good as
913		well. And I think that's about emm, helping develop the thinking of all the cross cultural thinking of
914		within teams. But I don't, I do struggle about why we are not able to have the conversations emm, but
915		if so necessarily, we are going to sort of try to meet needs of some of the families. Emm, that are
916		coming, all of the families. Emm, for me this is a conversation that is a revolving conversation. Though
917		whether it was five years ago, or two years ago. I think it is the same conversations, emm, systemicly
918		we, we you know, we folk so much about the grace, etc. But (.1) yeah, I, is emm.
919	R	Thank you FP2, do you have anything to add FP5 before we go back together as a group.
920	FP5	I was thinking about this last point that FP2 was making which are so so important than how emm,
921		and I think its how we started when we talking about making this space safe for this group today.
922		Emm, and I think even though as a systemic therapist this is very much part of her training, and our
923		conversation we still emm don't do as often as we could, or should, I don't know. Emm, and I am
924		connecting with emm, if we think specifically about race, for example, I am thinking about the idea of
925		white fragility and emm there are so many kind of err, ideas around around that you know, put people
926		emm off, the hook or arr or or people feel afraid of emm, of saying something might offend. And I think
927		that is not just about race, its true for other things, from religion, for culture and other things. Emm, and
928		and what FP2 say that its its **far** from over and I think that, there are going to be decades and generation,

929		generation until emm, perhaps we feel a bit more comfortable and confident to have those
930		conversations (nhh)
931	R	What's your view about how we manage that risk then, in terms of like, the risk of assuming, assumptions?
932		when we are working cross-culturally, how do we manage that the the, as family therapist?
933(2.05	FP5	Emm (.1) I don't know really. I think we do make assumptions all the time, that's :: we have to just
934		accept and acknowledge that. And and may be more active in, in questioning ourselves and the
935		assumptions that we are making, and be more curious and ask more. Emm, I do think that emm, the
936		model you know, if you think about FTAN which is the model that quite a, most of err community eating disorders
937		emm judgement, services use. Emm, I think it close down some of those conversations (nhh). So there
938		is something about us being a bit more skill and bringing those conversations into the mix. Emm, but err as I
939		said I think you know, this is a model that delivered by non-family therapists and I think it get completely
940		missed. So I am thinking about equality in terms of emm, the service start that the family gets will be
941		very different if it's a family therapist or if it is a nurse for example, delivering the model (nhh).
942	R	Thank You, FP5. Shall we open back together as a group FP1, FP3, FP4.
943(2.06	FP4	I think that was such an interesting conversation. Emm, make me think of a lot things. I mean I
944		recently did the FTAN training and I am, I was pleasantly surprised to err find out that :: they really gone back to systemic principles and the emphasis they were making
945		was on engagement, and that without that none of the subsequent phases of treatment will work.
946		And I think engagement is particularly when doing cross cultural work. And I think what FP2 said about
947		going back to just asking our ordinary systemic questions, why don't we do that? But I think is the frame
948		of the very goal oriented treatment. I got to get them to put on weight, we got to get that happening
949		soon. That speed things up too quickly and then like you were saying FP5, if you stick too rigidly to the
950		model you lose all those subtler engaging sort of questions.
951	FP1	That's a conversation I had with somebody I supervise who also fairly recently has done the FTAN

952		training. Emm, was you know, she was talking about this family that she was working with. She said
953		you know ↓(FP1 dramatise voice in lower volume) oh you know but I am trying to do this and
954		I am trying to this. And it is like you know, I said to her, but I am not sure that actually the work. I said
955		the work is actually getting them to sign up to the work (FP1 laughs) and she was like ↑Oh, do you think?
956		YEAH, I think that's it. I said its its actually getting them on board with what, with what we are trying to do (FP3 yeah).
957		Emm, that actually the work and she was like oh. And she was like and, and, her approach just
958		completely shifted and completely changed. But I do think there is a sort of the, as you say, there is the
959		the come on, we got to do this, we got to get them restore, we got to get this^. We got to get the
960		physical health. You know, its, its sort of takes away, isn't it, from <u>all</u> the other stuff we really value.
961		Emm, about building a relationship with the family, its about building the relationship with the young
962		people. Emm, it's a thing about reminding people that's, that, that's you know <u>IT</u>. Once you done that
963		all the other stuff you know, is sort of maybe not quite as tricky.
964	FP3	I, I was thinking about emm (FP3 hiss) this thing about kind of working cross-culturally emm, and I was
965		thinking about some, I think you could <u>argue</u> that if I see a Scottish family but they are not, you know they
966		are, they might be from another part of Scotland. They might be have completely different values and
967		beliefs, religion. Thinking I am cross region, there is a big things in Glasgow about Catholic and Protestants.
968		Emm, I remember a family therapist who work in London, going to Glasgow and saying, they made a
969		comment about the football. And they used to say that in London that's a way of joining and there
970		was this kind of horrendous silence because they <u>were</u> like, ↑they said the wrong thing. ARR I think
971		I think you can trip up just as much as with your <u>own</u> culture, as cross culturally, may be because of
972		assumptions, don't know.
973	FP4	Nnh, I am not sure. I mean I agree with you, you can trip up the, the time but the <u>tripping</u> up, and causing
974		a <u>trip</u> up that tap into really <u>deep</u> racism isn't, isn't there, there is a bit more than.
975	FP3	Yeah [yeah, YEAH, yeah. But I suppose I am saying if you were are, if you were a family therapist like

976	FP4	[you know
977	FP3	working in Northern Ireland (FP4 nhh) you could trip ah ah in Glasgow you can really trip up talking about
978		religion, like really (FP4 yeah) and there is a culture. I don't want to sort of argue emm.
979	FP4	I agree with you
980	FP3	I suppose its :: but yeah yes you are right, you are absolutely right. And as white therapist we do need to be
981		incredibly mindful. Emm, yeah.
982	R	Mindful of what FP3?
983	FP3	of privilege, of white privilege. But I suppose may be, may be there is also, a kind of also invisible
984		privileges, that you might walk into and not realise.
985	FP4	Like class
986	FP3	Like class or or culture like my mother was English in Scotland. That was a very emm (FP3 hiss), ehh
987		very complicated thing actually to manage as a child that to, to people who don't understand the
988		idiosyncrasies of the west of Scotland may not see. Emm, all sort of stuff I, yeah, all sorts of stuff. And
989		class, I think it is a very kind of very interesting topic all together, but also particularly thinking about
990		eating disorders services because of the type of people that come through the door, which is kind of
991		like taking us back to the beginning in some ways. But.
992	R	How do you manage your white privilege then FP3 if I put you on the spot?
993	FP3	Ahh, well I mean that ehh
994	R	How do you see white people can manage, may be from yourself rather than generalise?
995	FP3	Do you mean in the work context or in my life?
996	R	In work context, like working with another white Scottish family, or like another someone from yourself?
997		You mention white privilege you know so I

998	FP3	Yeah,
999	R	How might that look like in the room with the family?
1000	FP3	I think I would probably be more tentative, probably (nhh) and careful. And I would probably assume,
1001		I would be more likely I will be making assumption around sameness (nhh) and if I am honest, with
1002		a white family or may be a scottish family. Emm,
1003	R	Anyone else have some, want to add to that?
1004	FP4	Sorry, I won't go on long. I was thinking also particular in eating disorders and the, the model, the
1005		Maudsley model arr, it really invites you to take an expert position which I think you know when a
1006		family in crisis. Of course they want advice and containment. Emm, but that might be particularly
1007		problematic if we are talking about working cross culturally and white privilege, because then that
1008		might feed into that. Emm, and that in turn reinforces something in those of us who are in the
1009		white privilege position. So you see what I mean.
1010	R	FP2, were you going to say something?
1011	FP2	Yeah, I was just going to say something about like, how the team need to reflect communities that
1012		we are serving and I know emm, some of us spoken about I think being in (area) and it was very
1013		white. I can't remember what was said about class for that. But, because with families we are
1014		trying to work with families cross culturally. When I come into the team, they need to see people that
1015		look like them, that aren't just :: one version of, of whatever that looks like. And emm, again we
1016		all know the whole emm, I mean I work in a trust where they are really saying we need to get a look
1017		at that end in terms of our recruitment, our development, our retention of staff from different cultures.
1018		Because we are not reflecting where we are in, in (area). We are not reflecting different communities
1019		so I think until our basic are really address, we are not structurally. Emm we need to address
1020		some fundamental areas before we can at it, or even attempt to get things better and get better
1021		outcomes on young people from different cultures, culture background◦

1022	FP3	Yeah, yeah.
1023	FP2	Because, otherwise we are never ever, we always in that position where we always having the same
1024		conversations and the same reflections and it just become too safe and too, too certain, and go back
1025		to the idea of, not needing to be curious because actually nothing is challenging it. But actually that it
1026		take it further and further away from trying to meet the wider sort of community needs really.
1027		Emm, and we are not learning, we are not developing so in a sense right, well, it, it in someway yes,
1028		that is really wrong, that is bad but actually can't necessarily blame the staff if they never exposed
1029		to something different. Or yeah, and so the family it is almost like we need to be in places where
1030		we are pushing ourselves into different rings of (FP4 nhh) comfort in our learning, in our development,
1031		otherwise we are not going to bringing it openly into space◦
1032	R	Thank you very much FP2, I am just mindful of the time. It's two minutes to go before four thirty.
1033		If feels a bit tokenistic to do feedback in two minutes. So I am going to be cheeky to say that emm, for
1034		those who need to go punctually at four thirty. Like FP2 & FP4, just thinking about the feedback is I was
1035		wondering if there is anything changes for you since you, when you arrive and where you are now. Is
1036		that okay, you know we might continue beyond after you gone FP2 and FP4.
1037	FP1	I need to go at four thirty too
1038	R	There are three people needs to go punctually. So I kind of complete useless in time management. So
1039		apologise for that. So on the question are there changes from, for you or
1040	FP4	I just want to say thank you and you know its really ehh stimulated my thinking and help me with
1041		some questions I was really really struggling with. So I really enjoy it, thank you all.
1042	R	Which are what? The, do you mind I ask FP4?
1043	FP4	Well just the dilemma, so many things really, the the dilemma of how to take relational risks with
1044		the family, what we need in place to do that. But then, thinking about the wider, more systemic issues

1045		of the team and staffing, and all, all those sort of sort of levels really.
1046	R	Thank you. FP1 are you okay, just mindful of the time. Any comment you might like to, any changes
1047		since you start the conversation?
1048	FP1	I think I think the sort of the main changes that I think I need to try and introduce this conversation
1049		a bit more into the team (FP4 nhh) I think I think I been a bit emm, I think I been a bit safe and may be
1050		I need to sort of start this conversation a bit more with the team, and not and not feel that OH yeah
1051		so everything else is more important and you know that emm, you know we got to do this, we
1052		got to do that and to start really trying to bring this to the team a bit more really (FP3, FP4 nhh).
1053	R	FP2, if you would like to say something if anything?
1054	FP2	I mean I think its been a really great exercise we part of this, feels really privilege. Emm, and I think in
1055		terms of this, it open more questions for me than, than not. Then I just thinking as well about, how I can
1056		take some of the thinking that the my day-to-day sort of practice. Emm, lots to think about who I am
1057		going to collaborate with, moving forward. Emm, at the moment there are a lot of around allieship
1058		and no one expected to have all the answers that actually right now. We are as good as it is, like we
1059		are the family therapists, so it is a responsibility on us. But we need to like use that power that
1060		really to take that back for ourselves I think, to think about, can we bring about change. It is going to
1061		be constructive and meaningful, and sensitive and cultural sensitive◦
1062	R	When you mention day-to-day practice, what are you referring to?
1063	FP2	All aspects of it really, ehh I think we, we talking here about eating disorders but I think in family therapy
1064		in our setting. They could be much more emm, lots of improvement that could be made day-to-day
1065		in terms yeah, how we present as a team but also which direction do we want to be going really. Emm,
1066		OH YES, I am definitely thinking about not just in my own workplace but how I can collaborate with
1067		people outside of that, think about what's the share learning in different settings and how we can all
1068		move on together with it. Very briefly being at Barry Mason's thing was really great. But it also makes
1069		me think oh my Gosh, the next generation, is like where, does that look like, sort of like we want to

1070		be part of the change discourse or do we want to just say look its find as it is. I know where I stand
1071		on this.
1072	R	Thank you FP2, FP4 and FP1, I know that in your own time you can. Because I did say that you can
1073		disappear.
1074	FP4	Bye everyone
1075	FP2	Thanks for that
1076	R	I will send you a summary when I finish the writing.
1077	FP1	Bye
1078	R	
1079		like, anything come to your mind, any changes from when you start
1080	FP3	Emm, like loads. I mean hhh I guess :: where is it, something about that idea of knowing and not knowing
1081		and the middle position. Deeper thinking about sameness and difference, I think and a kind of
1082		frustration too. But I think what FP2 was saying about like we are still having the same conversations
1083		(nhh) and I feel like that more broadly about the Black Lives Matters stuff like, why has it taken that
1084		(nhh) for us to get to where we are. Okay, I am very, very frustrated. I just feel that we got so far to
1085		go and its about structures actually. I agree with that. There is something about me, its been really
1086		helpful to think about the impact of COVID, the impact of COVID in our team, but actually what
1087		matters, and taking that some of the, you know that thinking back to the team yeah .hhh. It raise
1088		my awareness of it, if that make sense.
1089	R	Is it possible to raise it with the team?
1090	FP3	YES, yes I think so. I think it is, I think it is. Emm, I guess it is also that comment about the expert position.
1091		And, and if FTAN, anorexia is very interesting too. But also that thing about FP2 also said about
1092		self care I think and trying to do all of it, and trying to do it perfectly. Emm, yeah. (nhh) that feel
1093		sorry Charlotte, that feel really dense, like this. I am not hugely coherent but I will
1094	R	No, I think you you are making sense you know.

1095	FP3	Okay.
1096	R	Because we had a two hours conversation.
1097	FP3	LOADS. Its brilliant really good, I feel really privilege to have been part of it thank you. Just sad we
1098		can't have another conversation. I think that is how I feel like, its like, its open up so much and
1099		yeah, where do we go with this, is that as well, where do we go for this individually but also I just
1100		met some people like once, that's also kind of interest to think about relationally (nhh).
1101	R	What about for you FP5?
1102	FP5	Em, I, I think to me : is emm. You know I, I think yes we have a lot to, to change and to learn and, and
1103		having emm conversation like this. I think really like this is really important. I think we have come a
1104		long way as well and I think emm, it it is, you don't change emm institutional discrimination, racism,
1105		one of very strong of them overnight. I think it, it takes a lot of effort, and , and and work. So I think
1106		its really important to have you know err someone dedicating a whole research to thinking issues of
1107		emm culture, race and ethnicity. And, and a kind of emm, emm talking and thinking a bit more about
1008		this. I think to me, is how I can <u>bring</u> this more to the, to the fore front and bring these conversation
1109		in all levels with the families that I work with. Emm, in supervision, in training and in service
1110		development. Emm, I am thinking how we can be more open to invite err, err families to contribute,
1111		to errr to our work really emm. And have more meaningful feedback from them that we, we can learn
1112		from them.
1113	R	Nnnh, I am so pleased that the conversation is stimulate some thinking and, and is interesting to hear
1134		you guys see the question that I put forward you know (FP3, FP5 nhh) okay, then.
1115	FP5	Charlotte I, emm, do you think you could send because I am in contact with everyone in the group.
1116		Or I don't know ehh if FP3 is aware of the emm, of the google group that we meet, in the forum.
1117	FP3	I did come to [the (name of the place) and then I think COVID happened didn't it?

1118	FP5	[it changed to monthly.
1119	FP3	Are you?
1120	FP5	Online. Yes
1121	FP3	Oh Wow. I would so benefit from that.
1122	FP5	Yeah, we been discussing lots of issues that, some of them
1123		that came up today. So, I wonder Charlotte if you, may be mention to, send an email to the group,
1124		to mention about err our meetings and give them emm you know, how to subscribe to the group.
1125		Are you getting the message? You probably not getting the emails then FP3.
1126	FP3	No, but I don't have a google account.
1127	FP5	It doesn't matter
1128	FP3	Does it not? But I haven't been getting the emails. No.
1129		No, it don't have to have a google account but you have to subscribe to the google group
1130		Okay, I will try and do that then. I don't know how to do that but okay.
1131	R	On that note, I am going to stop the recording now.
1132	FP5	Okay, sorry
1133	FP3	(laugh) sorry.

Appendix 1h: Transcript for Focus Group 2

1		Focus Group 2 Transcript	
2			
3		R : Researcher	Researcher
4		FP6 : Faith	
5		FP7 :Gabby	
6		FP8 : Helen	
7		FP9 : Ivy	
8			
9			
10		Transcript	
11	R	Record in this computer. (.2) okay, so let me go back to share screen. (.2) So, just bear with me. I am talking (R laughs) err a little	
12		bit just thinking about confidentiality as well. Emm, because we are small group, as usual the group rule is like, what we say, what	
13		we talk about stay in the group. And me as a researcher, I obviously will make sure everything we said are anonymised and keep,	
14		keep its confidentiality. Emm because it is a group, you know as usual we will be expecting we keep the confidentiality for each	
15		other. Emm, as family therapist we all familiar with that. So err I think I just have to state it clearly as a researcher. So that we	
16		will protect each other, so we can feel comfortable to talk you know. And the other thing is also highlighting that race, ethnicity	
17		and cultural conversation tends to generate a lot of emotions. Sometimes people might feel very passionate about this	
18		subject, taking a position or sometimes people might feel very silenced, they feel they don't have right to talk about it. So I was	
19		just thinking about emm if we look out for each other in terms of people feel inhibited and they can't speak or people emm feel	
20		very strongly err passionately about certain thing, which is to say take this away from you. It is a kind of just mindful of the	
21		emotional challenge of our conversation and keep ourselves safe together. And the last thing I like to say is about my role as a	
22		researcher, and err so ahh. I just want to say I am not really a trainer although I am running a focus group. So this is not a training	

23		session, it is about that, it is about enquiring your perception, your view, your experience. So, there is nothing right or wrong, err	
24		emm, I am certainly not claiming expert. But I am the nosy person want to know what you guys are thinking. Does it make sense,	
25		so don't think that I have all the answers you know. If I am enquiring I am more interested in what you are thinking you know.	
26		So, that's more or less I, I a kind of like, a bit of ground rules. Emm, so emm we have two exercises you know emm. Each hour we	
27		have some exercise, so just encouraging you to join in, you know as much as you can you know. Emm, so I am going to stop sharing	
28		the screen. But come back to, just thinking about. Perhaps we will start with introduction, err in terms of, if I suggest that you	
29		mention something about your name, your, how would you describe yourself, ethnicity, where you go? Err which is an	
30		optional thing. If you don't want to say where you work is fine. Emm, and most importantly is what enables to speak	
31		comfortably within the group? So emm, yeh. So perhaps I start, I am Charlotte Chiu, I am the enquirer of this research and how	
32		I describe my ethnicity. I am Chinese born in Hong Kong and I am first generation immigrant to UK, to London and err. I have been	
33		living here for thirty odd years. So London is my home. Emm where I work, I am semi-retired. I have worked in eating disorders	
34		field for children and adult for long time. So emm so err, so I am at this stage I am sort of like working Honorary in a CAMHS	
35		clinic but also continue with this piece of research. And how enable you to speak, myself to speak comfortably? And I think is	
36		tuning in, for me is tuning into emm the emotions of how the group is going, how everybody, there is no right and wrongs.	
37		So that's what I, my position. (.2) Anybody like to, to say a bit about, introduce themselves.	
38	FP 6	Did you want to go? Hello my name is is (name) and my ethnicity is Irish. Emm, I am currently just return back to (place) and back	
39		about two years. And I am working in an inpatient, and service with, obviously for young people with emm eating disorders. A kind	

40		of taking a number of our beds. And what make me feel comfortable, I don't really know (FP6 laughs) I know enough about	
41		culture. I, I you know, I qualified quite newly in the last few years in family therapy and err, where I did in the UK actually. I trained	
42		and lived in London for a number of years. So I am, I am just hoping that everyone will be open (FP6 laughs) not too judging	
43		of me. And may be. Emm but I am kind of, yeah I am looking forward to this process, I think it is great, a kind of taking part in	
44		some research on, on the field. And may be hopefully will add to the field.	
45	FP 7	Em, yeah, I am (name). I err describe myself as yeah British Asian, born in this country. I work in (area) and lead for family therapy	
46		in the community Eating Disorders team. So 0-25, emm I think in terms of comfort that just the ability to be clumsy. We don't	
47		always get it right or wrong. It just being able to say it, express it in a safe group (thank you).	
48	FP 8	I am (name). Emm I will describe myself as white British. I was born in England and I live in (area) in (county). Emm, I am a	
49		systemic psychotherapist and a consultant clinical lead. And I work across emm, patches, various patches across the (area).	
50		In an inpatient groups, emm in an outpatient trans team in all age eating disorders service in (Area). I been working in eating	
51		disorders about twelve years. Emm, and we are quite an open trust in me. And I am also a (number) year (training level) student at	
52		the (name of institution) as well. And in terms of comfort in the group, err I think what everyone else had said. I, I already	
53		feel particularly comfortable emm, I yeah. I will probably say it if anything was making me feel, you know if the temperature	
54		was raising and I wasn't feeling comfortable. And I hope that's something we can talk about and I really looking forward to	
55		hearing what everyone has to offer today.	
56	FP 9	Hi everyone, and I am (name) and I :: well I describe myself as white British, kind of. Don't know what category I fit in. I am	

57		mix heritage, so my father was born in Africa, my grandmother was born in (Island in Indian ocean). Emm and that to all intents	
58		and purposes to the outside world. I look and sound very white British. Emm, so I work at (place) eating disorders service in (area)	
59		And I am the systemic lead for the eating disorders team which is nought to eighteen. Emm, prior to that I was working with	
60		eating disorders inpatient unit as well. Emm, and have been working for quite a long time as well. Emm I suppose what would	
61		help me to feel comfortable, emm in addition to what you said. It, I think it would be really great that we can celebrate being	
62		clumsy around this topic. Err because it's, because there isn't a neat way of talking and expressing it. And I hope that, therefore	no neat way of talking
63		we can take some risk and have quite a rich discussion about it. Emm	
64	R	Thank you. Yeah. Emm, so emm I am going to share screen again, just to say a bit about where my research has got to, without	
65		overloading you. Err, back here, here. So err this is my little diagram to show my research topic which is the race, ethnicity	
66		and culture in family therapy with children with eating disorders. So err, my particular interest is that orange circle. So err because,	
67		yeah the orange circle, what's in this circle you know. And err so, in terms of where I have got to, err and relating to this focus	
68		group is that emm. I have done six individual interviews, err with family therapists and gather some ideas about their thoughts	
69		about and feelings about the subject. And I have done one focus group, and from the interview that I got some idea, some	
70		curiosity going and I took it to the first focus group and hear their views. And this is the second group that I have looked at all	
71		the data that I had gathered. And I am thinking, still interested in something, so that is what have decided to put into the	
72		exercise that we do today. But if we start with, just thinking about how you see this orange circle. Its like, if we are all	

73		family therapists, it might be reasonable to think about how we orientate ourselves towards race, ethnicity, culture and	
74		children with eating disorders. Emm, if we were to position like this, how do we see race, ethnicity, culture. How do we see	
75		children with eating disorders? Do we see them as connected, or do we see them as individual, single lens? And :: so err	
76		so I really opening this to your thoughts about what might, what might, what your ideas about how to think about these	
77		space?	
78	FP 7	I think as a non-white family therapist I immediately position myself in terms of self, as therapist, you know with (nnh) whatever	
79		ehh yeah. With whatever family I working with, in whatever context is the family therapist themselves and the race ethnicity and	therapist's self
80		culture (nnh) and them, and the family we are meeting with. And that interplay, you know things we might ask or not ask (ahha).	
81	R	What about other people, other people have any views?	
82	FP 8	I think, I think for me, I (.2) I think see them all as completely, I don't position myself in one of the particular. Because	
83		it is a bit like a Venn diagram isn't it? And I suppose emm, I actually picture myself as being within that orange question mark, if	
84		that make sense. Emm, its actually closely link. Emm, I suppose in terms of the connection between both ethnicity and culture in	
85		family therapy. I suppose that's about, I suppose about our own ethnicity, our own view of race, ethnicity and culture ourself.	our own view of REC
86		And how do we think about differences when we are working with families who may be different to us. How do we bring that	
87		into the room even with subtle kind of hidden differences. Because we can't always make assumptions about people race,	
88		ethnicity and culture just by looking at them. And how do we actually bring that into a live space in practice (hhn, yeah).	
89	FP 9	I think when I look at this emm, I am really thinking about my role as a family therapist in the context of eating disorder	

90		service when, you first meet with the young person and the first paradigm and priority is, is the medical model, is a very	
91		black and white, what is the weight, are they healthy? So err thinking of a very multi-disciplinary team. Emm, kind of may start	
92		err with some very black and white paradigms. I kind of see my role as bringing in, you know the context emm, and you know	
93		race ethnicity culture very much so. Because I don't know I find that, err with a medical, with a team that has got a strong	medical makes it
94		kind of medical component it can be harder for people to hold onto that, or anchor themselves of that. So emm, so that's you	harder to hold onto
95		know the dance between context and the physical, and the body and how a team moves around that. Emm, its, that's a kind of	REC
96		what's coming to me when I looking at that diagram (Haa, thank you).	
97	FP 6	Yeah, am I, I suppose for me as well. Ideally (FP6 laughs) I want to be in the orange bit and I suppose is a kind of figure out	
98		what that looks like and how that looks in practice. Emm a kind of reflecting on, on a number of (.) family therapy. Emm, I am	
99		really interested in that, how does it look like I guess (nhh). And ideally how I can improve it.	
100	R	Do you have any hunch that might be, is not a right or wrong? It's about the hunch, what might be relevant.	
101	FP 6	Emm, well I suppose I was, did consider it (FP6 laughs) may be (yeah). That were kind of actually thinking about this emm. And	
102		I hope I round it and end up in the discussion as well (nnh, okay). And I think may be that subtly as well, and and beyond spoken	
103		I suppose, err the unseen, whatever, it felt like it does coming in. And how we will, how I will may be : raise that ethnicity race	
104		and culture.	
105	R	Okay. Yeah. Thank you. So I guess like : if we continue with some conversation and to, to think about emm, a little bit more as	
106		a context of our conversation today, you know. Emm, what I would like to do next is to, to do a bit of exercise in terms of	

107		brain storming err food and eating. What comes to your mind, so as you are doing that emm, I will do a scribe, to put the	
108		whiteboard up, to scribe it. And so if I put food and eating in the middle. So it is like, similar exercise if we are in the room	
109		together, we just brainstorm food and eating, what comes to mind. Then I will scribe it on the flipchart. Would that be okay?	
110		So you can just call out, or you might even use the chat you know, just like if you don't get your word in. You just put it in the chat,	
111		we will check the chat box see whether, emm and then bring it into the flipchart as well you know.	
112	FP 8	I suppose what comes to me is emm, actually there is meaning within food and eating and if there is meaning, then there is	grant statement of
113		automaticly culture. Culture, particularly culture. (nhh).	meaning= culture
114	R	What do you mean by automaticly culture emm?	
115	FP 8	I suppose for me culture is meaning (nhh), really can't have one without the other, if that make sense?	
116	R	Yes, what about if that makes sense to other people? (.4) I see nodding. What else? What else food and eating come to mind?	What does the
117	FP 7	I think for me, this is that pleasure. You know, I think about. When I think about self, food and eating. I think about pleasure and	nodding mean?
118		then when I think about families, I think about complexity and just how hard that can be when you work with eating disorder.	
119	R	I am typing what you say (FP7 name), just correct me if its not what you mean you know. Emm	
120		So it is pleasure but it is hard in eating disorder (nhh). (.2)	
121	FP 9	I am thinking of function, emm, obviously the function of, of eating, the body and food, and actually the function that food and	
122		eating, then has in the context of the illness. Emm, (.2)	
123	R	Do you want to say a bit more (FP9)?	
124	FP 9	Yeah, and then that connects to you know. I am thinking of the patient, the parent or the mother or the father who prepares the	
125		meals. You know the function of caring and nurturing, your child emm, so you know. I know we talk a lot with kids about the	

126		function of food on your body. But it has so many layers the function of the offering of food, the preparing of the food. You know	
127		the, you know wanting to care for your child and help them grow. But then also, DISORDER eating err eating disorder has a	
128		function, they have a different function, don't they? They have a function of managing their emotions or strategies. So, there	
129		seems to be many functions.	
130	R	Ehh, (FP9 name) I didn't quite catch th last one, you say the disorder of ?	
131	FP 9	So the function of err disorder eating, or or an eating disorder that (nhh). It plays a different function.	
132	R	Is it reasonable I reframe it right here? (.4)	
133	FP 6	For me, I guess I a kind of thinking ALIVE. I went to John Burnham's training recently under the (.) model and I suppose in	
134		inpatients eating disorder particularly. We are admitting young people that are very unwell, so at the alive conversation. And	
135		food connect, for me it is.	
136	R	Nhh, (.2) what else, what else come to your mind? Because food and eating like, emm is, can be concrete or symbolic? I think	
137		we cover various dimensions. I just wonder if anything else come to mind.	
138	FP 9	It connecting (connecting), the social connecting.	
139	FP 7	Celebration, festivities.	
140	FP 8	I think about ritualistic as well.	
141	FP 7	I think family came to mind, as I am thinking about food and eating.	
142	R	You mean eating as a family?	
143	FP 7	Yeah, yeah coming together as a family. (.2)	
144	FP 8	I am thinking about structure and routine as well. (.2)	
145	FP 9	I am thinking about emm privilege, actually, mindful of the big advance of pandemic (hhn).	
146	FP 7	I am thinking of the different senses, tastes, smell, sight, sound of cooking.	
147	FP 9	Creativity.	
148	FP 8	I actually thinking of emm, what you say about taste, smell and sight. I am thinking about emm, families feeling overwhelmed,	

149		the individual feeling overwhelmed, for example sensory overwhelmed (nhh) when you think about ARFID and things like that (.6)	
150	R	Can I just come back to you FP8, you talk a little bit about err meaning and culture. Do you want to say a bit more about that?	
151	FP 8	I suppose for me if you kind of think of biological level about food over time, and how it evolved as a kind of practical kind	
152		of thing to keep. I suppose to keep us alive and then if you look over time of various different rituals and, and how they	
153		develop in different cultures and, and you know, a very ethnographic kind of level that actually. If you look across, for example,	
154		the UK, we obviously got a whole of plethora of people from different races and different ethnicities. If you driven in	
155		different ways. For example, emm some of the people I work with they practice Ramadan, etc. And I think it takes on a whole	
156		new meaning in that way. And for me, if we think about culture, we are thinking about what is culture. Culture is actually	
157		meaning and actually food is really embedded in many cultural practices that many different cultures have. Does it make sense to	
158		you, Charlotte?	
159	R	Nnn, what about the other? Does it make sense to the rest of you?	
160	FP 9	So connected to that, is there something about expectation. So you know I was kind of (.1) thinking of you know actually there is	
161		sometimes there is pressures attached. So some family may love dinner time because they come together and they catch up.	pressure
162		But some family might dread Christmas dinner because everybody is around. There is the expectation that you have to eat, and,	eat
163		but not only just to have to eat, but not only just to have to eat. You have to have a CERTAIN dialogue across the table.	certain dialogue
164		So (nhh) I am, and also that you, CULTURALLY there are expectations around you know, how you eat, what you eat. How you	
165		share, all of that. Err and I, I and that would be experienced by people in different ways I guess.	etiquette

166	FP 7	It makes me think about gender, Ivy when you said that you know. I was just thinking about particular age where your voice	gender
167		of eating is, eat as much as you can. Eat, eat, push pasta, hunger eat a bit more, so you can build yourself up. And or eat less,	build up/ eat less
168		if you are a female. Sometimes or, you do the cooking. You are responsible for the food and eating of the family. With	responsible for
169		different roles responsibilities expectations.	cooking and eating of
170	FP 9	Then, that led me onto think about people who are on their own. Because we are thinking about families. And lots of people	the family
171		are on their own, might not choose to be on their own. And what HAPPENS to them, how much pleasure do they get out of	roles and responsibility
172		cooking and because, then have the sharing aspect. Emm, so you know what is food if you are someone on your own. (.4)	
173	R	Thank you for sharing a lot of ideas and I am just thinking about what informs you regarding what you said.	
174	FP 8	I think I am informed emm, I think I am informed GREATLY by the (name of the course) course that I am on at the moment. And I think that's	study
175		me looking at my practice through a very different lens. And I also think that demographic of different families who I am working	demographic
176		with. Emm, some of the families having moved from one service to another service, original service I was in was (area) white	
177		middle class families. And now emm most of my families come from a kind of lower working class background and there is	class change
178		many different races and ethnicities within that. I think it, leads me to think about things away from a white British lens. And	race, ethnicities
179		away from my own biases and my own almost the white privilege lens in my previous service and my own experiences, if that	white privilege lens
180		make sense.	
181	R	Yeah.	
182	FP 9	[Err, I think umm err influenced by my own relationship with food, growing up with different foods, err the meaning of food	influence by own
183	FP 7	[Sorry	family, community

184	FP 9	in our family, and a kind of meaning of food within the community. And and yeah growing up feeling quite privilege to grown	
185		up with a passion for food.	
186	R	When you say meaning in your family and in your community, do you want to say a bit more, ehh FP7?	
187	FP 7	Yeah, I am, I guess I am just thinking about I am not particularly religious, I am not. But I grew up in a Muslim household where	death
188		somebody die you had to kind of you have the responsibility to feed, well people have the responsibility to feed you if you were	funeral
189		the family who suffered a loss. And and but then kind of around the time of the funeral, you feed the communities, is a kind of	
190		symbolic. It makes a lot of food and everybody comes. Emm, I guess I was thinking about being in a bigger extended family and	
191		just having people dropping in to eat. So that meaning of food, in terms of welcoming, thinking of my mum, when she had	
192		a chiropodist come home and she, they have to change their appointment time around lunch time. Because they knew they will	
193		always be fed. You know it would err, it was almost like an expectation you eat if you come to their house. And yet in some	
194		culture you know you just won't do that in a professional context (nhh).	
195	R	What about other people's cultural background? How does it inform what you, what we created in this brainstorm flipchart?	
196	FP 8	I think emm, I come from a really kind of upper middle class family. But my grandparents, my mother side were very working	class and grandma
197		class. And my grandparent, especially my grandmother very much fit into a kind of stereotypical grandma who would feed you.	
198		It was very important to feed you, plus everything she possibly could always. Emm, I wonder if that might come from her	
199		background may be not having enough. And wanting to, do it differently for myself and my brother. Emm I think you know,	
200		I think I suppose I think of the privilege and the luxury of, for example Christmas time. When there is an EXTORTIONATE	christmas-festival

201		amount of food and in my family for a period of time. And how I am not sure that is, we are not a particular religious family.	
202		I will say that I am quite spiritual but I don't think that, is to do with a nurturing practice or a religious practice. I think its	
203		almost just become a stereotypical socially kind of constructed Christmas. And then I also think that's been some brief and	
204		lots of my, in my wider network recently. And some of my Jewish friends. Emm, and I am aware of their kind of cultural	
205		practices and Shiva, and and food. And they are so, they been so grateful of me, embedding into that and sending food as	
206		a part of the griefing process. I been really, I been really interested how we don't necessarily do that in emm. For example,	
207		stereotypical if you like church of England, white British families (nhh).	
208	FP 6	It feels like a kind of, similar, we, we are kind of talking and listening to everyone talk. I am thinking about, yeah I imagine people	
209		that I work with in the past, and thinking about my own upbringing. I suppose I would have family member that were	obese and obesity
210		obese or overweight, which was emm I guess in the 80s and 90s in Ireland wasn't, emm that common so that probably a bit of	
211		shame around food and eating. I, I wonder for myself and, and but also there are something very ritualistic about kind of	shame
212		funeral or. I a kind of more remember woman coming to the house, we will be doing washing up, was quite a emm, food	
213		was always on the go. It was, I love that kind of that kind of ritual part of, of making food and, and serving people, and and	love making food &
214		its quite nice. But I think, or even the idea of, of class I wonder some of my family probably from different class background	serving food
215		more rural farmers, and then maybe we are kind of middle class and there were certain expectations about manners, table	
216		manners. How you eat your food and so I yeah, I just wonder about kind of all the messages maybe I got when I was younger	the message received

217		around how to eat food properly and, and all of that as well may be. That's coming off me, when I hear all this speaking.	from family about
218	FP 9	I think for me, ehh, I have been informed, I suppose my experiences of being a daughter in a working class family. Emm, err times	food
219		very : you know very poor with my grandma. So she would make food I mean, Oh my God, I don't know how she ate. I ATE	Very poor
220		some of the things she ate. She would make like a bread pudding and it would be literally bits of teabag (FP9 laughs), like	
221		creating making amazing stuff over strange leftovers. Emm, there was something about you know, real nurture and caregiving	nurture by leftover
222		and, and life. And I am influenced to think, that's carry on into my experiences as a mother. As I got three teenage children,	
223		but my children were emm born very prematurely. So you know the first part of their life it was very much about food and	function of food?
224		know the the, the thing of food being something of being nurture and care emm, and connection. I think is err what I am	
225		informed by, I think. You know as well as my experience at work.	experience at work
226	FP 7	I think I resonate with that Ivy, yeah I was just thinking about I am the mother of very, extreme, extremely premature baby	
227		and how important that was, that became your parenting function. I remember my husband delivering milk to the hospital in	
228		the middle of the night you know. Just so that she had enough supply, and that sense of being able to be part of your child's	
229		treatment by doing that when you can't be together with them. Yeah they are in the hospital and a bit like the family that	
230		come to us their part of the treatment when their children are under our treatment in the hospital. Just how important that	
231		felt when you, you feel helpless but just be able to, to do that part as a mum and as a dad.	
232	FP 9	Yeah.	
233	FP 8	It is really interesting for me to hear what your both say because I was a very premature baby (Gabby ahh). I born nearly four	

234		months premature and I remember, I hear the story from my mum and its resonating with what you are saying	Connection through share experience
235	FP 7	Well, my daughter is nearly four months, she is three and a half months prem (Helen yeah) prem. So it is [interesting	the story of
236	FP 8	[We are like a PREM club	premature baby
237	FP 9	YEAH. (Gabby, Helen, Ivy laughs) I did come, I think that's when err at work, when you see parent in crisis and desperate over	
238		you know even small amount of calorie, how it destroys parents (Gabby nhh). You know you really connect with, from your own	
239		experience. You know you really are on this cusp of life or death (Gabby nhh) over you know them, needing to grow to have food	
240		to survive, and you know that's a really frightening place to be in. I suppose yeah, I am informed by being there emm. And how	personal experience
241		that completely kind of takes over your, you know, in complete crisis, very frightening (Gabby nhh).	
242	FP 8	It interests me that I think is, is that thing for parent isn't it, that surely one of the most basic thing you can do is to feed your	
243		children. You might not know what you are doing with everything else (Gabby nhh) new baby comes along but you know you	parent instinct
244		can feed them. So I think for that then suddenly happen when a different life cycle stage. If you have the feeding, you kept	
245		them alive and for example, a teenager. All of a sudden you can't feed them anymore, it is completely disabling but then on	
246		the flip side of that there are parent who. I mean you said FP9 about emm, err parent who worry about every last calorie.	calorie
247		Then there are parent who I think who disable themselves so much that is like. Oh well, they are eating it doesn't matter,	
248		as long as they are eating something (Gabby nhh).	
249	FP 7	You make me think of you said food, emm being able to feed your child and thinking about as a mother of a prem baby and	
250		then having another child that you are trying to feed, that you are running to and from hospital. And I, I always remember one	

251		time where I was just trying to feed my then three and a half years old, or three years old he was. And this kind of	
252		deconstructed shepherd pie in our, do the onion goes to the hospital, come back do some carrots you know, add that in. And	
253		this shepherd's pie took all day to make, it felt so important to be able to make something for the NOT unwell child. You know for	make something for other child/ guilt? regain control
254		the well child when you are managing a child who is really unwell.	for the not unwell
255	FP 8	Nhh, I mean everything isn't it really. I mean I had emm, I had triplets which is why they are premature.	child
256	FP 7	Oh Wow.	
257	FP 8	WOW	
258	FP 9	You know it would twenty four hours a day, many many many weeks and months. But you are thinking about how I am feeding	
259		I can't, I mean the science and the thought of how you are feeding food at the same time. You know this is the stuff that really	science and feeding
260		brings me close to HOW, you know as a parent how fundamental the, err the function of feeding and the connection to care.	
261		And train, until your child to grow up. And I am very aware that, that something quite unique to me. And I do wonder, I am	
262		really curious about what is, because I only had triplet but WHAT, you know I am curious about parent who had err a normal	
263		pregnancy and have not skirted near the edge the live or death. Emm, everything was absolutely fine and then you know they	
264		are here with their adolescent and there is an eating disorder. And we are having that kind of conversation to raise their	
265		awareness and anxiety. Emm, but it is these life experiences that bring us near or far to life you know. I get really curious	
266		about how that position the parent that I work with (FP7 nhh).	
267	R	I am beginning to hear a very rich conversation and I was just thinking about how do you think you would like to talk to	

268		families about food, eating and culture. Because we start with food, and then becoming, expanding and expanding and expanding.	
269		I am going to save this emm flipchart and we will come back. We privilege we can have a discussion about. We just have a	
270		discussion about food and then we move into what inform us, and then we share a lot of our experiences. But also thinking	
271		about how culture influencing meaning that we give as well. And I just wondering how do we reflect on this exercise before we	
272		going into how we can use it with family (Gabby nhh).	
273	FP 8	I think it always amazes me how emm, there are so much in common sometimes emm with lots of the, kind of people who	
274		work in eating disorders. I think there are always somewhere that embedded threads and themes, and how. And my reflection	
275		from this exercise is how much everything that someone said is a springboard into further kind of really rich dialogue that	springboard
276		really resonates with other people.	
277	FP 9	Emm, I am, been thinking about regarding culture is following from FP8 for what you said when you talking about your Jewish	
278		friends and you are curiosity about you know, why did it feel a bit different with you know with Christianity in church of England.	
279		AND it brought something up in my mind, when because I am not religious but when my kids were really young and I was trying	
280		to figure out how everyone was getting fed. Emm, I went to my local church (FP9 laughs) being very unreligious. You know	
281		lots of lovely cute old people there. Just said I wonder if anyone can help me AND they said absolutely, and the vicar and his	
282		wife and the community start making dinners. So and BRINGING them round. So then what I really was thinking about, rather,	
283		it is making me think isn't, not just what does another culture do per say. What it is about my culture that influences what	
284		I am seeing and how I access it. What was it about me being quite unreligious and British that make me NOT go to them	What silence

285		sooner. You know what is it that silence me and think that I am not really going to talk about it. Or there is cultureless and	
286		there is a culture that's very different. So you know I quite mindful of, of me and my british culture.	
287		Emm, I can feel my britishness because I have this strand of dual heritage which leaves me sometimes in a bit no man's land.	
288		Emm, so yeah that's that kind of what I am thinking about my, my lenses, my interpretation (.4)	
289	FP 7	I think because I come from a strong culture of eating. Emm, I am curious and I am interested when families come and just to,	Own culture / identity
290		to have a sense of, how THEY grew to, you know the meaning of food, for them. How it was perceived or, or use within their	me curious about
291		cultural setting. And I, I grew up obviously eh. WELL with my parents in a Muslim household but actually I, I lived with	other families
292		somebody else who care for me who is emm white British. So I had two very different, you know that was for my, all of my	
293		very young year. So I had two really ehh, a real diversity of culture around food. You know the other, the big endless carb	
294		or the serving to a plate. You know made just prior. So:: I a kind of have a sense of, yeah I guess it feels important in terms of	
295		the cultures, and the rituals around food in families. And sometimes heard that, that makes a eating disorder more or less	
296		comfortable. Emm, I am thinking of as well, about a family I worked with came out of inpatient. And emm they had a white,	
297		they were Asian family and they had a white emm, British nurse. And err she was such a caring person who wanted to do the	
298		best but culture kind of come between them. In a way that didn't feel that useful in a, in her best intentions. And at that	
299		point, we knew a bit less about working model with eating disorder. She, she said to this mum, no, you need to stick to	
300		western food because that would mean we can really measure and we can know. And actually, this mum became so dependent	
301		you know even in outpatient care that, we kind of have to wean her as a family therapy. Well, as family therapist having to	

302		wean her off this nurse, and this position. And err, you know re-engage a trust in her own culture. I remember just saying	
303		at one point, you know just make a curry and when you are thinking about a portion of meat, you know think about three	
304		four, you know chunks of chicken like that. That would be what your nurse meant. You know, that that's what we are	
305		expecting but it felt like it really stifles the treatment (nnh).	
306	FP 8	I think what I think about, charlotte are you okay. Are we going to the next bit now? Or we still reflect on what we just talk about?	Supporting researcher
307	R	Yes, I was just thinking, hoping everybody have a chance to think, reflect on the exercise and then we can. Because, as I am	
308		listening to you, you guys are having, I have some questions that I want to, rather than be pouncing on you, not giving your	
309		chance to speak you know. Err FP6, do you want to, may be FP6's screen is frozen, her screen is frozen. Oh, are you back?	
310		Err, do you want to share any reflection you might have about this exercise FP6?	
311	FP 6	Emm, yeah sorry I think I froze there for a second. Emm, I lost, I don't think I heard what FP8 had said. Emm, yeah I suppose	
312		it, it definitely brings up a lot of thinking and wondering how to emm, yeah, what would that look like and as I say the influences	? Talking to family
313		of our kind of relationship with emm food, and growing up and actually may be the conversation that we haven't had in the	about ??
314		therapy room emm. And I wonder if there are some assumptions I made er er some ideas that, aren't as, as intune with cultures	
315		as it could be, I guess.	
316	R	Thank you for sharing your thoughts about this exercise. As you are talking I was thinking about how would we let the family	DOES the family
317		know we appreciate their culture.	know we appreciate
318	FP 8	I suppose in my practice, I think emm probably due to my studies and stuff, and having more of an awareness purely because	their culture
319		of the course I have been on. Because I think prior to that, I would have like I had an awareness, but I don't think I did. I think	I am more aware

320		I still saw things in my own idioms. And emm now at the point assessment, where I am always saying you know. This is me.	not, I don't think I did
321		you are you. I don't know anything about you. You are the experts on you, please tell me about this. Tell me about this, and	
322		very often I will name. You know, I am white British emm you know what about you? And, and really kind of think that I actually	
323		want to hear about how it is for you. Because even within one culture there is still different ways of doing things, and	
324		different meanings. So we actually brought that in across the board, at the point of assessment in my service (nhh). And also,	team ethos??
325		we do something call a family meal as part of the kind of process. And I think within that it is just really important to set up	
326		from the outset that emm you know there is no right or wrong here. This is your family and you have your rituals and your	
327		meaning. And it is just about me learning news and information about, so it is taking a really kind of ONE down non expert	
328		position on that. So the people don't feel blame, shame or box into a kind of this is what you are suppose to do. So, err I	
329		suppose very similar to what you were saying Gabby (nhh).	
330	FP 7	I think one of the things I haven't say is that there might be we asked them to emm, TO DO you know during the treatment	
331		of eating disorder and, and you know. Go back to your own ways and what you enjoy and your cultural kind of positions	
332		after but there might be just particular things that cross the cultures you know. Buy a table while we are managing the	
333		eating disorders, go back to eating on the sofa if that's what you prefer after you manage the eating disorder. But, so there	
334		might be sort of certain times when we are drifting across cultures because we need a particular way of eating during an	explicit about
335		eating disorder but. But actually really being mindful of, saying that we respect families cultures. When I asking you to do this	our respect to family
336		for always you know. GO back to however fits (nhh).	culture

337	FP 9	We got quite a large Jewish community emm near our eating disorders service. Err and SO you know we, I mean the great	
338		thing about the Jewish community is they, they themselves are so connected. Emm, and so directly with a lot of the support and	
339		the charities. But also, I think we have become, and we become better and better at, trying to understand emm their you know,	
340		they meaning of food in that culture. Because it is, its so incredibly important the Jewish culture. It is connected to all of their	
341		kind of holidays. You know and then at times, especially with our orthodox Jewish community that you know, we would say well	
342		you, with what the Rabbi say? You know what, you know what's your community saying? What is your family saying? And	
343		working with them to understand that, and and you know, sometimes you know the, the community support or the liaison or	
344		they get invited to join, join with. And you know, it does mean that because we have an intensive service and it. You know	
345		some of the things we are doing are interfering with Shabash and things like that. And as far as possible, we are organising	
346		treatment around that. So as in frequently you know, even with kids in the intensive service. Emm you know, families will be	
347		like well, you know I am not going to answer my phone because it is Shabash. Emm, you GOT to get my TAXI before the sun	
348		goes down. Emm, go to every length and then at times if it is a case of they have to you know they have to do something	
349		contravene their religion emm then, we kind of you know default hhh to the, the the the part in THEIR religion that saids. Well	
350		actually because this is life and death that your religion would say will be allow (Gabby nnh). We try to ate with, you know our	translate understanding
351		community resources really to, to meet them somewhere in the middle. To, to engage them, emm otherwise it’s a big block	into action, meeting
352		between you that, err you are like talking a different language really. You are asking too much of them to, you know to, to, to	in the middle

353		fix this in a different paradigm. Its emm, you know my experience is just never really works (Ivy laughs).	
354	FP 8	I agree with you FP9, I think it can become alienating if we try, and I think. You try to take something so fundamental away	
355		and it doesn't matter if you try to fit into medical model or. And we really had to adapt because otherwise you know there is	
356		this huge risk of disengagement and then you start to go down to some pathways that I think you know. Safeguarding becomes	pathways of
357		involve and it all gets really quite messy and ostracising, and you looking at difficult to engage, policies and everything. And	safeguarding
358		actually do we have to do, do you know like, I know I say like pick your battle. But its like, we we don't have to do that. And I agree	
359		with you I think you know, we try really hard within my service to emm, almost integrate our service into the culture of	
360		each family (FP7 nhh).	
361	R	So do you feel the family know that you are trying to fit with their culture, I am just thinking at their end.	
362	FP 8	I ↑don't know if they would explicitly see it like that, that's a really interesting question actually? I don't, I don't know if they be	lack relational
363		aware that’s, that’s what we are trying to do. Emm	reflexivity??
364	R	What about FP9? You talked about you know how much you know, Shabash err send the kids home before sunset you know.	
365		Err would they feel that, this, the service trying to offer and support their cultural practice?	
366	FP 9	I would say for the Jewish community yes, because they are, they are big community and they have a voice. And they say look	big community/voice
367		you know, you know I haven't got kosher food and I am on the ward. And they have a voice and they use it. And and I suppose	safe/ power
368		in the (name of service) because we have so many you know. And lots of Jewish people that you know work for us, that was	
369		really really helpful. That's the Jewish community that we were really familiar with. If I think of other cultures, emm say for	
370		example we have got a family and, and the mum is from the Ukraine. MY GOD, the cultural difference is unique to everyone	UKRAINE nuances

371		but the ANXIETY that happen in the mdt throught the bits, the nuances that they don't get. And that's the frightening thing	escalate so
372		because the anxiety in mdt can ESCALATE so quickly and you can be down that safeguarding rabbit holes so quick. And then this	quickly (unfamiliar)
373		happen, so the point that you know you risk people leaving the service. I mean historicly I had an inpatient, a family just took	
374		their, where were they from I can't remember. I think might have been Ukraine as well but they literally took her on home	
375		leave never came back, just went to the Ukraine. Err and that was so much intwine in, in, in people not understanding this	
376		culture actually is quite a. I think you know, we really quite ignorant about that part of the world and what they been through.	
377		REALLY ignorant and we got SO MANY culture especially in (place) so many cultures. Okay, SO I think it depends.	
378	R	Thank you very much for sharing and I just mindful of the time (FP9). But as you are talking I have a question mark them how	
379		would you like to talk to this family about food, eating and culture. And I am just mindful it is three o'clock, we need to wind this	
380		bit up but if I save this question at the last bit when we coming to the end. I am sorry that I disrupt the flow but I think its, you	
381		just raise a very interesting question and I don't want to lose it but also I want to stick to the structure a little bit, if that's okay.	
382		(Ivy yeah) Emm, what I have plan for, if we have a five minutes break, stretch your leg, get a cup of tea or loo break or whatever.	
383		So at least you can be away from the screen and not getting zoom out. Is that okay? So if you come back at 3.05, just quickly run	
384		to the loo, that include myself. Thank you.	
385		(Five minutes break)	
386	R	Hi everybody, thank you for coming back. Err so, for this part I am going to show you a video. Everybody okay yeah, I am kind	
387		of bombarding you with it (nhh). For this part, I am going to show you a video which is only four minutes ish you know. Err it is a	

388		family of, Taiwanese family err it is from a movie err it is call the eat drink men women, and so I find this movie and a clip from	
389		You tube. So I download it, so it is in chinese language mandarin, and so don't bother about understand it, because there is	
390		subtitle. You might hear a little bit intonation and the rest of it. Is that okay. Let me just share screen, in terms of what I am hoping	
391		to show, my powerpoint. As you are watching it, I err would like you to just notice, and what you see and how you feel. As you	
392		are watching it. So err quickly go onto the movie itself, yeah (.2) so here. Can everybody see it? (Movie running) Can everybody	
393		see it?	
394	FP 9	Yeah we can (good, good.)	
495	FP 6	Yeah, we can see it	
396	R	Yeah, you can hear it so I carry on.	
397	FP 6	I don't know everybody, I can't hear the volume I don't think. If there is a sound on it.	
398	R	There is a sound, I think I might be. The sound is not particular high but I turn it to the maximum for you.	
399	FP 6	Okay.(Yeah).	
400		(video clip running)	
401	R	Err, the next thing I would like :: the group is to think about. I have a question for you to think about is, this is a family of difference	
402		Can everybody see the powerpoint? Can you see the power point early on? Err is basicly is (.2) what resonates and what doesn't	
403		resonates and why? (.2) So it is a rather simple question, when you watch that video, what resonates and what doesn't? and	
404		why?	
405	FP 7	I think for me is that resonance of, lots of dishes on the table you know culturally (nhh) growing up.	
406	R	Do you want to say a bit more FP7?	
407	FP 7	I was just thinking about eating, I don't know in an asian household you might have lots of different curries and salad, and rice.	
408		You know have it all on the table and help yourself, so that resonates. Its I saw that happening (nhh). So, emm the food, emm	

409		(what doesn't resonate) Do you want me to answer what doesn't resonate? I was thinking about what resonate at the minute	
4410		(Yeah). The colour, the colourfulness of the food I think, variety.	
411	FP 8	What resonated for me was the kind of emm, a meal time setting where everyone together being that kind of opening, may be	
412		for loaded conversations or sharing of news and and that, that resonates with me.	
413	FP 9	Emm, what resonated was gender. So all those WOMEN and one men. Because that was what my dinner table's like. But what	FP7 & FP9 opposite
414		didn't resonate, for me, you know was all of the dishes. Emm all of that FOOD and therefore all of the care and thought that	resonance
415		goes into prepare lots of dishes. Emm which is different for me and my culture which is very much about you know, cooking	
416		something quicker, faster and stick it on one plate, and getting everyone to the table (nhh).	
417	FP 6	Yeah, similar to me. I, I suppose emm, in terms of my own. I couldn't imagine my father kind of taking charge of the food	
418		and the preparation. So I was kind of interested that seems to be the father that was more in charge of the food and the	
419		preparation. And so that kind of, could resonates I suppose that me or the kind of food been cook from the table as well.	
420		It wouldn't be, wouldn't be generally come to the table. Emm, I suppose I kind of could resonate with that idea of you know	
421		it could be a different conversation when it come up or trying to (FP6 laughs) that something might be said, or somebody	
422		might not agree with emm. And the kind of thing a bit of tenseness in that about. What might be said, and how might be	
423		response to, in terms of her, a kind of she said she bought an apartment but also the idea that he said anything against the	
424		food is seen as taken quite badly, even though it is a bit over smoke, which I thought wasn't terrible of a thing to say but it	interpretation
425		sounded like it was, it seem to be taken very badly, as if how could you insult, insult me that way. In a way, in a way doesn't	
426		seem like the ( ) of food. Emm,	

427	FP 7	I think the amount of err food, didn't resonate for me, there was, I looked at the amount of people round the table then.	
428		The amount of FOOD and it seem keep coming you know, there was more in the steamer. Emm, so that felt yeah different.	
429		Probably for me now, you know growing up. Well, having a family now, probably moving from the culture that I grew up from	second generation
430		where, we were a lot more house conscious than we, we don't just make a big pot and have lots on the table. We kind a bit	with different
431		more according to proportion. Emm, you know and kind of that, divert emm. Yeah, I guess connecting with the culture that	culture from
432		we live in. And there is time my husband said OHH, why don't you make a great big pot like my mum used to, you know right	
433		you know our parent would ever said. Well, I haven't got time because I am a working mum. And we just keep eating you know,	working mum
434		so keep saying we want to lose weight, and whatever. So, there is, so different cultural context, professional families (nhh).	want to lose weight
435	FP 9	What was also different for me, was the emm (FP9 hiss) the behaviour emm, so kind of you know. Well, first of all the, the	
436		prayer you know which we don't do. But then, there is lot of food really delicious ( ) everyone was very reserve, calm and	
437		polite and careful. Compare to my dinner table where you know if I, we had a take away and dishes on the table. We are	
438		quite LOUD and pass me this. And I want some rice and, so the behaviour is, the emotional tone is different but also the	emotion and
439		behaviours are different. I found myself having this rising feeling of COME on, tuck in, looks delicious and I found myself	behaviour at dinner
440		getting a bit frustrated that, how delicate and careful they were. So that was quite different from ours, I think	
441	FP 8	I, I think what didn't resonate for me is, if I was a kind of emm, obviously it seems to me the Dad was preparing the food	
442		and it was Dad who cook the meal, and I was also really interested in how when all the girls were together they seem	

443		quite bright and chatty, and the moment Dad came I can see the room, the tone kind of changed again. I found myself	
444		feeling quite sad for Dad. Because obviously they were touching on his age, I think in terms of his taste, sense of smell,	
445		taste going or something. And I was, I, yeah I suppose and, and may be the grief, and the loss of one of the daughter's moving	reflect on Dad's age
446		out which I then maybe she is the eldest, and yeah. So I was thinking about that, I wonder where their mum was as well.	where mum is
447	FP 6	And I was interested in the end where he kind of got a phone call and left the table without any discussion. And, and I think it	
448		wouldn't happen in my probably family origin. But I could imagine in my partner's that wouldn't be like, you wouldn't expect	
449		have an explanation but I would like, where you are going, what are you doing, you know. And its like, it just seems he just	
450		left, don't forget about the food. And there was no, I don't know (.) there was an expectation	family interaction
451	FP 7	I kind of resonate with the pot cooking, just reminded me when we, we got really good friends and emm they cooking of	
452		a similar way. And err they invited us to dinner and we, I remember we sat on this table and my little boy ehh, at the time	
453		very little. And no, although I just love the meal, was just so delicious with all this different things going in, different layers	
454		to the food, you know you are having a fish, a vegetable and the meats and your sauces. But, I couldn't get pass that level	
455		of feeling scared about what if that pot falls over. You know at the time, and then I a kind of look to it, on the table there.	
456		Although they are adults and I am still felt a little bit of that sense of, kind of felt what if this conversation spills into an	
457		argument and you got this pot bubbling on the table. And it just reminded me of the, the time I was there at the meal with	
458		these friends and you know, a lot of liveliness and it was a small, relatively small kitchen with a big boiling pot and a little	
459		toddler. What if he gets a bit too playful (nhh).	

460	FP 9	I felt a bit sad really, because I thought its lovely food and all of these effort into making it a beautiful presentation and	
461		I thought oh, whats going on. I couldn't figure out, my impression was they all too tense to enjoy and relax that, in that	
462		experience and eat food. But then, I thought I am not sure I mean how much this is about how they, you know behave and	
463		eat around the table. But I just, I felt a little sad that, that Dad's effort and intentions and then what happened when he	
464		is in the room with the table. And then when he leaves and I was thinking about the mood and the emotion and how that	
465		was affecting people's relationship to their dinner in front of them.	
466	FP 8	And I was thinking about a kind of incongruence between the words that were coming out of their mouth and their facial	
467		kind of affect when Dad was there. And when she said about the, the ham over smoke, I just thought oh my goodness that's	
468		so mean. Of all the, I wouldn't have said anything because I would have wanted to keep my, my dad who is clearly aging	
469		happy.	
470	FP 7	It make me think about emm, she is able to quite openly to say things like that. But then things in this culture you might think	How easy to say
471		it's a, so easy to say or parents are waiting for you to move out. Or that felt like a tip toeing. You know and actually the,	
472		the comments on the food were just, you know uncontained, and they were out there. And the other things in terms of live	
473		transition, it felt really scare, scary.	
474	R	If you, if they were family that come to the clinic. What might be your curiosity about them?	
475	FP 7	I wonder how you know what you eaten when there is so much on the table (FP7 laughs) you know how do you measure whats	food portioning
476		right for you. How do you, keep a check on what your, your child has [eaten Yeah. Cause it	
477	FP 8	[Yeah, what a portion can actually look like	

478	FP 7	look very little and very big, doesn't it you know, little tidy bits of noodle to the mouth in big period of time. But they are	
479		actually wealth food on the table.	
480	FP 9	I mean my curiosity is what's really going on here, I mean WHAT really going on, what's not being said and how, and and	
481		my British position is, whats not been said so therefore you know how is that translate into being quite punishing Dad about	
482		his too smoke ham. OR is it that, that culture can talk really quite direct here about food. Because if MY DAD brought a dinner	
483		to the table and it was completely burn. I think it is very British of us to say, DAD that was lovely, no leave it, we will carry on	
484		eating it (FP9 laughing) even it was DISGUISTING. So emm, that's where I go and then I know, I have to check myself because	
485		I don't, I don't know where the, the overlaps are between culture and between what's been, seems to be being really felt around	
486		the table.	
487	R	So what do you do when you are in the place of you, resonates or not resonates, or knowing a bit and not quite sure whats	
488		going on. How do you go with that then? [I mean, this is a question for all of you.	
489	FP 8	I think, I think [with a family I always said, I name it, that I don't, I don't you know. I am	
490		looking at this through my white British glasses and this is what I am seeing. And it’s a kind of tell me if there are any what I am	name it
491		saying that does resonates with you. And you know, help me understand what this is like for you and your culture, and and	what if therapist
492		a kind of help me, give me a map through that.	has not notice it
493	FP 7	Yes, I think that curiosity questions feel like an important things to bring in.	
494	FP 9	And also sometimes we can get a little bit tongue tide by jumping straight in with a big culture question you know. Well, I am	
495		white British and I am really different. So sometimes you know I might start a bit more subtly and say you know how is this	

496		similar or different to how you normally have your dinners together. You know, before you have these issues, how might	
497		you eat dinner, so emm may be a bit, you know a bit softer around, rather than how are you different from me, that how	
498		you different from how you were as well (Gabby nnh), to gauge you know, how near or far they are from what, where they,	
499		their problem. OR how they comfortable, so try and get a bit creative and that way is what I think.	
500	FP 8	Because otherwise we are naming it in that really direct way, that in itself is so othering.	
501	FP 9	Yeah (Ivy laugh)	
502		You know what I mean, if you, they just came in and I HI, I am FP8, and I am white British, what are you (Helen dramatise)?	
503		This is like (FP7 nhh) you know what I mean.	
504	FP 6	And I think even the idea about what might be relaxing, I guess I have an idea about you know, I guess important kind of	
505		family around, planning before meals what might be helpful, what after meal might be helpful, and to me what is relaxing	
506		in your family, like may be sit at the table, would that family, they know this is what they are used to. So it wasn't may be	when I know, is
507		tense for them, if they were, we were to ask them, is this okay or relaxing or what, or suppose to a kind of , yeah, try to be	time for curiosity
508		curious about what actually is relaxing in your family when you are having meal. Whats that like, :: emm ( ) I guess when I feel	
509		I guess go on	
510	FP 6	like when I think I know what, I probably, when I need to be more curious (Faith laugh)	
511	FP 9	I get really fascinated by the food and err, so I get ask and get really curious about all the different food they have. And I think,	
512		I do really, I don't know. Emm, almost quite cringey really because I not really the best cook (FP9 laughs) and so. But I, I	
513		absolutely genuinely. I mean all of the things that the families made, we come into the service, ready to be microwave, and	

514		they prepare the most amazing thing. So well, what did you have for the snack? Oh, we made this thing with honey and	
515		cinnamon and there is all these rituals. And I am just absolutely so interested in, and I just I genuinely, so I think they sense	food, rituals, culture
516		my emm, you know my excitement really, some of their culture. Emm, so I suppose that's a genuine part of me that, that emm	
517		(FP9 hiss). I don't know, sometimes I almost wish I am sitting at the table and emm, and sometimes its really hard because you	
518		got a child who is very ill and won't eat anything. And I hear the descriptions of the food, is beautiful food. And I find it really	
519		hard not to say, it does just sound delicious (FP9 laughs) which is so inappropriate with a kid who is absolutely doesn't want to	
520		eat. That you know, there is that real human part of me, that get quite excited, about some of these cultures, and how they	
521		are different.	
522	FP 7	You reminded me of emm, emm a role of supervision group with the MSc course and err. I remember this family just, they heard	
523		that we weren't going to be eating with them, you know, we will be behind the screen. Therapist will be in the room, so they	Therapist practice
524		brought this big take away. Well, they packed one for all the reflecting team (FP7 laugh) and err because culturally for them	family culture of
525		to be able to eat. And know that we hadn't got any, so the therapist had something in her hand. She didn't eat it, she did	Eating
526		actually in the end. Because dad won't eat with the young person, so but actually they brought the food for everybody in it.	
527		Just calorie give me a bit of that, I guess I just saw all that food there on the table. And emm, **yeah what is like for families to**	people watching
528		**eat together and have other people there and not eating**. I guess that's all round that table, it felt like a bit of a gap, a space.	and not eating
529		Somebody said where was the mum, and I think the way that the table, the chairs are organised in my mind. It a kind of felt,	
530		didn't felt very cosy (nhh) don't know whether if there was still space for the mum (nhh).	

531	R	What do you think is like for them to eat in their family?	
532	FP 7	Feels a bit of pressure. Felt like a bit of pressure, you know they all look ( ), something for me being comfortable when I eat.	
533		You know, changing out your work clothes and putting something comfortable. They all look very well groomed and you	
534		know emm, can feel a bit very pressure, how you eat, the way, yeah.	
535	FP 8	For some reason, it felt like it seems easier for them to eat when Dad wasn't in the room (Gabby nhh). There was a definitive, I think	
536		difference in, even that, I think they are they may be putting food on the plate when he wasn't there. I don't know if that's	
537		to do with rituals and hierarchy and politeness, I am not sure within that culture. But there was, it felt like a difference for me.	
538	FP 7	I got the sense emm, they didn't eat until he nodded to them. I don't know if that happened or I just thought that happened.	
539		He kind of came in, then they all seem to pick their you know, chopsticks or whatever they are eating with. It kind of felt like	
540		they started to eat once they were, yeah, allow to or that's praying rituals.	
541	R	I think, I think they did. Its almost like a recognition of let's start.	
542	FP 7	Right	
543	R	Yeah, and that got me to think about what aspect of culture are influencing their family meal. Do you think, you reckon?	
544	FP 7	A kind of got a sense of religion (right) you know a blessing food, being grateful (.4)	
545	R	I was thinking about (gender) yeah. We are taking a position this is a video, and for us to watch and then we can think about it.	
546		But in real situation, err the family are not like this they might coming for an eating session with you guys. Emm, things are	
547		all happening in the moment. I was just wondering in the moment when you feel things perhaps resonates, not resonates. How	
548		you position yourself? (.4)	
549	FP 9	I suppose in the moment in the meal. I wouldn't, I think I would just be really getting the feedback from my being in it.	just in it.

550		Because it felt, I mean if I was at that table I would feel really anxious and I really as delicious it looks. I feel LIKE I struggle to	
551		eat and SO, you know, not wanting there is something, the minute you, you address it in the middle, you punctuating and	manage self reflexivity
552		changing things. Emm and of course, you know the moment the young person trying to eat, that you don't want to disturb	the meal process
553		what you hope might happen. But I suppose I wonder you know afterwards, I want to reflect with them about how, you know	and …
554		how that was for them. I be wanting to know what the feelings were. I mean THAT was a table, you know that didn't have	
555		someone with an eating disorder. Emm, if that was a family coming into our service and there was someone with an eating	
556		disorder at the table. Emm, I suppose it is easier because there is an obvious problem that you all kind of addressing that i	ED as a context easier
557		suppose, I don't know.	to address
558	FP 8	I don't know, I, I, because it is interesting from we first start watching the video I wonder if the daughter who eventually said	
559		she was moving actually had an eating disorder because everyone was looking to her. And the Dad was asking essentially	
560		is there a problem? And I was, I was thinking, OH is that going to be a family with an eating disorders presentation? And I was	
561		kind of thinking, I don't know, I think in terms of what you ask Charlotte about their culture. Because culture to me, is is like,	
562		a characteristic, isn't it? And the knowledge, emm a kind of people and that include includes their kind of language, their cuisine,	
563		their music, lots and lots of, lots of different things and I suppose we were seeing a snapshot of, in terms of their language,	
564		their cuisine and I don't know that gives you enough of a contexts (nhh).	
565	R	I kind of like agree that you know, if this is a family that come to the clinic you have permission to ask and be curious. And a	
566		kind of if you are allowed to be curious and ask question or just do whatever you want to do, to make sense of your feeling	

567		about resonance and not resonates, what will you might be doing next you know?	
568	FP 9	[Yes, sorry. Quite concrete I go to be, would be whether the food actually get eaten on the table. Because and if it didn't	
569	FP 7	[oh, no no	
570	FP 9	I like to understand WHY, we all full up, everybody eaten or, that might be my go to place to try and figure out. Is there a	start with concreteness
571		problem? I suppose I will start with that concreteness of food (nhh).	about food
572	FP 7	Yeah, I want to. I think we are onto how long did it take you to prepare all these. What do you do with the leftovers, do you	
573		eat it tomorrow or would you? Are there other people coming, the you know, they are kind of (Ivy nhh) yeah, not wanting	
574		that waste element and what happen to all of these afterwards?	Waste
575	FP 8	I be interested in terms of, obviously you know what an eating disorder we were looking at you know, every last bite finishing	
576		your plate, not leaving anything behind. And actually in the culture, in this family we were watching is it actually within	
577		their kind of cultural practice around food, to finish their plate or do they leave things behind. Or would it that they agree to have	
578		a proper portion and, and is it. Yeah, so I suppose I was interested around that (Gabby nhh).	
579	FP 9	What is the meaning of waste? (Gabby, Helen nhh) you know how, how rich or poor privilege this family, what is it mean to nnn	Waste
580	R	So if we turn to one of your clinical family that you work with, that stuck in your hat at the moment if there is any. So	
581		what might, you know when you first met a family of different, and you know something like something you are curious,	
582		something you might, it might resonate and something you might not resonates with, how do you, what is your next move then/	
583	FP 8	In terms of after we kind of may be name it and then said you know.	
584	R	In terms of when you met a family that you like, imagine that they, your family that you work with recently, yesterday or	

585		whenever (FP8 yeah), and they might have, they might come to you and there are things that you resonate and not resonates,	
586		something, how do you go on from there you know.	
587	FP 8	I suppose, in terms of things that resonates is for me, is a kind of obviously the use of ourselves as a family therapist. So I will	use of self
588		, I will, I would SHARE you know, that, that resonates with me, etc, etc. But all, I know, I know could you tell me more about	
589		that, or you know and I suppose working out from there, whether that does have any meaning to them, whether what I noticing	I notice
590		or not noticing is actually IS, is relevant. Does that make sense or am I making it too relevant?	
591	R	Nhh, so you check it (FP8 nhh). I was just thinking about like ehh some of you mention this family create tension, you know	
592		that it feels tense. I just wondering if a family create this sort of tense feeling in you, that when you are a little unsure,	
593		you know how do you go on you know.	
594	FP 8	I think again I name that, I think I often say, you know oh, you know I go back to a point of biological level saying you know that	biological, body
595		make, especially sometimes when families don't always have that emotional language, and that emotional coherence, about	Sensation
596		you know all that made be feel hot, or cold especially when you are working with younger children. And you know I make	
597		my tummy feels funny when I, you know what I mean. So I think something about really naming the emotional tone of that and	
598		ehh, I like to think that I always do try to do that. But then, I wonder if that's just to do with skills and experiences over time.	relational
599		And if I look back in the beginning, when I first started working with eating disorders. I, I don't think, I am not sure I will done that	Reflexivity
600		in the same way (nhh).	
601	FP 7	And there are sometimes, I wish, I wonder about not naming it, but a kind of using that resonates, you are feelings something	
602		so throwing that out, you know what do people feeling at this, this moment so that kind of second order positioning. I think	second order

603		I am feeling something quite strong here, but I don't want to put my language onto that. You know, what, what's the temperature	
604		in the room at the minute. Or what is it like, you know what are people feeling as they are sitting around the table.	
605		You know, knowing that I am feeling really really tense, holding onto that and checking on their sense of that.	
606	FP 8	And I often say things like, these are my words, these words might not fit for you. If I am kind of sad, because I am really	
607		aware that this might, my description of it and that might not be okay for that.	
608	R	What about for other ehh? You are on mute Faith, you look as if you are going to say, wanting to say something.	
609	FP 6	Yeah (Faith laughs) do I interrupt, were you going to say something Charlotte.	
610	R	No, no no. I was saying you are on mute, you know like.	
611	FP 6	Err, I was just thinking there are about, especially in inpatient services and I think in all service. It sound like may be families	
612		have a bit more and freedom may be in your services. I think they have to bring in food, and different things and we don't	
613		actually do that. So, as nice as it is I supposed to have these important conversations, the reality and obviously COVID has to	
614		be different now for family having dinner over skype. What I guess, you know there is an expectation that you set in this	
615		room. This is what the room looks like, eh round table and you know who comes in, you eat the food that's, everyone needs	
616		to eat the same food and I don't know, and I wonder about how we could, may be a bit more, a kind of thinking about a family	
617		and, and their culture and I suppose. And whats important and how those conversations, but also there is a limitation and I think	
618		you are a kind of talking about that FP7, like it’s not that we are, we acknowledge there is a culture but there is a kind of	
619		an expectation around meal time and, and the meal the family have together. And, and how we can kind of marry them, for	

620		was, that who they are (emm) I think we, I don't know. How do you prepare about that, I suppose about you know,	who they are
621		acknowledging it and also the limitation of it.	
622	FP 7	I am just thinking of transition then, from inpatient into outpatient their own meals are going to be very much can, can we not,	
623		they are going to, family might bring in meals into an unit. Emm, young people are going to be on home leave and how you	
624		kind of re-connect them. With the kind of meals they are going to have when they go home.	
625	FP 6	Yeah, and I think that comes up a lot with families as well is like, you know what kind of the moment, when that fear about	
626		emm, I suppose all those conversations, do we have a bit little more re, more because of covid and they are not getting	COVID interrupt
627		actually home leave. We are a kind of ended up doing longer and emm, longer leaves and actually yeah. Err I think may be	Home leave
628		something your service could be talk a little bit more about actually, if that how we can culture and meal times and all of that.	
629		And food, the actual food that people might eat, and how they might you know.	
630	FP 9	Because, that I mean an inpatient unit and a hospital is (.) isn't it?	
631	FP 7	It's a what?	
632	FP 9	It is a culture, an inpatient unit (Gabby yeah) a culture on itself being in a paediatric ward is a culture on itself. And then sitting	ward/unit as a
633		it in these rooms with you know. You know tables, and chairs, you know it’s a false environment, its you know the journey	Culture
634		of the young person, near the TRANSITION that they made, the leap that they made from whats familiar to them. Emm,	
635		you know we, you know we OTHER their culture where actually in an inpatient unit, in the hospital culture we are the	
636		OTHER, we are the, their, their, the you know the false place, aren't we? (Gabby nhh) Don't we, because we are in it and	
637		work around it all the time.	
638	FP 8	I think even in the outpatient and day programme as well, every team has a culture don't they. And its and I think that I thought	team acting like

639		about what you said earlier FP9, about you know we talk about how the anxiety and, and how that raise a safeguarding and	eating disorders
640		the team almost kind of goes off on this mimic about anorexia sometimes I think. And the culture of the team almost	
641		starts to mirror eating disorder process but in different plain. And then yeah (FP7 yeah), is tough.	
642	FP 7	Yeah, I think when you are talking about resonates Charlotte. I was thinking about just how do we hold onto neutrality, so	
643		when we see that amount of food and for us that like, seem like a vast amount and how do we kind of keep that position	neutrality
644		of neutrality, because in some cultures that would be the norm. And the expected, and I guess as you were talking FP8 about	Norm
645		you know team mirroring. I was just thinking about, as an eating disorder team, we often we used to have buffet before	team mirroring
646		emm covid. And actually one particular member of the team had a real issue with that, you know happen to be the dietitian	reaction to food
647		actually you know. There are so much, it is really glutenous, people are bringing in so much and actually the more she did	
648		that, the more other member of the team would bring deliberately [EAT YEAH, say I got a lot more to bargain, this, I am just going	
649	FP 9	[bringing	
650	FP 7	to eat it all. And she was saying you don't need it. But I want to. You know its like all playing out. With, yeah it, just may be	
651		thinking about those reactions and that OUR reactions when we see, you know different family meals. Because family meals	
652		are different.	
653	R	What does other people think, do you share FP9's experience that sometimes some families evoke strong resonance?	
654	FP 9	I think so, and I been thinking about you know we trying to get to the nub of what do we do, what do we say, how do we	Difficult
655		manage, we feel that real difference. And then I was thinking, that's a really difficult place to be in. And I notice what WE did,	wonder away

656		we all kind of talk away from it a bit. And then I (.) you know, is that a reflection on really how hard it is for us to sit, and know	is that a reflection
657		what to do and then I was thinking, well how do I do it then? And I think its, its so hard. I think I say a lot less actually. When I	
658		with a family where it is so different, culturally different emm, I say a lot less and just sit and be with it longer (Gabby nhh) and I	
659		think emm, I don't know. And I think that opens a space for their voice more. And I kind of then hear and learn more, and try	
660		and change, you know make, trying to what, create that one down position but I definitely speak less (Gabby nhh) and feel	
661		more. And that's a kind of, so they hear me less and that actually. That's I am probably bit practicing a lot better with them,	
662		that with a familiar white British family, I, that I don't have this difference. I probably just sit and talk, and MUCH less	
663		reflective (FP9 laughs) and they probably get you know far WORSE family therapist for it. But its, definitely influences how	
664		I be in that space, and that I would have. I don't know, affordances and constraints I guess (.4)	
665	R	So, got me to think about this space between resonance and not resonance, the space in between. I was just thinking about	
666		how, how you relate to that, you know.	
667	FP 8	Can you explain that differently Charlotte? Sorry.	
668	R	You know the space between resonance, you find something resonates or something not resonates, and the space between that.	
669		Because it is not like two distinct positions, resonates or not resonates. Although my question is a bit like that, but actually	
670		its, it's the space between is, you know, how do you relate to that? Because some	
671	FP 7	Is that sort of wonder enough of similarity, or difference?	
672	R	Yeah, if you frame it as similarity and difference, is not always distinct isn't it? Not everything is similar or everything is different.	
673	FP 9	I suppose in our mind, we quite <u>active</u> aren't we? We all the time trying to figure that out, so I don't know I suppose its human	space in between

674		beings. We always trying to seek out points of you know, similarities, you know I don't think that we occupies a space where	is to build rapport
675		we say, right we are here and they are different or they are the same. I think we have a sense and we are actively in our minds	Connection
676		trying to, I don't know actually you know, we are trying to build rapport I guess. And that's a process of trying to find	
677		points of, of connection, emm and you know I think, when families are resonates so much and so similar. I am much less	
678		curious. Emm, we miss loads, its frightening. But when there is, when its too different, the other extreme, when it is too	
679		different, I fear that we are not going to make a relationship, we are not going to find the point of connection that would	Being in the middle is
680		enable us to do some works together. So it is an active place, being somewhere in the middle.	an active place
681	FP 8	I, I think somewhere in the middle. You almost always pin, ping ponging between similarity and difference. And you know,	
682		I think you are always doing that, especially in ED works, we are always kind of hypothesing and formulating, and reformulating	
683		and coming out with hunches, and may be when I am in that space in the middle, I might bright forward oh, you know I have a	a hunch
684		hunch and I might bring my own kind of hypothesis into that space, to get more of an understanding, and the working out.	my own hypothesis
685		I think that's what I might do in the space in between.	
686	FP 7	I think it’s a space where you don't get too wild, sometimes its really different you can lose the sense of why you are	not too wild
687		there you know. You so kind of emm, wild by this difference and the many questions that you have on a personal level and	
688		the, if it is too similar you might sort of thinks you know. This a kind of create more of a space to wonder, and to think and to	
689		step beyond (nhh) to question.	
690	R	Anything you might like to add that Faith, or	
691	FP 6	Emm, yeah I kind of wonder as well about what are the purpose as well in that, a kind of I suppose I work, a kind of	

692		connect and wondering whats emm the experience might be family and, and the young person. Emm, and yeah, I guess	too much or not
693		sometimes I, I worry that we try to get into, into too much kind of trying to find out lots of, may be too much information	enough information
694		or, without may be kind of thinking what is going on in the process and. So I find sometimes we either get too much information	
695		or not <u>enough</u> I guess. So maybe that's the resonance, or when its not, and when do kind of I don't know. Emm, I suppose	knowing/ not knowing
696		because I am a kind of bit more newly qualify, maybe I question more, I guess so I have more conversation with my	the resonance
697		supervisor about things like this. Emm, or she might kind of point something out here. Or wonder about something, err I might hear	
698		the kind of group supervision as well. I think we all look into that, we, we have a team emm, systemic supervisors and, and I think	
699		that's really helpful. Because we get different, from different members of the team, not just the family therapy. And a kind of	
700		what we really hear from other people's experiences and cultural kind of emm (FP7 yeah) and I don't know. I think it is really	
701		hard not to, to feel that, that fear of either you feel that other, this family is exactly like me so I know what I am doing here. Or	
702		the opposite. And yeah, how do we say for the similar. And what does that MEAN, how does we do with it I guess. My what	
703		camps is it? (Dog barking noise from the background) I hope this make sense.	
704	R	So what do you do with it then (R laughs)? If you like, that space.	
705	FP 6	Emm, I suppose I kind of, what do I do with that? Ideally you know in a perfect situation, I will be able to have lots of, lovely	
706		conversation with families and, and connect, and make you know, that something that helpful for the family I suppose. Emm, but	
707		also realistic in what are the expectation and the restriction of working in inpatient care. Emm, but also prepare to empower	
708		parents when their kids are going home. And what that was going to look like for them (nhh).	

709	FP 7	I think sometimes, not naming that difference, so you know if you think they are just there, very similar to you. But you just	1st order?
710		say, what you know family like you having a therapist like in the room. It's kind of not, not defining each or the other by	not defining each
711		that difference or sameness. Its just, you know opening it up (R nhh). That make sense, so I, I very often use that as a question.	Other
712		What is it like for a family like you meeting a therapist like me, so I am not defining myself in my cultural, or race, or emm	
713		contexts. Err not making any assumptions about that and sometimes it just brings a bit more detail to that, because people ask	
714		what, what do you mean? You know, just to them be able to say well, our differences or our similarities because, because	
715		just we don't look the same, we might have you know quite a lot of similarities and.	
716		Right, thank you very much. Emm, I just noting the time. Emm, does anybody have any last words for this part of our conversation.	
717		If not, shall we have a break. Someone was going to say something. Were you going to say something Gabby?	
718	FP 7	No, just going to say on the one level I was watching the video and looking at the subtitle. Somehow I was going down but I	
719		wanted to look at them (yeah). And so I was trying to coordinate between looking as much at them, but then a kind of having	
720		a sense of what was being said (nnh). Don't know if other people were doing that, emm. I find myself keep looking down, and	
721		then going back up again.	
722	R	Yeah, the challenge of err yeah coordinating yeah. (.2) Okay emm shall we have a break now. Give you a bit of break from the	
723		zoom screen. Shall we come back at err, where are we, four O five? Four o'clock, four o five, we need to have a longer break for this	
724		round. Yeah. (FP7 okay) Thank you very much.	
725		(Ten minutes break)	
726	FP 6	Hello, did you say five past or its, what time?	
727	R	I said five past, but err	
728	FP 6	I was like, god I hope I haven't, conversation that I, my computer just froze or something, so that's okay (FP6 laugh)	

729	FP 7	I thought it was five past, but I couldn't see anyone back, so (FP7 laugh)	
730	FP 8	That was same as me	
731	R	So is it, ahh, I was waiting at five past, you know like (everyone laugh). I :: should have turn the video on, it is my fault you know.	
732		Sorry. Then we have to be, kind of like what john burnham say you know try to do the best of twenty five minutes of the hour.	
733		That sort of thing (R laughs)	
734		Okay, the next part is ehh, inviting you to do a fish bowl exercise. Err if I share screen, to just give you what I am hoping to err	
735		share, is like. So a fish bowl exercise in terms of what next for your practice in race, ethnicity and culture, whether it is food	
736		or the context of eating disorder, because we all know that eating disorder has food plus other things you know. Emm, and then	
737		the, your practice, your team and your service, if anything. Any I just added FP9's example, in terms of she mention about	
738		this family in the first exercise, this family of Ukraine, this is very very different, so a kind of like a prompt. Thinking about	
739		family of very different you know, less familiar. So in terms of your practice, err your team and etc. So it is yeah. So what I have	
740		done is like, I put the question on the chat in case if you wanted to refer to it. Emm, what next to your practice, food/context	
741		of ED for your team and for your service, if anything. And FP9's example, I thought it is quite helpful to put it there. So on that	
742		note. Emm, in terms of fishbowl, emm is err, there are four of you, so its two by two thing, err is that okay? Err, so we will do	
743		ten minutes the max, you know each round. So ten, ten and then the last ten or fifteen, to round up the fish bowl. Emm, is there	
744		a preference, I think maybe I should assign, to do an executive sort of organising. So FP8, FP7 on my left hand side. Shall we say	
745		you are in one group. Is that okay. FP9 and FP6, and then I will join the last round. So when we come back together. If you are	

746		not in the fishbowl, I invite you to turn off the camera. So that how we do reflecting team nowadays you know. So, I will be in	
747		the background, so the people who do the talking will be on the camera. So off you go, ten minutes FP8, FP7.	
748	FP 8	Okay.	
749	FP 7	Hi, Hi	
750	FP 8	I suppose really interesting for me because emm, I am putting forward (a study) myself and a lot of that is base	
751		within emm culture and eating disorders and various things. So, within my service, I think I been in a really privilege position	
752		to be able to take some of the idea, some of my thoughts and learning into the wider team. And and I suppose, have a , we got	
753		a group emm where called cultural reflexivity which is based on thinking about it in a slightly different way within the team. And we	
754		try to bring it into training in a non othering emm subtle, I suppose way in terms of just having it. I suppose not just thinking about	GRACES can be
755		GRACES is it? Because GRACES itself is quite othering, sometimes I think. I am getting to a slightly deeper level and we have	Othering
756		done things like look at the manual and deconstruct them a little bit to think actually how white British are, the eating	deconstruct the
757		disorder treatment that we tend to deliver, how we kind of white wash are they, how inclusive are the to some of the families	Manual
758		that we work with, and I don't know about you FP7 but sometimes we might use, like the animal metaphors from the	
759		Maudsley model and things like that (FP7 nhh) And we notice like that could be really alienating for example I am working	
760		with a Sikh family and if I was say to them, you know get alongside your child like a St Bernard DOG (FP7 yeah), that would not	
761		have a same meaning as it might have to a family, where dog have a different cultural construction. So we kind of use	
762		different things and adapted models, and thought about things really differently. I don't know if that's emm the same.	

763		Obviously you are in a completely part of the country to me as well, so might be really different for you.	
764	FP 7	Yeah, I am I went to the Symposium with (name), I don't know if you went to that? And err, I have been involved in the	
765		systemic programme for a quite of number of years. Actually my tutor group or supervision group, they always come into	
766		an eating disorder, clinic is that all I see. I only, I only in the eating disorders service there. So, I guess we been thinking about	
767		what we do in terms of changing the readings, how do we kind of creates space to think about the difference amongst us, as	
768		a training team. Emm, and I guess I am thinking about the wider team that I am part of, and err I am I kind of emm coordinate	lens of REC
769		the new assessment clinic, and err, just thinking about how we look through that lens of race, ethnicity and culture when	
770		new families are in, and how we define is, and isn't an eating disorder, and how we yeah, how we might look at it from a	
771		practice, from a yeah therapist or emm clinician perspectives, what we spot and what we don't. Emm, who we decline, who we	what we spot and
772		accept within the service. I have doing a lot, you know in terms of that, probably noticing a lot, noticing just the kind of faces	don't?
773		or families that clinicians are quite, you know readily say. Oh no, that's not an eating disorder. And you know, so what was spotting	
774		and what we are not at the entry level. Really thinking about that, helping people to think you know. How come, how come	expert in spotting
775		you, you thinking that person hasn't got an eating disorder today, and that person has and yet the risks that you describe been	
776		at the same. Because I guess, is my role when they come out of those sessions (FP8 yeah) to come to some decision about	
777		acceptance, noticing patterns.	
778	FP 8	I think something to do, I, I am making an assumption here but in terms of the outcome measures. I think they are fairly	
779		standard across most of the NHS, some services have lots of them, some services might have fewer. I mean we certainly have	outcome measures

780		AWFUL lots of outcome measures that we sent to the family in the beginning (FP7 nhh) and we done some closer looking	
781		at those in terms of actually, are we asking questions that sit with all the families, all the demographic that we work with,	
782		that might get the right, not the right answer, but an answer that gives enough meaning and enough information for that	
783		culture and that family. Because, if the question aren't kind of, don't have the same meaning to them as they might to another	
784		family, then the answers might be different, and you know with NHS services and commissioning, and waiting list and referrals.	commissioning
785		I think that sometimes emm, some families might be more marginalise, or have smaller voices. They are at risk of not getting	waiting list referrals
786		the service, that, that they need. And, and I am certainly noticing a lot more, like you said in terms of actually, you know why	
787		is it that we privilege some families over, over others. When actually if you get really underneath and behind that, may be	
788		ask slightly different questions and. I ↑suppose work a bit harder which can be difficult with time constraint, I do get that.	work a bit harder
789		But, they are actually they need the service just as much as the other family that you said yes to.	
790	FP 7	Nnh, Nnn, I think we have err (FP7 hissed) were things we notice you know, I am ashamed to say we are a huge .hhh service in	
791		(area), probably the largest camhs, you know team in the country, when you think about us as one whole service.	
792		We are nought to twenty five now, so and, and yet as a wider service emm, ethnicities often is not captured that at that	
793		early stage. So as an eating disorder, we have been really really careful capturing that, so its been a struggle, you know quite	
794		often we are accessing, I don't know about twelve new people every week. So, when I am coordinating to get those clinicians	ethnicity not asked
795		to go back in, and say ask the question, you know don't just, and guess or don't just not ask. Because quite often it is	
796		not being captured on our, you know on our data base.	

797	R	We have one minutes left (R smiles).	
798	FP 7	[So we	
799	FP 8	[Yeah, I know. Yeah, you just can't go on a kind of tick box on the kind of, and I think it it, and I complete, because our	
800		referrals are up, I think they are up nearly three hundred percent now for our eating disorders, in my camhs team. (FP7 yeah)	
801		and : and you know with that volume coming in. I think people sometimes loose sight of it and go straight into the medical	
802		model and the risks (FP7 yeah) and tick boxes. And its just as important (FP7 yeah), and its suppose to changing the culture	
803		of the team in the context of, its difficult isn't it because we are so organise by death and risk (FP7 yeah), that culture gets	
804		a bit lost but we risk at the loss of culture, not paying attention to death and risk of other people in the same way	
805	FP 7	Yeah, absolutely, recruitment is far more because we are huge team. And actually we have a small amount of emm people from	
806		diverse ethnicities, and actually we are the, we are very diverse city (FP8 yeah) so really thinking about our recruitment	
807		policies. Emm, I think we are doing that as a wider trust, having somebody an inclusion you know, member of the panel just	
808		to think about inclusivity and diversity.	
809	FP 8	Yeah, I agree with you.	
810	R	Thank you, can we invite FP9 and FP6?	
811	FP 9	[Hello okay, SO FP6 you are in an inpatient setting. Emm, which I got, I am wondering actually was resonating for you	
812	R	[I need to turn off	
813	FP 6	Hello	
814	FP 9	because its, you know, hearing lots of really exciting things that are happening in FP7 & FP8's service. I am wondering you know,	
815		what came up for you when you are thinking about your experience in an inpatient unit and what you do?	
816	FP 6	Yeah, I think when I was listening to their conversation, I was thinking okay I will move, may be actually we are not so bad because	

817		I don't know if we are : as a team thinking about culture and not for as we should be. At the moment, we are kind of, introduce	trauma inform
818		a lot more about trauma informed, emm approaches. And it almost feel like that, the whole body of work in a way is kind of	approach fit with
819		getting people into training and, and have a more conversation about it. And I a kind of feel that actually the same like, I think	local context
820		about culture and policies, and thinking about how we even emm, feels like a question as for like FP7 was talking, about, about	
821		how you capture referrals and who is referred. And I am not even, I guess I feel like almost I need to go and check, emm how	system
822		do we do that? Emm, so it kind of makes you think okay that not everyone is ah ah kind of feel like I am a bit behind,	
823		may be and may be that's actually not the case, but its more about bringing it into the conversation and I have a emm, but it is	bringing it into
824		talk about and that I am bringing a lot more perhaps.	the conversation.
825	FP 9	I think what emm, I was thinking something you said earlier that resonated with me. And you were talking about that, I don't know	
826		it’s a bit like a dance between am I asking enough, not asking enough, you know that kind of, that’s may be that’s may be	
827		that space in the middle Charlotte is talking about. That kind of dance, and when I was listening to you, it really strikes a chord.	
828		Because it reminded there was another example, and it was an inpatient where it wouldn't with me, but the clinician I think	over enquiring of
829		the clinician has, was so overly enquiring about culture that it completely alienated the family because the family said. For	culture
830		GOODNESS sake whatever you call it, my daughter has got an eating disorder, can we just get on with it? And so there is that	
831		you know there is the policy level, but then you make me really think about there is that in the moment space. And er, I suppose	
832		if I think about our services, we got an intensive bed and an outpatient bit. Emm, I think you know I think, thinking about the	

833		things that we don't, still don't do so very well. Emm, so we got, we are very white British team. We might think we do culture,	
834		Oh that may be that's cultural, or maybe this is because of this but we say it and you know, maybe we move on. So may be	we say it and move
835		some of this is not very good at it. And I think the way that I have been trying to improve that is to holding lots of lots of	on
836		supervision groups. And so actually you create spaces to bring a family in, where people feel really safe to get really cross	
837		about this French parents and then for us together to kind of deconstruct that. Emm, I think you know on one level I think	
838		we think we are doing really well because we say you know we have a meal plan, we changed it. And all the meal plan talks	
839		about is your cultural food, whatever you normally serve. I think the pandemic really help, or not help because referrals have	
840		gone up. Everyone in our service, may be a bit like yours where people had to be at home more. And many of our day patients	
841		kids are at home. And so they are still in their cultural family of origin. And that has been emm, a benefit, emm but I was,	
842		suppose I was thinking of the small ways you make a difference, so how can we have the courage in an mdt meeting just to	mdt
843		you know, be the voice of the family or to challenge somebody's assumption. Or not to challenge, to pause to think, our	
844		service is so stretch aren't they. I mean certainly in outpatient, we are not pausing, so how do we have the courage to pause,	pausing
845		and get people to just to think a little bit more about difference. How can we emm challenge at that level really? So that	
846		was a kind of where I went and then I kind of went to an even more, well actually I went to quite a hopeless place (FP9 laughs)	
847		which I think we, we have been kind of sit with the fact that, its probably what it could BE, we are only one part of something	
848		so there is something about family's barrier to help and their experience within their society because I certainly experienced	

849		that we can be really inclusive in our service. So I am thinking of a particular polish family who become SO difficult to	
850		engage with, really difficult and we you know, we got emm member of staff who is polish. So we are being really culturally	
851		sensitive. Yet, their experience is far through school, social care and their external experiences of being emm a minority.	
852		That will come into play, doesn't it? So it is not like you know, we, we can be as brilliant as we are. And have all the policies	
853		and all the supervision you know. But they would, their exist barriers to help is relationship with help. And I suppose we have	loss and empty
854		to learn to sit with that. Sometimes, an incompetent feeling it might give us. So that's it, loss and empty (FP9 laugh) and	
855		(FP6 laugh with FP9) but I, I think it is the same as culture in a way. That kind of OH Gosh, emm that it might stop people.	
856	FP 6	I don't know enough about culture, I am not going to talk about it. Or or another (.) maybe you know like. I think that	
857		probably in our, in our team allow the time, this is the real, eating disorder that's what comes up. Or to follow this rule, its	medical model
858		medical model and everything are nice and safe and certain within this. And obviously not that way at all and I think its almost	safe and certain?
859		like the trauma work, trauma discussion is almost help them, people know that the team okay, okay to talk about trauma. Its'	
860		okay to talk about culture, we might mess up, we might not get it quite right but its its, how do you start the conversation	how do you start
861		and talking about it. But the family will, actually this is how the family see this. This is different may be how you go over it,	
862		and seen it, I think. So it doesn't feels so threatening or scary or unsure to talk about. Or in, in the session may be as well.	
863		Because I think sometime as family therapist we can, may be talk about culture and difference in a way that, err support	
864		the family and then they go out to the other part of the world, that they have to engage with the other member of the team.	different members

865		That are kind of different expectation to help. Where does that leave them then as well? That well actually these people are	in the team have
866		difference to who is really difficult (.)	different view
867	FP 9	Yeah, it is true. With an eating disorder they got to liaise with SO many different members of the mdt (FP6 nhh). A bit you know,	
868		family therapy means to do all this, yeah we are something to a family. But certainly I feel like work just as hard, if not harder,	
869		systemicly around them through the team and through the other systems (FP6 nhh). And that's you know such a big part of	
970		the work isn't it. Emm, I MEAN I am wondering, I don't know because in (place) what the cultural diversity like, is it, the staff	
871		in your inpatient unit?	
872	FP 6	Emm, yes I guess probably majority white (ethnicity) and we would have African nurses and doctors, emm we would have	
873		and some asian doctors as well, may be about 25% it could be. And might be more kind of ethnic diverse and then the rest will	
874		probably be white (ethnicity) and (.) and then admission is probably, probably similar enough around that as well, in terms of	
875		ethnicities. And of course I am in (place)	
876	R	You got two more minutes	
877	FP 9	Yeah, we are very white British, very <u>female</u>, we are in a population in the world which you know, we kind of, we are across	
878		(area), we got the most richest, the most wealthiest families you can possibly wrap your head around. But we	
879		also got some really you know poor (areas). And then, you know we sometimes try and wonder well, is that because	
880		they are not referring kids from the poor (areas) you know. There was a suggestion that, oh well may be they just	
881		don't refer because their relationship to help. And would be: may be they have more resilience and they are not having	
882		these eating disorders like the very privilege (area) you know private independent school. Emm, so it is emm. I am, and some of	
883		the narratives as well I heard around, you know families of, sometimes err I heard across systems that are so painful, for me	

884		even to hear like the assumptions that are made you know that are made around. That was the poor young chap who err,	
885		from a parkistani family was so autistic. Emm, but the narrative, yeah the really big team across the (area) but the narratives	
886		around the parent and the family is that, they just you know getting frustrated with the kid but it was very damning and	
887		damaging and disrespectful to their culture and emm. And is HARD isn't it, because sometimes you can use your voice and	
888		you try and it becomes. It can be really exhausting, you can feel all of, a bit of what a family feels like. That kind of (FP9 hiss)	
889		you know. I don't know sometimes is like a professional neglect. Emm, that can happen (FP6 yeah) and I have seen and then	
890		its frightening, you don't know how to kind of catch them and hold them. So it is, is you know it's a, its not just an issue for	not just the service
891		our service I guess, I am thinking. I am thinking this is something about our society and all of our partnering services. And the	but society and
892		system that these families and children are passing through (FP6 nhh).	partnering service
893	R	Thank you FP9 and FP6, shall we come back together as a group? And so we can kind of reflect on our conversation (.6)	
894	FP 7	I guess I was thinking as I heard emm FP9 & FP6 start from the position of practice and err, yeah. I just thought the importance	
895		of all at different levels in our organisations. That you know I been qualify, I don't know eighteen, nineteen years now. So, my	
896		role has changed and just thinking how progressive it felt that FP6 was at that newly qualify stage but really working hard to	culture at multiple
897		bring this diversity into the conversation, culture into the conversation. And how you know, our contributions are so	levels
898		important at a multiple levels that we are in, within our organisations.	
899	FP 8	I think I really empathise FP6 because although I have been working with eating disorder for a really long time. I am in a	
900		slightly unusual position of only having actually qualify as family therapist two years ago. I think this is my second year	

901		post-qualifying now. Emm, and I just threw myself straight into a doctorate because I am a kind of barking mad. Emm, but	
902		(FP8 laughs) emm, so I really empathise with some of the things you were saying and I was thinking that, that must be, I can't	
903		imagine how difficult that must be, to not just have to grabble with your kind of self as a newly qualify family therapist but also	
904		grabble with any, an eating disorder service and being working in an inpatient eating disorder unit. And its, its such a challenge,	
905		so difficult.	
906	FP 6	And, and I suppose for me, I was a kind of thinking as well about how do we kind of bring that, or idea into our service and	
907		obviously charlotte doing her research. And people doing research is so important, because then something that is easier	
908		to disseminate I suppose. Or do a CPD training on, or you know about how, this is what been band and I will (.) clarify from	
909		her research. But I think yeah, I guess it is just make me feel a bit more hopeful to be honest, listening to you guys that, yeah	
910		its its all those time to containing and keep it in the fore and (.)	
911	FP 7	I think often in teams people get so embroiled in the eating disorders, and you are in an newly qualify position you know the	
912		kind of things from a position of curiosity that can bring in. And you are bringing in that, that feels really key.	
913	FP 8	And for me, I think it is about making, not being afraid of the word culture, that make sense (FP7 nhh), that kind of placing it	Not afraid
914		at the centre, makes you think about kind of some of the old, unconscious processes, your biases, and it just makes you	
915		have a different awareness I think as a therapist. I suppose it is not about going round the team like you MUST think about	
916		culture and come smashing into their head with a hammer. It is just about that real subtle kind of stuff that you can do by	
917		you know. Obviously culture change within a team, isn't, it can't be just a one man band, and its not going to happen overnight.	

918		Teams are resistance to change at the best of time. And I think, yeah I think its just about I suppose just having an awareness	think about biases
919		and thinking about your biases in a slightly different way that might then seek out in practice of the professional around you.	in a different way
920	R	That got me to wonder about err family therapy, how do we work with a medical model? You know like FP8 you mention	(the professional
921		biases, you know like the, the sort of like medical position in eating disorder. I just wonder what are your ideas about that.	around you)
922	FP 8	So I come from a really unusual position, in that my core training is as a (profession). I don't have a full mental health	
923		training. And then I ran off from this radical tangent into family therapy. So when I first started at eating disorders, I was very	
924		driven by this kind of medical model, not perceive, the risk comes first doesn't it. It's a strange place to be as a family therapist	
925		because dealing with life and death. And I think there is always an umbrella around you of risk, risk, risk, risk, risk. That might	5 risks
926		emm, make you operate slightly differently, I think, to to some of the, not to perceive self harm might be the same as well.	
927		And I think it is difficult to work within a medicalise model, because it has to be a medicalise model because its such a physical	
928		health and mental health illness. That's the nature of illness. I also think that, it doesn't mean that you still can't do all of	
929		the wonderful systemic stuff we usually do, even when you are working within. I don't know what everyone else works within,	
930		we work within a kind of family based treatment which isn't family therapy, is it? It's a model within itself but you can	
931		obviously do systemic, lots of systemic things if that's how your training within that model. Emm, so I think some, in time, there	
932		had been times my career went, it has constraint my ability to think systemicly because of the risk. I think experience over	
933		time has changed that. I don't know what is like for other people.	

934	FP 7	Yeah, we use the FTAN model. And I guess emm, thinking about my training within the MSc programme and trainee coming	
935		in and say. Oh actually, how can we possibly emm, how can we use our systemic skills when it is quite a directive model.	mdt like a family
936		And I often said to them how can you not? How can you not draw on your, and I found actually may be a change in me.	around you
937		Because that clinic, I run it since two thousand and err twelve, year upon year, and different trainee come each time. And	
938		I remember the anxiety initially and now I don't even asked. They just come in, they don't even bother to ask me. You know	
939		about what, can I have a case that isn't an eating disorder. Because I would say no, you are coming in, you are coming to	
940		a systemic emm supervision group that happens to be an eating disorder one. You will get everything you need. Ehh, they	
941		don't ask anymore and I think maybe that's a shift in my confidence along thinking actually you, this has to be done in a	
942		multi-disciplinary way. We need each other. It is the both and. Emm, I remember somebody coming to me and saying, do	
943		you do any private work, can you see my daughter? And I am thinking gosh I just wouldn't want to see a young person with	
944		an eating disorder, not that I do, you know independent work of that nature. Err, you need your mdt around you, just like	
945		a young person needs a family around you.	
946	FP 9	I agree, I quite, I like the FTAN model for that and I think you know, coming away from the model is like, what is not systemic	defending something
947		about a family whose child is <u>very ill and</u> is now on a paediatric ward and you know, if they can't get a food inside of her.	
948		She is at risk. Emm, its you know, whats not systemic about a family being thrown into this horrendous crisis. Their CHILD,	
949		their lovely child is almost like, completely overtaken such hideous level of distress. Family have had to see and witness,	
950		and is, THEY don't get respite. It’s not like, OKAY WELL you know she does this anorexia an hour a day. They are in it, every minute	

951		of everyday for such a (FP7 nnn). Its devastating for families, and then WHAT the fam, the experience of the family, so I try	
952		to do a lot of thinking from the point of entry. From an err the crisis end of the service, so the intensive bit, thinking about	
953		what is the journey you know, for the parents you know, what is going on for a parent at that point in crisis, and then you	
954		got to kind of understand what the illnesses. And then you got all the stuff you got to learn, then you got to manage all	team supporting
955		these behaviours. Then you got to, you know, you got to think about your other kids. Then what about your relationship,	each other
956		then what about your own emotions, then what about the job you can't hold because you got to be everywhere. Emm, you	
957		know, so its, it and I completely agree with being NICE. I would never want to touch it without my mdt. Its just ehh, I think it	
958		speaks to the complexity of the illness that (FP7 nhh) emm, you know I love the fact that I can run to, my psychiatrist, my	
959		dietitian, my nurse, and so you kind of get a connecting in a, I know, in a way of being around, around this. And that you know,	
960		you can get that right, that's very containing for family. That's systemic right, isn't it, that's about really, (.) the family.	that's systemic
961	R	.hhh Right, I am just mindful of the time. FP6 would you like to add anything to this or just mindful.	
962		Yeah, I think I agree, obviously in an inpatient service. We are a kind of, the team was quite close (FP6 laughs) to us, all together.	
963	FP 6	Emm, but I definitely like that we can kind of, have those conversation. Unfortunately, COVID making them more difficult for	
964		emm, the kind of, do get time to huddle together, and they be emm, particularly under the kind of challenges that are coming	
965		up. Or support the member of the team, and may be the challenges that are coming up and with different members of the	
966		team and families, and parents as well (R nnh).	
967	FP 7	You make me think actually emm (FP7 hiss) FP8 as you said, you are, did you say you are a dentist in your, yeah and actually	

968		I err, our dietitian become really interested in you know making connection with dentist and. She uses that, that was her research	
969		actually thinking about it. And the, the impact and how dentist can be part of that wider	
970	FP 8	Yeah, and that early intervention, and actually I have been in this massive kind of stampede within our service reaching out	
971		to dentist. Because everyone is like why you are doing that, and I am like, because they are early intervention ↑too. They	
972		actually have very very (FP7 NNH) valuable conversation especially with people who are vomiting (FP7 yeah). We started	
973		doing that which everyone was initially like, what is she doing. But it is actually been valuable.	
974	FP 7	Yeah, absolutely.	
975	R	Fantastic, fantastic work. Emm, I am just mindful of the time and we need to bring this part together. In order to leave us time,	
976		for a bit of reflection, in terms of the process we just went through. Emm, is that okay.	
977		Ah, we have been talking for two and a half hours you know, I am just showing the last slide that I have got, in terms of, which is	
978		our feedback twenty minutes. And probably less than now. Emm, what has changed for you, if anything, and give example to	
979		what you mean. Or any other comments you know.	
980	FP 7	Do you mean in this process?	
981	R	Yeah, or any other comments you know. If you think of things you haven't said, you know, is not too late.	
982	FP 6	I think for me coming to that, I was quite nervous emm, and I am a kind of, oh gosh. Do I need to do a bit of reading here. Or do	
983		I know enough for and what could I you know. And how to prepare, I know you have sent the lovely email last time, that wasn't	wasn't sure
984		necessary. But I was still kind of, gosh I am not sure about how I am going to contribute to this group. And I think would really	performance of self
985		if definitely have given me a bit of confidence about emm, about my work may be and, and have some of the conversation and	
986		how to continue to think about race, ethnicity and, and culture, and to keep emm those things alive I suppose and, and the	keeping it alive

987		discussion, openly talk about them. It has given me the, the confidence.	confidence to talk
988	FP 7	I think	about it
989	FP 8	Oh sorry, you go FP7.	
990	FP 7	I thought similarly, I thought oh god, what do I need to read. I haven't got the best memory, you know. And er, so that email did	
991		really help actually, to say actually just come along. And, and I think that the favour of the, of this experience that actually you	
992		know, you can be clumsy to say what you want, we, we are here for discussion, no right or wrong. And it a kind of, took that idea	
993		in my mind that I need to be prepare. I need to read, I need to be able to say the right things.	
994	FP 8	Say, I now feel bad because I didn't feel any of that when I was coming today. I just felt actually quite excited and really interested	did not cross her
995		in what other people were going to say. I think that why is it I didn't think should I read something or do something or, or check up	mind
996		(FP8 laughs) on something. Because none of that even, to be quite honest I doubt even if I saw that email, so that was	
997		ridiculous too. Emm, but I just, I think it is really, I felt really hopeful that other people are thinking about culture, interested in	
998		it too. Because I think, sometimes you can felt like you are the one kind for this torch, running around trying to place the trail	
999		through your team. And everyone thinks you are barking, you like bonkers. And so it is been really nice to hear from other	
1000		people when other teams thinking about things and, being culturally reflexive and yeah. I really enjoy today.	
1001	FP 9	Yeah, I have. I think emm (FP9 hiss). I haven't thought, no I hadn't thought do I have to read, anything BUT I was really looking	
1002		forward to it because I mean I am guessing, I mean the impact to an eating disorders this part of the year been horrific. And so,	
1003		you know the, the, the time to reflect is just as, JUST NONE. There are just none in (.) its really hideous really. And so, I was so	

1004		looking forward to the hour, like an indulgence of a, all of this time to really reflect but moreover, as much as I love my mdt.	
1005		Err but to reflect with other systemic mind really. And to really, because you know bring forth these ideas about culture.	
1006		Because I have been interested in it for a long time. I think I did it for my, I did it for my masters dissertation. Emm, because	
1007		it is the BIT, the pinch point, we rub up against SO much in this service. And then we have a model and the model is ↑GREAT.	
1008		You have weight loss in anorexia, but you also fit a very white british. You know that is, you know yeah, its all GREAT but	
1009		what that forty percent of our patients. (FP8 yes). What about the rest and the others, and the ones that make, SO MUCH is	Our culture
1010		around not understanding of the fabric of their, of of, not their culture, of ↑OUR culture (FP8 nnn) how that bumps into theirs	bumps into theirs
1011		you know. Emm, we are, we are you know, I mean we are getting more family therapists but the, the systemic is an exhausting	role of FT is
1012		position I think being the family therapist in (FP7 nnh) an eating disorders team. SO really exhausting and that's not just the	exhausting
1013		exhaustion of looking after these patients, being the constant voice and constantly like. Okay, I got my voice, but how am I	
1014		going to use it. Am I going to be BIG and LOUD, or am I going to be small and subtle. And its you now the way we do it is, that's a	
1015		good thing about our approach, is that we just plant seeds don't we. We take this one ↓down approach, plant little seeds.	
1016		Emm, you know explore things in supervision, you know in our very kind of subtle kind of ways (FP7 nnh). We can, we can	
1017		influencing so enormously for family you know. Emm, yeah I mean the task is for us, isn't it? It is more than just the patient on	
1018		our caseload, it is the systemic thinking in the team. It's a (FP8 & FP7 yeah)	
1019	FP 7	which is, make me think actually we deliver some training emm, myself and the inpatient emm family therapist. And, er I	

1020		actually that, we use their tapes, graduate families. All white, emm all white middle class actually and then I thought about	
1021		eating disorders in (area) just such a high percentage of err asian families you know, mixture Chinese, Black. We have a lot of	
1022		Polish families, you know difference and diversity. And I am thinking actually we think we need to emm, review those tapes	
1023		and think about how we choose the graduate family you know. Emm, yeah I guess really, and I nearly said at the time actually.	
1024		Emm, to the family therapist who brought it in. But, emm, yeah made be think of, go back and make some tapes, get some	
1025		diversity.	
1026	FP 9	We always thinking will be in it, because you know our service is very white british middle class. I mean incredibly wealthy	
1027		and then you know you got, these different eating disorder services across the country we have different populations don't we?	family of similar
1028		of patient (FP7 nnh). You become very well at our population, then when someone outside of our population comes in. We	family of difference
1029		are not so good at it. And so, we might really floundering and struggle, and put loads of effort into, I don't know the, the, the	
1030		young girl from Poland or whatever. So, you know its making me think, at a high level, how we will be so good to connect	
1031		more with other services across the country with different populations, to think about you know what approaches to work	looking for expert?
1032		with eating disorders WORK, what, what is helpful, not even just the big way but the small subtle please (FP7 nnh) how do	share learning
1033		we adjust and mould our ways of working.	
1034	FP 8	I couldn't agree more with that because I used to work in (place) down in (city), literally on the cliff of a beach and practically	
1035		every family had a, we put a Tesla charging station in, because so many parents had Tesla cars. (FP9 wow) you couldn't got	
1036		a more emm upper middle class white british caseload. And in how many years they never had an non-white british emm	

1037		patient, in a really long time. And all at a sudden, a muslim family emm came in and I assessed them. And it was that moment,	
1038		in my career when I, it crystallises me. These manuals are just, I blew up the manual basicly. I said I CAN not sit here, and try	
1039		and do this, and this way of being with this, with this family. It won't fit them. And it created this massive kind of rumble in the	
1040		team. Well why you just going to do that for one family, why they are so special blablablablabla, and I say well why is	
1041		everybody else SO special. Why is difference, so dangerous (FP7 nnh) and it were, it, yeah. I, I, completely agree with what	
1042		you are saying FP9. It is hard.	
1043	FP 9	I think it affect our formulating as well because you know, we are all, because then we kind of get a bit of narrative. Well, you	
1044		know they fit the type, they were very perfectionist, quite driven, and then school. So you know it effects our formulation and	
1045		then we, WE become a really quite a fix about our ideas of eating disorder. One thing this pandemic has shown, that, its kind	
1046		of blown it all up. Because when you put the nations kids into lockdown. You know it's a year of COVID is also the year the kids	
1047		stop eating. (FP8 yeah I agree). Wow, about their relationship with their anxiety and isolation. So, you know we, we got a	
1048		really kind of, check ourselves with our formulations and our ideas, and sometimes a lot of them are attached to a certain	
1049		population of patient, aren't they (FP7, FP8 nnh).	
1050	FP 8	Something about the families as well. I think this, I HOPE this will help restructure the narrative that kind of pathologising a	
1051		family. The minute they come through the door, there is this (.) OH well you know they go to private school blablabla, you	
1052		know there is lots of mother blaming and that it yeah. Its rubbish.	
1053	R	I am really curious about your, your, you, you, your work with that muslim family that the manual doesn't work. You know	
1054		like err I hear the the team were surprised you know (FP8 yeah) and I was just thinking about err how, really curious about	

1055		how do you go on, but it looks like a case study? Discussion.	
1056	FP 8	It was, it was to do with emm, its Ramadan actually at the time. And it was to do with bringing the grandparent in, and helping	
1057		them, what, you know actually blowing it up in terms of the fact that, there is nothing in the manual about you know, about	
1058		religious practices, and what to do, and this that and the other. It is very much like well, you know, you have to do this, biff baff	
1059		boff. And it was also about what I was talking about the animal metaphors and things like that. And it was the first time, I	
1060		realise animal metaphors don't fit. And made me realise actually I am SO, everything felt very white wash. That might not	
1061		be a very politically correct thing to say. But in terms of the whole team down in (area). Everyone of us was a white British	
1062		woman, but except we had a white British man as the leader for the team. So there wasn't a single, there was no diversity at all.	
1063		And it was this kind of crystalling moment and it was I think, when a family came in. I thought how othering is this experience	crystallising moment
1064		for them, even being in this waiting room. Surrounded by just, just being othered (FP7 nnh). And then I, they are coming in and	
1065		here I am with this kind of you know, very medical, no matter how systemic you can be. You GOT to, the model wasn't	
1066		very person centred within our team, within the culture of the team at the time. And I think it has changed things a lot for me.	
1067	FP 9	Yeah, it has ideas also parenting isn't it (FP8 absolutely) when you all young, you are this and your parent and then, at this stage	
1068		of the model you are individuating. Well that’s (FP8 NO) very white centric isn't it (FP8 Totally). How culture and family do	family transition
1069		transition and what looks like is SO. Who are we to tell them what they should be doing.	culture
1070	FP 8	It is a very, it’s a model that's got, its just an assumption making all the time. And yeah.	
1071	FP 7	I know one thing we have done is really develop those relationship with the religious, you know Institutions or within the	

1072		trust even. You know have the Imam come in talk to us as an mdt. So we understand, we think we know, we think we know that	
1073		actually you know muslim are exempted from fasting if they are ill and we kind of have a line that we threw. But just to really	consulting iman
1074		more understanding of somebody to bring in as a figure head to help the families. So just for the family to know we have	
1075		done some research at least. We try to educate ourselves, we got that connection. He became kind of part of our wider	
1076		mdt, so we can call upon for him, for some family if that helps.	
1077	R	.hhh right, I was just curious about you know like we started the journey from looking at food and eating and the sort of what	
1078		inform us, what culture inform food and eating. And then we move onto emm resonance you know. And err, and then we back	
1079		to like err what next you know. So I was just thinking about emm, any thoughts you might have before we wind it up.	
1080	FP 7	I guess I was just thinking about my training group this year and they are all white, but it happens to be from parts of the	
1081		country that. They said I am never, you know (areas) particularly part of the country then, they often said they never ever	student working in
1082		work with anybody of diversity and so you know to be able to come to different training institutes, and HAVE that kind of	diverse institutes
1083		real you know exposure and, and emm experience feels really important (FP9 nnh) in terms of our training experiences (.).	
1084		I was thinking I am in a big diverse city but I am the only non-white family therapist actually, thinking about it at the minute	team composition
1085		within emm, our inpatient and outpatient. Emm, so yeah	
1086	FP 8	And I am thinking about, so I am in emm a trust where we got lots of different faces, vary, in various of the (area) and there are	
1087		about thirty family therapists all together. It feels like a massive privilege (FP7 yeah) to have that many family therapists	
1088		around me. Emm, but we are all white, every single one of us (FP7 nhh) and you know what does that yeah. I : I just wonder	

1089		what you know, I wonder about training, going down to really boil down, level of training and access. And yeah.	ethnicty
1090	FP 7	Yeah, I just start teaching on a supervision course. And I notice not only we are predominantly white, well exclusively white	gender
1091		actually but mainly man. Well, high percentage of man, at that level of training when we kind of get, you know get more and	
1092		more qualified, to thinking about the gender and the white gender mix. One of them said actually, there is hardly any man here	
1093		and I said actually this, there are eleven of you and six of you are men. And when you think about the family therapy population	men and white privilege
1094		that's big isn't it. When you are at that kind of supervision level (FP8 yeah).	
1095	R	But I am interested in when FP8 say that her team is ehh white dominant you know, and I was thinking about white also	
1096		got their own unique culture, because not all white are the same. I was thinking	
1097	FP 8	Yeah, yeah, yeah	
1098	FP 9	I think that's fair to say Charlotte because at the beginning I said you know I, I identify as white British but actually I always	
1099		kind of, I DON'T really know how to identify because I have dual heritage, you know I have black family, that are white skin	
1100		does not say anything about your cultural past. And so also you know we look to say okay, so they are polish, they are this	
1101		and the other. But, actually there are lots of us who are not, arena kind, there was no mansland. And MORE and MORE because	
1102		we are having so, err you know so:: err there was so much mix heritages and its <u>really</u> great thing. BUT the issue with all of these	no mansland
1103		people in boxes and its polarisation is that, lots of people are in a bit of er no mansland. So I kind of carry the skin of white	boxes/ polarisation
1104		british but I really feel the pinches and notice, you know racist practice or emm. So and you, you get these or lived experience	pinches, pinch point
1105		you know create different pinch points for you (FP7 nnh). And so there is something for us, there is me a kind of all this dual	

1106		heritage and even I been engage in this conversation, haven't I. I say oh wow, you know the white british, isn't that funny how	
1107		we do that.	
1108	FP 8	Well it was funny for me as well because often people make assumptions. But I actually, I don't know if you can see on the screen	
1109		I actually got quite emm olive skin (FP7 nnh). Especially in the summer time, I tan very very easily. And I often get comments	
1110		you know, oh you know where you meet and greet, way from there, you are not from here blablabla. Are you from Persian,	white being seen as
1111		you look Turkish, all of those and that it pinches at you, doesn't it? That you have vague snap shot of an insight into that kind	non-white
1112		of othering experience and assumption making experience. And I say about my whole team, we are all, we are all white and	
1113		we are all white British. And I think that, I think it is a real privilege to be able to be culturally reflexive. Its really sad for me to	
1114		say that. I don't think it should be a privilege. I like to think that we, one day could all be able to do that. But I think when we	
1115		are in this big pool of all being like, oh everyone is white British. I wonder what that shuts down in terms of being culturally	
1116		reflexive within that paradigm. Does that make sense?	
1117	FP 6	And I think for me definitely moving back to (area) that idea of:: I was working with a family recently and and the father is	North and south
1118		from (area) and so on paper you know, quite quite close I guess. But, but actually his experience is err quite significant. And	
1119		even he would say he wasn't from a political family but also they emm, kind of emm experience lots of trauma from living	
1120		in the (area) as well. So its you know, there is, and, and, and in the face of it you mightn't tick that off but rather seek and	
1121		start in conversation about his experiences. And more evident and sometimes is the feeling of, very similar to the families I am	rural and urban
1122		working with. Emm, but actually we :: even within that, culturally you know we all rural to urban, there are differences. Emm	

1123		that are small and how do we pick up on them yeah. I think that definitely what I am, kind of learning as well.	picking up small
1124	R	Thank you for sharing that, I notice that we gone pass five. And I really enjoying this discussion but I kind of have to err, honour	differences
1125		the, your generosity to come on three hours, to engage in this discussion. And so, I think I am going to bring this to an end.	
1126		Err I usually say last word you know, just in case that people need to leave everything here. Rather than, leaving here with	
1127		something but I guess you know that we will continue to evolve our conversation in our own head you know. So err, so thank	
1128		you very much, thank you FP9, thank you FP8, thank you FP7 and FP6. Yeah, thank you all of you for participating in this	
1129		conversation. So I am going to work very hard now, to (R laughs) bring all my data and try to start. I have been told that I need	
1130		one year to do it. (FP7 arrh) It will be six months for analysing my data, and then six months to get the findings together. That's	
1131		the advice, don't think that, I was very naive to say in a months time I will be writing to you. And let you know what happened.	
1132		I actually been told slow down, you are ahead of yourself. So I am a kind of thinking, you will not hear from me for a little while.	
1133		But, I am working on it you know. When I got something that makes sense, that I will send it to you and you can have a look	
1134		at your part in the whole thing. (FP7 oh brilliant). And so er, so er because I have so many conversations with everybody. And	
1135		so I will bring it together you know. And er, so hopefully that you would enjoy it at that time. Or like, at least you pick up the	
1136		bit that you think whether it is accurately reflect what you say. Err if its not, we can have a chance to clarify that.	
1137		Okay, I am going to say goodbye you know, have a nice weekend. Three hours hard work, thank you very much. I am going	
1138		to send the certificate out, at least you can kind of like err get some CPD points.	
1139	FP 7	Good to get some CPD points	

1140	FP 9	Nice working with you all	
1141	FP 8	Nice To meet you all.	
1142	FP 6	Thank you	

Appendix 2a-2c: Ethics approval and recruitment of participant

Appendix 2a: Tavistock Research Ethics Committee (TREC) Approval

(1) Original Ethics Approval

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement
Directorate of Education & Training
Tavistock Centre
120 Belsize Lane
London
NW3 5BA

Tel: 020 8938 2699
https://tavistockandportman.nhs.uk/

Charlotte Spencer

By Email

10 January 2020

Dear Charlotte,

Re: Trust Research Ethics Application

Title: Race, Ethnicity and Culture in Family Therapy for children with Eating Disorders

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

If you have any further questions or require any clarification do not hesitate to contact me.

I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

Yours sincerely,

Best regards,

Paru Jeram
Secretary to the Trust Research Degrees Subcommittee
T: 020 938 2699
E: academicquality@tavi-Port.nhs.uk

cc. Course Lead, Administrator

(ii) Approval of amendment

From: Academic Quality
Sent: 21 April 2020 10:41
To: Charlotte Spencer; Academic Quality
Cc: Hilary Palmer; Hilary Palmer; Britt Krause; Academic Quality
Subject: RE: Response to Paru (1) : RE: Submission- TREC Change form - Charlotte Spencer

Dear Charlotte,

I can confirm that I have received your updated TREC documentation in light of the current crisis and that the changes have been approved. You may proceed with your research.

Best wishes,

Paru

Mrs Paru Jeram

Senior Quality Assurance Officer

(Research Degrees and Research Ethics)

Academic Governance and Quality Assurance (Room 259)

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https://tavistockandportman.nhs.uk/research-and-innovation/doing-research/student-research/

Appendix 2b: Research Participant Information Sheet

The Tavistock and Portman NHS
NHS Foundation Trust

Participant Information Sheet

Title of research project: Race, Ethnicity and Culture in Family Therapy for children with Eating Disorders.

Introduction

My name is Charlotte Spencer (nee Chiu). I am a family therapist who has worked for many years in CAMHS and Adult Eating Disorders Services. I would like to invite you to take part in my professional doctorate research, that is part of the Professional Doctorate Studies for Systemic and Family Psychotherapy at the Tavistock and Portman Centre, University of Essex. This research has received formal approval from the Tavistock Research Ethics Committee (TREC).

Purpose of this research study

My research project aims to explore how family therapists within Child Eating Disorders Services consider race, ethnicity and culture in their practice. I am interested in exploring the cross over between the subject of Eating Disorders and the subject of Race, Culture and Ethnicity because although much has been written about each subject, little has been written about their connection. I am curious about family therapists' professional, personal, cultural and institutional narratives.

Why have you been chosen?

You have been invited to take part in this research project because you are a family therapist working in Eating Disorders services for children or have been in the last five years. I am aiming to involve fourteen family therapists from all over the UK. Six therapists will be involved in a one to one interview and a different eight therapists will be involved in two focus groups. Each focus group will have four therapists and

last for two and a half hours. You can choose to participate in either but not both. Places will be offered on a first come, first served basis.

I am asking if you are interested and willing to participate. I am available to answer any questions if you wish to discuss this further. If you decide to join the study you will be asked to sign a consent form.

What will happen if I agree to take part?

One-to-One interview:

If you wish to participate in a one to one interview, I will meet you at a convenient location, lasting for up to an hour and a half. I will ask you questions about your clinical work and your narratives about race, ethnicity and culture in working with families with Eating Disorders. Issues such as risks in Eating Disorders, NICE guidelines, and wider discourses influencing practices will also be raised. The interview will last about an hour and a half.

Cooperative inquiry (focus) group- online:

If you wish to participate in a cooperative inquiry (focus) group, you will be in a group with a maximum of four participants. The group will be divided into two sections, which will include current practices, reflection and forward thinking.

When the analyses are written up, I will send you the findings so that you can give me some written comments. In particular, I will be interested in “What stood out for you?”. Any comments you offer will be analysed and incorporated into my final report (dissertation).

Right to Withdraw

One to one interview:

You are free to withdraw your consent at any stage without giving a reason. You can do this up to the point before analysis of data starts in July 2020.

Cooperative inquiry (focus) group:

You can withdraw your consent without giving a reason, at any point before the group discussion. It will not be possible for you to withdraw your data once you have participated in the focus group due to your contribution to the group discussion. I will not be able to conduct the analysis without consideration of your influence on me and the others in the group. You will be reminded about this limitation before the

group starts and will be given a final opportunity to withdraw, should you so wish. However, I would like to reassure you that all data will be anonymised so that your contribution will not be identified in any part of the analysis or results.

What are the possible benefits of taking part?

Participants will potentially benefit from reflecting on their own practice because the one-to- one interviews and the group all focus on reflection. This may resonate and inspire your relationship with race, ethnicity and culture. You may find your families respond differently to your sensitivity and reflexivity.

The outcomes of this research will be shared with you and may benefit your own practice.

What are the possible disadvantages of taking part?

To be a participant in the one to one interview, it will take up to an hour and a half with the researcher.

To be a participant in the group discussion, it will take up to two hours online discussion.

Confidentiality

All interviews and group discussion will be audio taped, transcribed and analysed. All names, teams, workplaces and areas will be anonymised and un-identifiable. This material will be shared only in the context of the research academic community at the Tavistock for the purpose of supervision, peer review and final doctorate examination. All material will be destroyed at the conclusion of this research process.

You are welcome to share clinical information but will need to keep any client information non-identifiable. However, it is important to inform you that confidentiality will not cover any disclosure of imminent harm to self and/or others.

In the cooperative inquiry (focus) group anonymity is, in part, dependent on the participants' respect of confidentiality for each other. You will be asked to agree to this but the researcher cannot guarantee compliance by all participants in the group. Nevertheless, all family therapists should be guided by the AFT (Association of Family Therapy) Ethics Code of Conduct regarding confidentiality. Contact between me, as the researcher, and each group participant will be individualised with no other

party involved. All data will be anonymised and you will not be identified in any part of the analysis or results.

What if something goes wrong?

There are no serious risks inherent to this research project as family therapists are familiar with reflection upon their practice. It is possible that the interviews and discussions may raise questions for you about yourself or your own practice. If there is any distress, this will be addressed during and at the end of the interview. You may wish to explore any of the above further in clinical supervision or another supportive space.

When you return to your workplace with your reflection, you may take a different position regarding race, culture and ethnicity in your practice. Your reflexivity about the subject may increase, which may bring up issues that touch you personally. Again, this can be addressed in your clinical supervision.

What will happen to the results of the research study?

The analysis and findings of this research will be written up in a report and included in my dissertation. A summary of the findings will be sent to all participants who take part in the study and would like a copy. The report and findings will make sure you are un-identifiable in the write up or any publication which might ensue.

Contact for further information

If you have any further questions about the study or interested in participating, please contact Charlotte Chiu at chiuc22@googlemail.com or telephone 07915070988.

If you have any concerns about the conduct of the researcher or any other aspect of this research project, they should contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk).

THANK YOU FOR YOUR TIME

Appendix 2c: Consent form

The Tavistock and Portman NHS
NHS Foundation Trust

CONSENT FORM

Name of Researcher: **Charlotte Spencer**

Title of Research: **Race, Ethnicity and Culture in Family Therapy for children with Eating Disorders.**

1. I confirm that I have read and understand the participant information sheet dated 21st September 2019 about this research.
2. I understand my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any legal rights being affected.
3. I understand the content of the interview will be anonymised and kept Confidential. The data collected during the project will be used in the process of completing a Professional Doctorate degree, including the dissertation and any future publication.
4. I agreed that the interview be audio taped and transcribed, and understand it will be destroyed at the conclusion of the project.
5. I agreed all written feedback to the findings of this research will be anonymised for possible use in the final report.
6. I understand all names and quotations will be anonymised, and will not identifiable in anyway.
7. I understand confidentiality will be limited where there is disclosure of imminent harm to self and/or others
8. I understand that all personal data will be held and processed in the strictest confidence, and in accordance with Data Protection Act and GDPR (General Data Protection Regulation) 2018.
9. I understand the legal limitation in confidentiality; data released for court matters will be unnamed and anonymised.
10. I understand participating in the cooperative inquiry research group will limit the level of anonymity that can be afforded.

11. I have had the opportunity to consider the information, ask questions and have had these answered satisfactory. ☐

12. I agree to take part in this research study which explores family therapists' narratives of race, ethnicity and culture when working with children with Eating Disorders. ☐

13. I agree to participate in face to face or online research interviews. ☐

Name of Participant	Date	Signature
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Name of Researcher	Date	Signature
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Appendix 3a-3b

Appendix 3a: Interview schedules

Interview schedule for first interview (REC)

1. What does the title of race, ethnicity and culture in eating disorders services evoke in you?

2. Can you think of a time in family therapy when a conversation in family therapy around race, ethnicity or culture was memorable?

3. How does working in the field of eating disorders influence your practice as a family therapist? What do you bring to the eating disorders service as a family therapist?

4. How does risk around your practice in eating disorders services affect reflexivity?

5. How does the NICE guidelines impact on cultural practice in eating disorders?

6. Have you ever noticed particular dominant discourses that have affected how conversations are conducted around race, ethnicity and culture with families in family therapy?

7. What has been your experience of this interview?

8. Is there anything that has particularly resonated with you about your current practice?

Interview Schedule for second interview- Food and Feeding

1. Tell me what is your experience of food and feeding?

2. What is the significance of food and feeding for you as a person, and in your work

   as professionals in Eating Disorder? What informs that?

3. Is there anything else come to mind when you think about food and feeding?

   Anything you would like to add?

4. What are you thinking or feeling when you are talking with family about food and feeding? (How do you talk about culture in eating & feeding?)

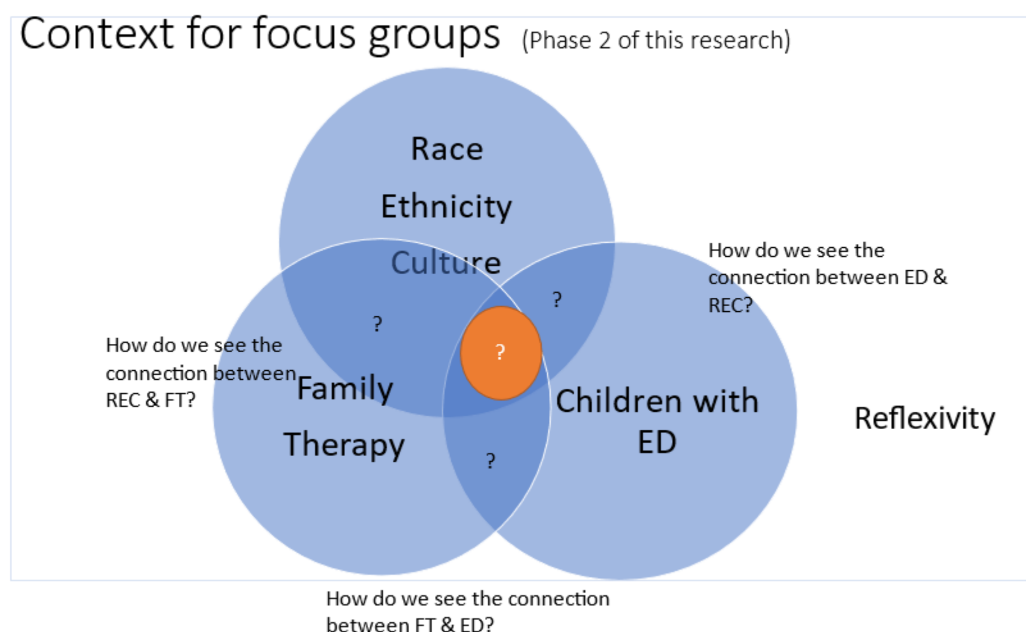
5. Do you think about your own eating when you are talking to family about this?

- Do you think about how you feed your family when you are doing this?
- Does it ever come to your mind about your experience of food and feeding when you are at that point of high risk?
- At the point of high risk, what are your thoughts and feelings? What informs that? (What are you drawing on?)
  - What about the enjoyment of eating is missing for them, relationship between family members?
  - Does any of this cross your mind? If it does, what do you do with it?

6. Any comment or reflection about our conversation?

Appendix 3b: Example of Focus group tasks

1. Introduction: to acknowledge sensitivities and emotions when talking about REC. Participants were asked to introduce their own ethnic identity, their work context (optional) and how they would like to work with the others in order to be safe.
2. Setting the Context: Introduce the Venn-diagram to illustrate the overlap of ED, REC, and family therapy. Participants were invited to brainstorm what they thought might be in the overlap area- the orange circle.



3. *Video Clips follow by discussion*

   Two film clips showing mealtime; one with a Nepalese family and one with a Taiwanese Chinese family. Each lasted about four minutes. The clips were sourced from You-Tube.

- The Nepalese family meal had been filmed for the purpose of introducing their way of living and cooking.

  Happy family || organic curry of potatoes, potatoes recipe || village life

  https://www.youtube.com/watch?v=W6ZjNI03hG0&t=272s

  (4 minutes out of a 19minutes clip)

- The Taiwanese Chinese family meal clip was from a movie called - Eat Drink Man Woman.

  Eat Drink Man Woman \\ Cooking + Eating Scenes { Full }

  https://www.youtube.com/watch?v=lWdjAVX15Zw&t=253s

  (4 minutes out of a 12minutes clip)

The Nepali family meal from a village which has an indigenous and tribal atmosphere. Mother cooked on an open fire; the children sat around. She ate with her four children, two boys and two girls. Two toddlers and the other two were also quite young. The family had very basic food. The boy had his own plate whilst the two girls shared a plate. Mother shared her plate with the boy toddler. They sat on the floor and ate with their hands. Almost no words were exchanged but the atmosphere seemed relaxed and comfortable.

For the Taiwanese family meal video, the clip came with subtitles because the characters spoke Mandarin. There was a father and three adult daughters. Father

had cooked a big feast and the atmosphere seemed tense. Father asked if the ham tasted all right. One daughter gave her honest critique and Dad disagreed. Another daughter agreed with the father, to smooth things over. Then the same daughter announced she had bought a property and was planning to move out. Dad thoughtfully said it is a good investment. Then he received a phone call from work and left very abruptly. The girls were left with a massive amount of food on the table.

The group was asked to reflect on what they saw and felt, as well as what resonated and what didn't. I was hoping to gather the participants' thoughts about the space in place between resonating and not resonating with families.

4. Group discussion

   The group was then asked to undertake a fishbowl exercise, reflecting on

   (i) "What resonated and what did not resonate" linking to wider ED practices such as non- food issues and give examples if possible.

   (ii) When working with families of similar or different REC background, how would you relate to that, and give examples if possible?

5. After a comfort break, the group was asked to undertake fishbowl exercise:
   - How do we reflect about REC in our practice?
   - Is there anything in ED or ED services that makes it difficult to consider REC?

6. Feedback on the process.

<u>Example of information gathered from introduction exercise:</u>

Participants' introducing themselves (their names are anonymised)

	FP1 Amy	FP2 Bella	FP3 Cynthia	FP4 Davina	FP5 Eleanor	R
ethnic identity (self-described)	White British	Black British African descent	White Scottish	White British Lesbian parent	White Latino	Hong Kong Chinese
Work context	Sole Family therapist in an ED team	Paediatric inpatient and Outpatient team	Adolescent Inpatient unit	Recently joined ED service; Sole Family Therapist, has training and supervision role	Inpatient and outpatient ED services – for eleven years	Recently retired from ED team
How the group might enable participation	Wait and see	-Remain Sensitive; curious about the effect of what they bring and the influence of the families they work. Took a Not knowing Position; not judging too quick	Took a Not knowing Position; curious and respectful		-Culturally sensitive -Self-reflexive -always learning - Aware of Discrimination Discourse - to be open with each other	-not an expert - invite participant to keep self safe, express discomfort -don't just go silent
Hope to get from	Share and	The topic is really	Interesting and	Think some more about		

the group	learn from each other; good for me	key and is a massive work in progress	important but not sure what she would like to learn	doing culture sensitive work		

Appendix 4a: Table of notations (Jefferson Transcription system,1985)

Table of Notations and meanings	
[ ]	Overlapping talk begins Overlapping talk ends
:::	Lengthening of the sound, proportional to the number of colons (a stretched sounds)
( )	Talk too obscure to transcribe.
(( ))	Transcriber's comments
(.08)	Numbers in parentheses indicates period of silence, in tenth of a second.
(.)	Pause that is less than 0.2 seconds.
.hhh	Inbreath
hhh	Outbreath
=	No silence between talk, usually at the start or at the end of line
^	Raised pitch
_	Underlining indicates stress or emphasis
CAPITAL	Louder
°	Lower in volume
-	A hyphen indicates an abrupt cut-off or self-interruption of the sound in progress
↑	Rise in intonation
↓	Drop in intonation
→	Entered by the analyst to show a sentence of particular interest, not by transcriber

Appendix 4b: Colour Coding system

1. All narratives identify from the transcript – in BLACK
2. Narratives that strike me as a person– in RED
3. Narratives that strikes me and relevant to research questions (how does that relate to the yellow dot?)- in GREEN
4. What are the situated and contextual issues – in PURPLE
5. My reflection in the comment column.

Appendix 4c: An example of mapping DPA of first interviews

Dialogical Performance Analysis of Race, Ethnicity and Culture narratives					
Use of Syntax					
Ada (P1)	**Beverley (P2)**	**Caroline (P3)**	**Diana (P4)**	**Eve (P5)**	**Fiona (P6)**
- **Orientating** the reader and offers information - Evaluates and shows how she discovers new insights - Repetition to create time to think and emphasis - "My"- first person position to describe her ideas and prejudices. - Position herself as learner, agentic and reflexive: how she works with her own prejudice, own stories and avoid it from getting in the way of working therapeutically - Performing how she use "self" and therapeutic skills - Expressive sounds: showing hesitant, and emphasis - Position family as expert of their life - Emotive words to show mother's feeling	- "I" first person position - Evaluative: **treatment model emphasis and over rides certain conversation**; psychiatrist position in families with negative experience of treatment; multi-generation; the team won't dismiss nor involve in these conversations. - Expressive sounds: hissed, smile, pitch, volume and hesitation - Repetition - Aside: political part of race, ethnicity and culture issue - Emotive words: awful, acrimonious, horrible - Actions: loading of awful experiences from previous generation; Father stood up for his daughter	- Hesitation to make time to think - **Deontic operator**: should - Orientation: who are in the story - Aside: **diagnostic criteria** DSM4 or ICD10 - Expressive sounds: emphasis, hesitation - Abstract: what is the point? - Pronouns: from he (3rd person perspective), I (first person perspective) and we (relational) - Evaluative: boy's action - Complicating action: What happen next in her story - Result: positive relationship with the boy. - Expressive emotion: smiled, giggled - Repetition - Positioning of mother and P3 - Emotive words: love - "I" first person perspective: about her accent - "Yeah and pause":	- **Emotive words** to show her feelings, address **power** and **trust issues** - **Rhetorical questions** to show her thinking, address power and trust issues - Aside: transfer audience to a different context- safeguarding, **domain theory** and communication theory - Expressive sounds: hesitation and emphasis - **Metaphors**: voice of eating disorder - Evaluative: family experience of safeguarding; food, race, ethnicity and culture; both-and position in holding relationship and feeding; the **Maudsley Treatment** Model and her how she uses the phase model flexibly- moving in and	-**"I"** first person: start of the narrative - **Aside**: invite audience to UK dominant model - **Actions- performance** of social interaction - **Repetition**: never shine away - **Expressive sounds**: higher pitch, emphasis, hesitation, pause - P5 **positioned herself as agentic, able to work with diversity** - Evaluative of **research** samples - Metaphor: invite imagination - **Emotive words** - Signal **ending** through expressive words, repetition & rhetorical question - **Orientation** to family background - **Grammar**: Past tense "was a teacher" 13. **Third person** quotation: Patient's questioning P5.	- Expressive sounds: hesitation, tutted, emphasis, breathe in, exclamation, disbelief (laugh) and hissed (small pause), laughed (excitement) - Emotive words; defensiveness, othering, exposed - Creative expression. - Evaluative: avoidance from people talking about culture and race, cultural issues around family's belief, family culture influences beliefs and actions, family dynamics- conflict adverse, REC as some of the threads and sometimes it's more important to look at than the other, REC is seen as something for minorities

- Metaphor to describe her empathy to mother's feeling - Aside: mention therapeutic relationship and phase model, both take reader to another space - "I" position- direct speech - Action: to show how she prioritise and invite third person perspective from family - Yeah, signalling ending of her talk	- Ending: concluding narration. - Abstract: What is the point? - Orientation: Who and when - Complicating action: Mother became very unwell and the daughter potentially have to go to hospital - Result: Focus on the risk of the girl whilst getting the adult team to support the mother. - Result: What happened in the end - Coda: return to her practice narrative - creative word.	signalling ending of her talk.	out of different phases. - Performative: how she builds relationship with family; offer psycho-education about effect of starvation; translating knowledge into creative drawings. - P4's identity as an experienced clinician who have worked with ASD - Parent's action: show appreciation by writing **complimentary letter** **-** P4 demonstrated curiosity in working with the family's sense of food. - Information about the characters: parents and GP. - "we": relational and together in feeding the child. - P4's knowledges and experiences in issues around feeding: **High Expressed Emotions, control of eating disorder, culture informed behaviours** and communication. -		families but not white British family, isomorphic process of criticism - Orientation: white British family - "I" first person position - P6 performed sarcastic comment, performed her thoughts about what to explore with this family - Repetition - Ending.

			"I" first person position. - Use of intonation in her speech		
Emerged narratives from each participant					
1st narrative is about the context of her previous team and how it enable her to **address REC sooner** whilst in her current team REC postponed until weight is stable. 2nd story is about her **use of self** in encouraging conversation between her and the Jewish mother to address **difference**. She uses a **one down position**, **hands over power and values honesty and transparency.** She tune into mother's shame, embarrassment and sense of failure	1st narrative is about race, ethnicity and culture issue being considered a **niche conversation** that comes below the treatment models or the individual 2nd narrative is Beverley as **more a social worker/ care coordinator when managing complex risk situation.** REC was around as a thought. Example of a black Afro-Caribbean family where mother has mental health issues and daughter is her patient. As mother's mental health is deteriorating, the daughter's physical health is at risk as mum can't look after the daughter	1st narrative is Caroline being mistaken as German because of her accent. This brought up how **she uses the visible difference in practice but also links with how some English families question if she understands them because she is not from U**K. 2nd narrative is her relationship with **managing risk at work and how it is organised by her core profession as a mental health nurse**. She has to remind herself that by **addressing culture and Grace she may reduce or eliminate risks**. 3rd narrative is about taking "parents home" because she was feeling angry with parents who argue and do not prioritise the needs of their child. Through supervision, she realises the	1st narrative is how Diana works with a black African family **accused of abusing their child.** Diana showed the importance of building trust, hearing and listening to the family before any meaningful work can happen. The effect of **respect, flattening the power** difference made a difference 2nd narrative is how she **manages low weight from a domain position**, how addressing all other contexts will take care of the low weight. 3rd narrative show Diana's experience and **ability to use the model flexibly and benefits from the structure it offers**.	**The first narrative** is about Eve's journey of adapting to work in the UK and paying attention to diversity (micro) whilst also the wider context Brexit and lack of training and literature in the field about race, ethnicity and culture (macro) led her to believe that there is no space to talk about REC. In the **second narrative**, Eve described a piece of memorable work which she thinks is "Very culturally main type of work" and shares the dislike of her body as a connection with the patient.	Culture in white British families is difficult to talk about because there is no visible difference Misunderstood by peer group for othering of white British culture and realised the group had thought she was critical of the family and therefore become critical of her.

	3rd narrative is Beverley's reflection about how her own **family therapy practice is not necessarily fabulously explorative** but directive and adjusting at first phase of treatment	influences on her beliefs and is able to re-position herself. It is interesting that **there are no indications of considering race, ethnicity and culture or Graces** as the parents **argument become dominant**.			
Type of narratives					
Experienced based narrative	Mixture of experienced based narrative and an event-based narrative	Mixture of Experience based narrative and event- based narrative	Mixture of Experience based and event- based narrative	A mixture of event and experience-based narratives	A mixture of event and experience Experienced based narratives
Identities					
As **reflexive family therapist** who reflects and critiques her practice. Through this research conversation, she felt the need to **add her own thinking** into the "unspoken philosophy" of her current team, allowing families to decide when rec conversations can happen. She is aware of family expectations of old man, white hair, expert therapist, when she is being diminished and	**As social worker who values power differences** and is mindful of being a white person, the power she holds when she is with others from different heritages. As senior clinician, and mature professional with experience in social work and family therapy since the 80s.	**As newly qualified family therapist** with core profession as mental health nurse. **Her accent, the visible difference,** seems to be the voiced issue but there are so much more beyond accent and language that remain unspoken. She is reflective and reflexive regarding her clinical practice. Her emotional response to parents or patients she works with.	As reflexive family therapist taking a **both-and position in her practice** with family, managing low weight and her position with phase treatment model. She will consider race, ethnicity and culture, food restoration, and relationship at all times, but with different emphasis. She is not organised by a phased approach but moves in and out of different phases fluidly.	As "diverse therapist", embodiment and representation of diversity. She brings her own diversity when she meets with diversity of the family. She is critical and knowledgeable about REC literatures. Compassionate, honest and reflexive therapist. Uses all her therapeutic skills without the restriction of the FBT.	Her identity as mixed race person, makes her in tune with invisible difference, when her non-white heritage is being ignored. (making implicit explicit). As senior clinician and tutor teaching on systemic psychotherapy course, she felt the obligation to invite trainees and team members to be aware of race, ethnicity and culture is not only through

therefore needs to be reflexive about what happens between them relationally. As cultural therapist, receiving training and practice in UK					visible difference.
Relationship with researcher					
No previous connection with researcher. Focussed on therapeutic relationship with client. Passionate and creative in her work	No previous connection with researcher. Focussed on team relationships, power differences between disciplines (Psychiatry and manager), as well as the rest of the team and the service users whom she is responsible for.	No previous connection with researcher. Might have seen researcher as more knowledgeable and experienced than her. Perhaps not feeling safe to talk about herself openly	Trained in the same institution.	Supervised by researcher ten+ years ago	Researcher was P6 ex-tutor more than ten years ago.
Reflexivity					
Values reflection, mindful of relationship between herself and the family she works with	Values reflection but not much opportunity; not sure when she last thinking she is family therapist	Values reflection and reflexivity in her own work. However, not sure if she felt able to speak openly.	She is reflexive of how contexts influence her thinking, feelings and actions. She works in a both-and position	Reflexive of the contextual and political influences on her and families.	Asked rhetorical questions to herself and about why she is thinking or feeling in a certain way or why she isn't.
Position					
Positions herself as transparent and honest, prepared to negotiate and	Positioned by the power difference within the team she works with.	I felt sometimes she is positioned by her visible difference as inferior, because	She offers her own experience of noticing social difference to family in the	Positions herself as "**ambassador**" to REC as she is someone from "**diverse"**	Positions herself as cautious but also takes risk in raising difficult question

adapt to team culture whilst holding the family in mind.		of comment from family "you are not from here".	hope to encourage them to talk about theirs.	**background**. Our previous relationship probably made her feel more comfortable in sharing her thoughts and feelings.	
Power					
Flattens the power by took a one down position in order to engage the Jewish mother.	**Hierarchical nature** of team structure is not acknowledged. REC goes into small group discussion, not in the big group. If raised, it is considered but over-ridden by feeding conversation. Her history and hurt of families from previous generation is not discussed. It separates the person's illness from their historical and family experience.	She aims to **flatten the hierarchy** and work with families in the same level. However, when she is diminished by some families who say she is not from here, she will empower herself by using the NICE guideline. P3 spoke about the power of the **dominant discourse about food and body image** influencing her relationship with her weight and body	Use of her **power** to hear and listen to the voice of this black African family as well as enabling the team to reposition from the dominant safeguarding story.	**Power, control and fear** of violent father positioned Fiona and the rest of the family in powerless position.	P6 talked about neutrality and centering the family.
Participants Performance of self					
Supportive, reflective and sympathetic to mother's embarrassment, shame and failure	Came across as focussed and confident in her critique of what's going on for the service.	Calm and respectful. Showed her passion in her work such as angry and annoyed with the arguing with parents whilst loving the boy who didn't want to work with her.	Sensitive and thoughtful. Empathic to family and their struggles and suffering	Thoughtful and critical. "Nothing" in training about culture in ED. Becomes frustrated and hurt when Brexit raised	
Wider Contexts					

NICE influence on clinical practice and expectations. Gender, religion and community expectation of Jewish mother Funding	NICE shapes both her team and her personal approach to thinking and REC discussion. Social work, NHS, NICE, big team ? Funding	NICE offers power and Caroline seems to enjoy the safety of what it offers but also reminds herself of her nursing influence and her connection with race, ethnicity and Grace issues. Mental health nurse and new in the profession	Working in a nurse led service and introduces systemic ideas gradually. She uses the treatment model flexibly and benefits from the structure it offers. Moves in and out of phases, without being organised by it.	Critiqued the lack of literature, books, training and that research focusses on the western population. Team's diversity and interests in REC influence her practice **Brexit** has political influence on practice Critique on family based treatment and how she adapts accordingly	**Gender story of women** with domestic violence in P6's country of origin and how it affects her food narrative. White mixed identity Uses NICE but also ready to go with formulation driven treatment

Other tables of linking narratives of food and feeding, focus groups into themes are available on request.

Appendix 4d: An example of a theme generated from DPA findings of the first interviews

Below is an example of a theme “Personal Experience”.

All participants talked about their personal experience of race, ethnicity and culture (REC). Five of them spoke about their experience of migration. Ada, Caroline, and Eve, who are white European, spoke about their visible and invisible differences, including their accent, when they first came to the UK as a professional. Diana spoke about the differences she noticed when she came to the UK as a child. Fiona, who described herself as mixed-white, felt she was only seen as white by others. Her other heritage is not seen or heard by others even when she tries to talk about it. The sixth participant, Beverley is a white British woman. She described her training in racism as a social worker in the 80s, when the McPherson report first came out, and this has never left her. Although they all have a personal experience with REC, their positions are different. Some keep REC conversations active in their practice, and some do not.

Ada positions REC as part of her identity. She talked about the importance of attending to diversity, race and culture in relation to her experiences of migration and not speaking in her mother tongue (364-366). When meeting families, Ada fees her presence brings a cultural difference. Therefore, not talking about it would be like ignoring “an elephant in the room”. She acknowledges who she is and encourages the family to express what they might see or feel about her (369-370).

Similarly, Eve also positions REC as part of her identity which she described as a “diverse therapist”, because she is from a diverse background. She said she “brings diversity to the table” and talked about the importance of understanding how REC influence identity.

Diana positions REC in the centre of food and feeding conversations (149-160) and described how she explored race and culture issues with a black African family, through their food, their dishes and their meals. The family felt their race and culture had been respected and were grateful for her support in successfully bringing their daughter out of the risk zone.

Fiona positions herself as someone who is interest in unpicking culture for everyone, not just for someone with visible differences.

Caroline talked about her personal experience as a therapist who speaks with an accent and is mindful of REC in her practice. She varies between using it to make connections with families by acknowledging her accent or defending herself when families question whether she understands - because she is “not from here”.

Beverley talked about the tension between managing risk and attending to REC in her mind. It is like a competition, and then she settled her dilemma by claiming there are only a tiny number of children from minoritized backgrounds who developed ED.

All the participants narrated different personal experiences and positioned themselves in attending to race, ethnicity and cultural issues in similar and different ways. The themes that emerged here are as follows (1) the risk of eating disorder is a contradictory factor that drew Beverley away from prioritising REC (2). Caroline was using her differences to connect with family. (3) Ada, Diana, Eve and Fiona talked about their identities and positioned them to relate to REC.

Appendix 5a: Full version of Pen portraits of all individual participants

Pen portrait of Participant 1 (Ada)

Ada, is a white European who has lived in UK for seven years. She felt cultural differences is a dominant reality for her and described herself working cross culturally. We had not met before and she agreed to join the research when she received information by 'snowballing' from others. Like myself, she speaks English as her second language, with an accent. She said she felt positive and was hopeful about this research because diversity and culture are vital for the field. She came across as thoughtful and reflexive.

She felt the management of ED is very organised by physical and medical risks. Cultural conversations are postponed, even though culture is always on her mind and included in systemic formulation. She comes from a culture where people interact through food, it brings family and friends together. There are long feasts on Sundays where family and extended family meet. All celebrations of life cycle events, such as births, baptisms, weddings and funerals, are all around food. To her, food and feeding is about caring and looking after each other. Her mum, auntie and grandmother were cooking, serving and making sure everyone ate. "No matter how much you have eaten, it is still not enough". It was rude if you did not eat as it meant you did not appreciate the effort of those who cooked for you.

She gave an example of her maternal uncle who owns a farm in the village. After her family moved to the city, every month her uncle would send honey, cheese and olive oil to her mother to make sure she had good homemade food. She hasn't seen that side of the family for many years but her uncle would always ask her mother if she

had enough olive oil. He would send her honey every year, regardless of whether she had enough or not. To Ada, her family and her culture communicate caring and looking after each other by sharing good quality food. She thinks this reflects the time when two generations ago during Second World War, there was not enough food.

When her brother visits her in UK, he will cook for her as he knows she will appreciate it. He will step out of the gender stereotype, cooking as a man, cook extra and freeze some for the following week. Again, Ada thinks this is about caring and sharing.

In her work with young persons and their family, she sometimes feels her thoughts and feelings are organised by “her need to care” because her personal experience of food and feeding is about “caring”. She attributes this, to her family origin, carrying on from previous generations, looking for solutions and making sure that “we care”. So, she focuses on enabling the kid to give permission to the parents to feed them, otherwise they might end up in hospital. She has an expectation that parents should be able to feed their child.

Sometimes she might feel “impatient” because of this expectation. She thinks “Just feed the kid”, we can’t step back and witness the deterioration. Reflexively, she tries not to communicate this thought but focuses on enabling the parents to feel they have the capacity to feed their child, as they had done when their child, two years old, was a toddler who may refuse food. She will enable parents to connect with their resources such as what they would have done back then and what have they done during the time before the ED developed

Working in the field of ED also made her more aware of her own eating pattern and that of people about whom she cares. Leaning from psycho-education regarding about dietetic and medical advice has made her more aware of the importance of eating regularly, and she reflects on this every day.

She feels all her work is cross-cultural. For her, it is important to explore how she influences the family and how the family position her, as they are important for the building of the therapeutic relationship. Furthermore, she feels “absolutely, one hundred percent” that issues of REC are relevant because they help the family to understand where they are coming from, what they do and where it stems from”. She feels it is important to talk about race and racism, not just food, calories and risk, when everyone is in the right place, later on in the treatment. This is when families are less organised by their child refusing to eat and are more ready for explorative conversations.

She spoke about one of the major transitions when she joined the ED field. She moved from second order practice to a more directive approach, using structural ideas and moving her position between safe uncertainty and safe certainty. But over time, she has integrated these ideas into her usual practice.

She talked about using her personal experience to connect with families and young persons. For example, she shared her experience of migration and how different generations within her family have different views about eating disorders and mental health. This facilitated a conversation between a first-generation Nigerian mother and her second-generation British born daughter, who has an ED, to talk about the differences in their experiences.

She also explored the meaning of being white and privileged, and how this might be perceived by the family, especially if they are from black ethnic minorities background. When she met with a Nigerian father with a son who has an eating disorder and is also on the autistic spectrum. Ada was sensitive to gender and power in the relationship. The father, as a man, was bowing to her every time and asking her, a white woman, to teach him “just tell me please, how ED, I know nothing”.

During the clinical sessions, she shares her own experience of eating as an adolescent and what her mother did if she was not eating. She felt the young person and parents were both surprised and appreciated her openness. She felt this connected well with the young person and gave confidence to the young person and parents to connect with her. She talked about being mindful of the boundary, being reflexive in what to share and what not to share. This is not only a personal disclosure but an ethical process.

As an immigrant, she thinks families with a similar history open up when she shares her experience of migration. She reckoned there is a “solidarity” and shared understanding. However, she made clear that all these conversations are delayed until the child is over the risky phase.

She also spoke about her attention to emotions, “feeling and sensing” the triggers whilst finding the fine line between when to push the family or stay back. She sees REC conversation as only possible when there is a rapport, when the family show readiness and willingness. She spoke about her work with a Jewish mother who has a daughter who is struggling with anorexia. She empathised with the mother’s feeling about her husband is not attending the clinic, as well as worrying about what her community might say. She tuned into the gender and social expectation of this

mother might be facing and I wonder if she has experience of being subjected to gender and social pressure.

Her service has a strong ethos in adhering to the Maudsley Treatment Model – phase approach. It is subject to some funding pressure as they are funded for short periods at a time (six months). This means the pressure to create change as soon as possible is there. Ada acknowledged that at times it is difficult to attend to concepts such as culture and diversity. Supervision can become risk management.

When I met her for the second time, almost a year later, she spoke slightly different about this view i.e., some families can have risk and explorative conversation at the same time. Furthermore, it is okay to be self-reflexive throughout the treatment and to have explorative conversations about such topics as diversity and culture.

She felt, as a therapist, that she has autonomy, using the NICE guidance as a framework. It is down to her, her service and her context to apply the guidance, rather than be limited by it.

Pen portrait of Participant 2 (Beverley)

Beverley is white British, holding both managerial and clinical role in her service. She reminds me of my ten years as manager and senior clinician for a CAMHS service, juggling between best clinical practice and resources. We never met before and I was captured by her kindness and warmth, as well as her honestly and thoughtfulness.

She spoke about her experience of joining NHS from social work setting, how she was surprised by the lack of acknowledgment of power difference and experience of

families from minority background. She is passionate about the FT-AN treatment model, she believes it work and have many successes. During the initial phase of this model, she prioritises refeeding and food in a functional sense. She parks all her beliefs in working with race and power. She stores her curiosity and hope to address it later when the child achieves safe or healthy weight. However, some families see that as not relevant anymore when young person’s weight is safe. Whilst some also engages in further explorative conversation. At times, she feels she is working outside the model, like a case manager, care coordinator when situation is risky and parent is not engaged for various reasons. She feels she is like a social worker with a therapeutic relationship with the family, working outside the model and delivering family therapy in a flexible way.

She spoke passionately about social justice, structural racism and multi-generational trauma that mental health service users may have. She is concern about the service might be paying lip service, she deals with pragmatically by setting up a smaller meeting for family therapist to attend, where they can have a safe space to attend to the REC issues, as they do not feel supported in the MDT group. This is also holding the REC thinking for the team, whilst waiting for the appropriate moment to explore with the family or the wider team.

I connect with her dual role as clinician and as manager, surrounded by “number of referrals”, “priority” and the reluctance to recognised power discourses within the service or NHS. This appears to compensate by clinical satisfaction, seeing the child out of risk zone and parent regain their confidence. Her previous experience as social work enables her to see REC issues, but also learn to wait until the next phase of treatment or holding onto the thinking through small group and supervision.

She talked about her relationship with food representing "familiarity and belonging" attributes to the change in who is cooking in her family, which represents the changes brought by parental separation. Food was cooked by her mother, then father, then grandmother, then the helper, eventually stepmother. She was in tears and fondly remembering her grandmother whom she had wanted to live with, but wasn't allowed, after her parent separated.

She revisited her sister's anorexia as older adolescent, her mum's anorexia as a child and believes herself has "dodged the bullet" during teen years. She has nearly forgotten about that, until this research conversation exploring her experience with food. She attributes to her friend, who insist and encourage her to eat. To me, it explains her connection with refeeding. It was how she get rid of eating difficulties without professional help. I imagine this personal experience and beliefs may in turn induce confidence to parents.

As the interviews took place during COVID 19 lockdown, she was occupied by transitioning from clinic to online practice, worry about the safety for the clinicians and the families. When I met her the second time, she has adapted to online practice but recognise she is "falling out of love" with her work because of the enormous amounts of referrals that had come through and she has to make difficult decision in refusing some referrals. She longs for the pandemic be over so she can start enjoying work again.

She referred to the beginning of her ED work, where she felt she know nothing whilst other brilliant therapists were receiving flower and chocolate from families. It was "soul destroying", therefore she makes a point to reassure the new comer to the

service, that they had to fake their feeling, in other to exude confidence and that their experience will build up overtime.

Pen portrait of Participant 3 (CAROLINE)

Caroline is white Eastern European. She recently qualified as a family therapist having previously worked in an eating disorders service for many years as a mental health nurse. Her manager heard about this study and suggested she join. She was unsure what she could offer to the study but was willing to join and consented to the study. She thought most research is gathering data from service users, so she was interested to participate in a study that focused on the voice of the family therapist. She felt that reflecting on food and body image in her growing up was very personal. Caroline spoke politely and softly, with an accent, I felt she was both open and unsure at the same time. Reciprocally, this invited me to be more protective of her, as I didn't want to add to her unease.

I was surprised when she spoke about the value of thinness in her society and culture. Even woman after childbirth is encouraged to eat less, so that they can become slim again. This is completely different from my culture, where nursing women are encouraging to replenish and nurture their body after childbirth. She passionately talked about how being petite and slim is seen as beautiful with opportunities to marry a rich man. So, as she grew up, being active, training and eating were all important. She is aware that her beliefs about thinness are similar to the thinking style of young girls with anorexia nervosa, who restrict themselves and strive to be as thin as possible. However, she did not have an ED.

She reflected on her connection with a white British mother who has a "can do attitude" and who was able to withstand all the challenging behaviour of her daughter

during refeeding. This “strong” mother reminded her of her own mum and women as well in her culture. This family positioned Caroline to “want to help them” as the mum was concentrating on her daughter and was not fazed by anything thrown at her, including her daughter’s abusive behaviour to her at times. Caroline admired this mother and her daughter’s weight was stabilised in about two months allowing more explorative conversations around emotions, their relational dynamics and how they can manage boundary around food and an ED. This is a piece of work that worked really well but Caroline thinks that REC never came up.

She also spoke about the parents of another young girl with anorexia. The parents had been through an acrimonious divorce and were stuck in the cycle of blame. They had lost sight of their child’s need. Caroline was annoyed and felt stuck as she had believed that not until the parents could be in the same room together to discuss their child’s needs, there would be no change. She did a lot of reflection during supervision, to address her own beliefs. Eventually she was less annoyed and was able to work differently with the parents, encouraging enough change for them to support each other about the child’s meal plan. She helped shift the ‘stuckness’.

I began to wonder the role of women in Caroline’s country of origin and how this influences her sense of success and failure, and her relationship with her size and body image. I also felt Caroline may be in transition and transforming her nursing identity to the dual identities of a nurse and family therapist. She showed integrity and loyalty to her core profession as a nurse with aspects of “safe certainty” in managing risk. However, she was also aware of managing risk in a therapeutic way through exploration and curiosity.

I identified with some of her narratives about her “foreign name”, her “accent” and being questioned whether she can understand English traditions. Caroline jokes about her English and invites families to ask if they don’t understand her. She uses the NICE guideline to show her expertise in the ED field. She reminded me of my early years as a migrant, mental health nurse. I remembered feeling vulnerable and judged, almost like an imposter, not knowledgeable enough to be in a professional role at the time. My focus at that time was to learn and “know the answers” in order to do the job.

Caroline was reflective, demonstrated at the end of the interview by her comments on our interview. She said she realised that risk has “blinded her” and she thinks less about REC issues. She is pleased to be reminded about the benefits of exploring those aspects with families. She felt that the expert position tends to build barriers whilst an explorative stand makes it easier to engage families and build a therapeutic relationship.

Pen Portrait of Participant Four (Diana)

Diana is white Irish, an experienced therapist whom I met many years ago. She was about to embark on supervision training and I was tutoring in the same institution at the time. We have had no contact since then. She came forward when she heard about my research and I felt we both are at ease with each other because of our previous connection. She uses a lot of rhetorical questions rather than statements in her speech and demonstrates her use of self, self and relational reflexivity in her talk. She spoke about Irish culture being synonymous to religion (Catholic). When she moved to the UK, she noticed the difference in food and drink between Irish and

British contexts saying hello to people in the street was different, and people at school seemed more distant. In the clinical setting, she talks about her identity as an Irish Catholic, and invites families to talk about their identities. She recognised that families not only position her in relation to ED but also in relation to her race and culture.

I was struck by her counter narrative about being called a "Mad Irish Woman" by a Black British nurse when she first joined the ED team. She gave a few examples to convince me and herself that her experience and understanding of the situation was real. I hear the opposite of the dominant discourse; whereby Black people are marginalised by white people. It was difficult to talk about it and there was no space for Diana to raise it. She used reflexivity to understand and manage the negative feelings generated in her. She came up with "respect" as the highest context in her relationship with the black nurse. Eventually, when the black nurse refused to work with P4, it became a performance issue intertwined with culture and race which required their manager to intervene. Diana felt she had to work really hard to make her relationship with the black nurse work. She feels they are getting on well now but what had happened then remains something they can't talk about. I sensed hurt and isolation when Diana was trying to be sensitive and respectful, don't wanting to be mistaken as racist but also trying to make sense of her own feelings and experience.

She spoke about her personal experiences and distresses as a mum. One of her children has eating difficulties, and eventually receives a diagnosis of Autistic Spectrum Disorder. Her personal experience has many similarities with families who struggle to feed their kids. This increased her connection and attunement to parent and child's distress. All she could remember, and found helpful, from therapy with her child was kindness, non-judgment and a non-leading approach, that informs her

practice. She is mindful not to take over the parents' role thereby causing resentment from the parent. She remembered she could had felt like this when she was on other side of the therapeutic chair. She didn't want the therapist to take her "job" as the mother. She values emotional connection and is mindful of what has been embodied in her during therapy. She uses her feeling reflexively and engages the parent to talk about theirs.

She described a time when she tried too hard to role model eating chocolate to a child on the zoom screen. She ended up eating a big bag of 'buttons' and felt unwell. Her attempt to go the extra mile made her realise she did not need to "move in with the family" but needs to be "far enough out" to be effective.

Diana has the lived experience of what it might be like to bring up a child who refuses to eat. She described the "penny dropped" moment when she was shocked to realise her child had lost so much weight. This is similar to many parents' experiences of discovering their child is very low weight. She talked about her frustration with school for not informing her, even though they knew her child was not eating his lunch. Socially, she had to negotiate with other parents about food when her child goes to their house for a party. Similarly, when visitors come to eat at her house, she learned to say he had eaten already. This is a resource which enables her to empathise with the family.

She is cautious that children with ED behaviour might come across as having ASD. So, she will ask colleagues not to go down the path of ASD diagnosis until the child is refed and no longer affected by the effect of starvation. She is of the opinion that the therapist finds it difficult to stay with food, and that considering the spectrum diagnosis is an avoidance in doing the work.

She also showed her confidence, flexibility and creativity in the use of the Maudsley model. She values its focus on refeeding, stopping the child “from dying”, but also uses it to claim the systemic voice in her team which is medical, “hierarchy and truth”. She does not follow the “one, two, three” phase approach but favours the developmental stage of the child and the family. In that, she means moving between the phase according to the family and the child’s needs. She is aware how she is being positioned and curious how the family is positioned in response to the psycho-education approach.

She talked about her own dissertation which explored the idea of “clients inform the therapists’ stories” (what the clients evoked and elicited in her. She talked about her clinical work and gave several examples. One is a black African family with a daughter not eating who was mistaken by a paediatric doctor as a safeguarding issue. It was a challenge for ED service to rebuild trust and address the imbalance of power in how she respectfully made a link with their culture and food habit. The other is a Chinese family living within hospital accommodation until they bought their own house. The children were subject to bullying in the new neighbourhood. Her work enabled the family to have a conversation about their loss and strength, and Diana show great curiosity and enabled intergenerational conversation. Finally, she spoke about her work with a white British family in which the team is considering safeguarding because the parents are resistive to the team’s involvement. The nurses felt undermined by the father. Again, Diana showed respect and curiosity which enabled her to connect with the father, and hence enabled treatment for the child.

Diana said that not everyone, including family therapists, can talk about race, ethnicity and culture; referring to herself not being able to speak to the Black nurse

about what happened between them. She wonders how she as a person, her culture, religion and skin colour, positioned the black nurse. She wonders how to open these conversations professionally. She advocates paying attention to “rites of passage” in different religions such as Jewish or Catholic which can enable understanding of how the child is positioned. Hence, the importance of “not to skip, don’t miss, don’t ignore, be curious”; so it is not REC that are important. But the context, relationship and how they talk about the way things are.

Pen portrait of Participant 5 (Eve)

Eve, white European, speaks openly and frankly, just as how I remember her from ten years ago when she came to UK as clinical psychologist and undertaking training in systemic psychotherapy. I was her clinical supervisor. We had no contact since and she came forward when she heard about my research.

Eve identifies herself as a “diverse therapist”, and considers herself to be an ambassador, both for her own culture as well as others. She reflects on her journey, adapting from being a “foreigner” finding her own voice in UK. She spoke about her sensibility in culture and as a migrant, she is proud that she can write out a meal plan based on Indian food and like by Indian parents. Brexit make her feel more vulnerable, feels she is being tolerated rather than being welcomed. European are never named within Diversity and BAME in the NHS because they are white, educated and some well off. It is like a bleeding wound, made her feeling cynical and disillusion. On Brexit day, she snapped at a colleague who said today is Brexit day. She replied sarcastically “there is nothing to proud of”. She is aware that colleague does not have bad intention but she was upset. She thanks families who have asked if she is okay and whether Brexit affects her. Despite how she feels, she appreciates

her privilege, better off in comparing to other white European immigrant who had to work very long hour in order to support the family.

She talked about food, eating and diet are the main difference between eating disorders and other mental health issues. She connects with the affective values of eating as well as many meanings such as love, care, tradition, culture, nourishment and having a good time. She emphasised food is not just about taste; food is more like a mean to enable people to enjoy the relationship and atmosphere. She refers to Marcel Proust who wrote about drinking a particularly tea and eating madeleine, brings him back to childhood, to his auntie and to the house and that particular place. This is similar to her making toast and bread salad from her grandma's recipe, the taste been the same throughout her life, and it will bring memory of her grandma and her father.

She takes her work and relationship with client very seriously. In order to understand how her patient feels when bingeing on angel delight, something she never ate before, she tried it. When working with family, her heart sinks when she hears mother say sick of cooking. She feels extremely sad that a mother would feel that about feeding their child. She is authentic in sharing her own experience with young people. An Indian second-generation girl asking why she wears dresses instead of trousers. She hypothesised that this young person needs a female model outside of family home. She told the young person about her likes in sport resulting in muscular legs and board shoulder therefore she wears dresses. It is only recently she had accepted wearing trousers outside work. She also aware certain type of family triggering her as they tend to separate themselves from mainstream society but demanding other to adapt to their world. She gave example of a Punjabi father, who became angry when translated material are in Punjab when he read Hindi. Eve wish

the family would tell her that hey read Hindi when they speak Punjab. Many more example of her commitment when she talks about her families.

She shows critical thinking and likes working with families who have moved out of refeeding phase, so she can be more explorative like a therapist. She critiques on NICE, constraining individual work with young people's identity within a manualised approach and wish for more space for psychodynamic or more eclectic approach.

She talked about the situation where cultural view split herself against the MDT regarding safeguarding concern for ED teenager. Young person is second generation oldest child, Indian background, weight is not fully restored but not critically ill. Parent expects her to travel on her own by cross city train, for weekend leave. Eve feels it is not acceptable but family feel it is okay. Not sure it is cultural understanding or working-class mentality (517).

She comments on everybody knew they have to include culture but not sure everybody has the same idea. There is multiple vice but no share narrative. She feels when more colleagues saying "I had to make this cultural adaptation", bring culture into their explanation, into their formulation- CULTURE INFORMED FORMULATIONS (580), then we are doing the cultural practice.

She has confidence in critiquing the National training Programme for Eating Disorders which does not consider culture (54,60). The fact that our practice knowledge is based on British and American view which open the question of how it is transferrable to other culture.

Pen portrait of Participant 6 (Fiona)

Fiona described herself as mixed race and white. She holds a senior clinical role in her service. I was her training tutor some ten or more years ago. We met again at the ED family therapist peer training day in 2019 and she offer to join this research study. She spoke thoughtfully and reflexively from a personal and professional position and I felt appreciative of her trust and openness.

I was surprised when she described an atmosphere of “defensiveness” had dominated her presentation at the peer training day. I presented in the morning but couldn’t stay in the afternoon for her presentation. She questioned the stereotypic approach to thinking about REC in relation to visible and invisible differences. But felt she was misunderstood as “othering” the families, and left feeling disappointed and frustrated. She described herself as mixed race and white. In order to protect Fiona’s identity, I am not explicit about her country of origin. She feels her mixed heritages makes her aware of both her white privilege self and the “invisible minority ethnic” self which often is silenced or ignored by others. She attempted to use herself to highlight the way we consider visible and invisible difference is not sufficient. She felt people did not understand and did not feel safe to discuss the emotional process or the elephant in the room at the presentation, and opted to think more about it by herself. I began to imagine the dialogue she had between the two parts of herself and her effort to communicate both parts of herself as a mixed- race person. Imagine how she uses her white privilege self to enable her invisible ethnic silence self to be heard and recognised by the dominant world.

She talked about her experience of growing up without her mother from a non-white heritage (to disguise Fiona’s identity). from the age of four and how there had not been much exposure to the maternal family’s food ritual, until just before she went to university. Her father did not cook, cooking was done by someone else or

stepmother who cooked for four years. Fiona loves cooking and learnt to cook at young age. She is also athletic and competed at national level when in secondary school. She ate well in order to have the energy. She enjoyed taking turn to bring food, sharing food with her sport team. At home, she enjoyed the family meal with her four sisters. Their family rituals expected them to stay together after meals. They played board games, laughing, joking. One of her sisters would eat the food that they don't want, and they were allowed to give it to her. So, although the dish was plated up and they were expected to finish it. They always could give what they didn't want to this sister. There was no battle over the food and she has good memories. However, their father who Fiona described as "very very violent" cast a shadow. She enjoyed family meals less after her sisters left home when she was fourteen. It was only her and her father and she cook every evening meals. She would sit and read a book for half an hour after dinner, it became the quiet time with him.

Fiona started cooking from the age of twelve, taking turn with her sisters to cook the evening meal. From fourteen onward she cooked all the evening meals. She recalled that during her GCSE equivalent examination she suddenly remembered she had forgotten to put on the oven timer. She felt the responsibility, especially of having to think ahead and plan all the time, so that her father could buy the food. She remembered the first meal she had ever cooked; the kitchen was a bomb site but she made an elaborate meal. She felt she was quite competent but not experienced in judging time. When she cooked for birthdays, there was lots of praise and appreciation from people. But she hated her paternal grandmother watching her, even though she was impressed with Fiona's abilities to plan and do the cooking. Fiona just wanted to get on by herself and not have the feeling of someone watching, even though they are not scrutinising or critical. She is aware this became part of her

attitude in just getting on with things. Being a good cook became part of her identity. She loves cooking, cooking elaborate meals, being hospitable, being together, being comfortable and taking care of other people's needs. She talked about sharing in her culture and there is a translation of "killing with kindness" meaning you try to make sure people are taking care. There are lots of cultural values in the food rituals.

When working with families Fiona leans towards the norm of the family, using neutrality, to centre the family. She works towards encouraging patterns and habits that they would make them feel confident and comfortable to bring about some healthier change. She recognises her own hunger and understands patients' difficulties is like a "torture" which was difficult to understand when she first joined the ED team. Now she feels "enormous empathy" for the terrible position they are in.

She spoke about how she works within the framework offered by NICE, but it doesn't always work for all sorts of reason. She described how she used the model to come up with what fits the family. When the model does not fit the family, the team would use "formulation driven treatment", and adapt to how the family is able to move into a "safe uncertainty position". She tries to find a path whilst keeping safe by physical monitoring.

She also told me she was "deported" because she had made a mistake about the deadline of renewing of her immigration papers. She had to leave the country very quickly, in order to return. Families were informed about her long absence due to immigration issues. Five months after she returned to work, a dissatisfied mother said to Fiona "wish you never come back, you make things worse". Whilst Fiona understood why the mother said this, she also felt that it was a "vicious attack". She reflected on the range of emotions that families with ED project onto her as a

therapist, some of them in the form of an attack, as in the case of this dissatisfied mother. Some do emotional appeal to negotiate boundary and some made her worries.

I am impressed with Fiona's resilience as a child, as a sister, as a daughter, and as a professional. I like her thoughtfulness, honesty, self and relational reflexivity and her generosity in wanting to share what she has with others. She found our conversation helpful in making her reflect about her team's practice in REC, and she is now thinking of more dialogue with her team.

She talked about her implicit assumption about me who, as a non-white person, would understand some of her experience. I wonder if there was a sense of safety from our previous supervisory relationship when we had had continuous boundary space, during her training, to explore social differences.

Findings from two focus groups

1. Resonance and connection with REC

Participants from both groups introduced their ethnicities to each other at my request. The followings were noted from the analysis:

Identities:

Bella (Black of British African descent) and Gabby (British Asian) are the only ethnic minority therapists in their respective services. They both described how they consider ways of improving cultural practice. Bella talked about her frustration in the revolving conversation about REC. She is excited that the Black Lives Matters movement has resulted in her NHS trust looking at race indicators and recruitment retention, matching staff with the people who use the service (889). Gabby wondered why she is the only non-white therapist in a big diverse city. She grew up in a Muslim household but was brought up by a white British carer. She feels she has experiences of two cultures regarding food. She would like to use more minority families as graduate parents when making video clips for the family group.

In the first group, Davina (white British) and Cynthia (white Scottish) spoke about racism, their white privilege and the power they hold. But they also implied personal experience of marginalisation. Cynthia talked about growing up in Scotland with an English mother, having to manage the complicated class and culture differences (986-988). Davina introduced herself as a Lesbian parent (44). This suggests their lived experiences give a closer connection with issues of differences.

In the second group, Helen and Ivy talked about their specific circumstances that led them to feel the pinch of racist and ‘othering’ practices. Ivy notices the “pinch” of racist practice; she is white British with black heritage. she feels her white skin does not show her black heritage and leaves her in “no man’s land” (1103). Helen has tan olive skin and is

often mistaken as Persian or Turkish. she feels the “pinch” and experiences the snap shot of being othered (1111).

Amy, Faith and Eleanor did not refer to any personal stories but spoke about their interest in REC. Amy is white British, works in a predominantly white area, and works with a team of staff from different racial backgrounds (841). She is interested in how to “unpick” family culture and other interconnected issues in the family such as gender and religion. Faith, white Irish, referred to her experience of moving between Ireland and London. She has increased her awareness of differences. Eleanor, white Latino, did not refer to her lived experience of migrating to UK. She talked about her interest in the subject and research into race, ethnicity and culture at her Master’s dissertation. I felt Eleanor has an untold story but this is the part of her identity that she chooses to share with the group.

<u>Emotional experience</u>

- Ivy and Gabby had very premature babies and were not able to be in the early life of the baby. Feeding is the only thing they felt they could do as a parent in the first part of their babies’ lives. The experience of being at the “cusp of life and death” with their baby connects them with parents of children with an eating disorder who are desperate and in fear. Helen also talked about hearing stories from her mother, as she was a very premature baby (223-234). (Resonance with clinical parents)

- Faith talked about the shame that was brought on her family member who was obese in the 80s in Ireland, which wasn’t common then (209-211).

2. **<u>Distraction from REC</u>**
   - Amy talked about how the medical approach offers certainty in managing physical risk but also shuts down any curiosity and exploration of REC issues (340-345).

- Bella performed the power of the medical approach and described her frustration about the “five minutes” to speak at ward rounds (see details in Methodology Chapter page XX). Also, her clinical lead told her that there is no time for reflective space because the workload has increased during the COVID lockdown (703-706). These comments show the power of the medical discourse and how service is the priority when organising a multi-disciplinary team discussion. It reflects how staff are supported in the team. Bella is conforming to the team expectation at the ward round but also puts up a resistance by running a reflective space for all multi-disciplinary staff. I felt she would defend and negotiate the survival of this reflective space.

- Davina spoke about a “double block” to curiosity in eating disorders. Both the tension in eating and the need to manage physical risks make her more hesitant in taking risks to explore issues. She fears that she might offend the family (436-438). Even when she was “super sensitive”, she received a complaint from a Bengali family (440, 636-651). In this therapeutic rupture the family became angry with Davina. She felt terrible and would have felt a lot worse without the support of her team.

- Ivy talked about how addressing culture directly (376) may risk othering, especially when the way of making enquiries is alienating (829- 830).

- Eleanor narrated the need for lots of time and said it was harder to have a meaningful conversation about REC with staff who are not trained systemically and who are expected to deliver in accordance with a medical systemic manual. So those conversation didn’t happen as much because there are always other emergent events (727-748).

- Ivy and Helen described their concerns about safeguarding processes when families disengage because of “alienating” practice such as when anxiety arises from the team, there is ignorance of some culture or lack of

understanding of the family culture (354- 357, 376). Helen felt this becomes messy and results in a loss of opportunities to work therapeutically with families and young people.

3. Resistance and Conformity to the grand narratives of treatment of Eating Disorders

- Helen performed a story in which she "blew up" the manual and did something different for a Muslim family. She called it the crystallising moment in her career when she realised that the manual did not fit the family and she was not going to try and make it fit. She previously worked in a white dominant area and they didn't have families from minority ethnic origins for a long time. Her actions led to a "massive kind of rumble in the team" being questioned why this family is so special. She defended her decision and questioned why difference is so dangerous (1037-1041). She acknowledged it was "hard" to be in that situation.

- Helen, now, is in a team which runs a group called cultural reflexivity. The group look at training and non-othering, subtle ways, of working with families. (752). She commented that GRACES can be othering, but one can "go deeper" to examine their white Britishness and work out how they can deliver eating disorder treatment (755- 757). By deconstructing the manual, they realised it is a white wash and is not necessarily inclusive to some families. For example, the animal metaphors from the Maudsley model can be alienating for families who have a different construction about dogs (756-761).

- Ivy conformed to the "othering culture" of the inpatient unit but also resisted it by offering lots of supervision groups to staff. She described her team as a very British team which thinks they are doing culture when they are not (833). She described the hospital culture of the inpatient unit "OTHER" the family's culture (635). She felt the "false" ward environment did not facilitate transition to home. The family and Ivy are being othered by the ward if they raised concerns. So, she has to work around it all the

time (637). She tries to run lots of supervision groups to provide space for staff to discuss their feelings and influence the culture of the team (835-836).

- Amy is unsure if her team does anything different for families from a different background (826-829) despite the staff team having a mixed racial background (821). She wonders if this is particular to ED services in which there is stereotyping of particular types of families and young people being referred. This reciprocally invites the team to make assumptions about them (830-839). It appears Amy's team conforms to the dominant narrative of what ED families and young people are like.

- Bella emphasised the importance of self-care and prioritising a reflective space especially when it is not seen as a priority: "there is no time" for thinking or reflection. She is concerned that race, ethnicity and culture is becoming just more of "a thing" which does not meet the needs of the families: a lip service (723-727)

4. Clinical Practice

- Bella argued for the importance of being kinder to ourselves, not trying to perform at all levels but to stick with the "normative routine" of systemic enquiry. In this was REC issues will come out organically (903-904).

- Bella also considers the context, describing a team approach and the development of cross-cultural thinking within the team by creating a safe reflective space across disciplines or by having external consultations (Bella 911-914).

- Helen, Gabby, Ivy and Faith talked about how they work with tension at meal times. Helen talked about naming the emotional tone and invites families to comment if it fits with them (597, 606-607). Gabby talked about

using what resonates in that moment. Gabby described throwing the feelings she felt to connect with what the family felt, taking a second order position. She will avoid naming it but checks how everyone feels (601-605). Ivy does not favour naming herself as white British, pointing out that the family is different. She prefers a less direct, softer, subtle, creative approach by enquiring what happens at their dinner - similarities and differences- to avoid othering the family (494- 499). When working with families that are culturally different, she said she spoke a lot less and sits with them longer. She opens a space to hear the family's voice and learn about them (657-660).

- Ivy talked about an "active" space, a space to figure things out, somewhere in the middle between similar or different from the family. This is a space where she tries to make connections and build rapport (673-676). She talked about when families resonate then she is less curious and misses loads. However, when the difference is too extreme then it is difficult to connect and make relationships.

  Helen also sees that space as a middle place, "ping-ponging between similarity and difference. For her it is a space where hypothesising, formulating and reformulating comes from her hunches. She brings her hypotheses to work things out with the family (681-682). Gabby sees the space as not being a space to go wild, but a space to wonder: not having too many questions because of differences, nor thinking you know because it is similar. It is a space to wonder, to think and to step beyond asking question (686-689). Faith thought the purpose of the space between similar and difference is about connecting with the family and a young person's experience. She advocates thinking about the process or the resonance with families instead of worrying about getting too much or too little information (691-695).

5. Position of participant in relation to REC

- Bella described how REC has become “more a thing” since COVID, as if it were taking a back seat before (723-725).

6. Meaning of Food

Food has a wide range of meanings (see below the ideas generated from focus group two). Eating Disorder treatment approach- Family Based Treatment - reduced the meaning of food to feeding and survival. It did not pay attention to the lens of race, ethnicity and culture which is highly influential to the meaning of food and feeding. It misses the opportunity to mobilise the resources from within their specific race, ethnicity and cultural background; to manage the tension and conflict created by eating disorder around meal time.

The brain storming exercise showed that food is more than survival and has many meanings. Feeding is being taken out of context, and is potentially alienating and disengaging families. This contradicts the needs to engage families to enable them to feed their child.

The following were generated from a brain storming exercise by group two about food and eating. Food is

- Functional: for survival. Ivy and Gabby both described the importance of food in keeping their respective very premature babies alive.
- Biological: relates to our senses of taste, smell, sound and sight.
- Social: key elements in parties, festivals, celebrations or when families come together.
- Cultural: Gabby talked about the role of food at funerals and the expectation to eat when visiting someone in the Muslim culture (Gabby187-194). Helen talked about Christmas and her Jewish friend’s Friday Shabash and funeral rituals. Faith also talked about the role of food at an Irish funeral. Ivy described approaching her local Anglican Church for

help, to bring food for her triplets, although she is not religious. However, it is in her culture to turn to the church.

- Gender: Gabby talked about how boys are encouraged to eat more to grow whilst girls are asked to eat less to keep slim. Females are responsible for cooking (166-169)
- Faith talked about shame around obesity (208-217)
- Structure, routine and connection with class (Helen 144).
- Privilege, creativity, pleasure and sharing. It is harder if one eats alone which was perpetuated by the lockdown (Ivy 145-147)

7. <u>Contexts: power of medical discourse, team, FT-AN and societal influence</u>

- The medical discourse has the power to organise priorities and influence team functions. We heard from the narrative of "five minutes" to get one's point across at ward round. On another note, Ivy talked about the systemic position of a paediatric ward offering respite to families who are dealing with the situation "every minute of every day" (950-951), offering family in crisis support to manage their children's' behaviours. This highlights the both-and position of what medical power can hold.

- The group highlighted the importance of team which can be both supportive and restrictive. Davina appreciated the support from her team, when she had a complaint from a family. Gabby and Ivy talked about not working privately with patients with eating disorder because it is too risky without support from the multi-disciplinary team (942-945, 957-958).

- Both groups talked about racism, white privilege and othering, and how these influence their relationships with power and their cultural practice.

- Davina and Bella spoke about the impact of COVID lockdown and the increase in workload, which made it even harder to be reflective when exhausted. Davina narrated in creative language "your brain is shredded" (671-672) and this leaves little space for complexity.

8. Influence of food narrative on clinical experience

- Ivy described the importance of respecting a family's culture, working round the "big block" rather than making them shift to a different paradigm (351). Gabby advocated that families should go back to their own ways of eating and their cultural position. However, feeding treatment might lean towards a western way of eating during eating disorder in order to accommodate the initial refeeding (297-305).

Findings from two focus groups

9. Resonance and connection with REC

Participants from both groups introduced their ethnicities to each other at my request. The followings were noted from the analysis:

Identities:

Bella (Black of British African descent) and Gabby (British Asian) are the only ethnic minority therapists in their respective services. They both described how they consider ways of improving cultural practice. Bella talked about her frustration in the revolving conversation about REC. She is excited that the Black Lives Matters movement has resulted in her NHS trust looking at race indicators and recruitment retention, matching staff with the people who use the service (889). Gabby wondered why she is the only non-white therapist in a big diverse city. She grew up in a Muslim household but was brought up by a white British carer. She feels she has experiences of two cultures regarding food. She would like to use more minority families as graduate parents when making video clips for the family group.

In the first group, Davina (white and British) and Cynthia (white and Scottish) spoke about racism, their white privilege and the power they hold. But they also implied personal experience of marginalisation. Cynthia talked about growing up in Scotland with an English mother, having to manage the complicated class and culture differences (986-988). Davina

introduced herself as a Lesbian parent (44). This suggests their lived experiences give a closer connection with issues of differences.

In the second group, Helen and Ivy talked about their specific circumstances that led them to feel the pinch of racist and 'othering' practices. Ivy notices the "pinch" of racist practice; she is white British with black heritage. she feels her white skin does not show her black heritage and leaves her in "no man's land" (1103). Helen has tan olive skin and is often mistaken as Persian or Turkish. She feels the "pinch" and experiences the snap shot of being othered (1111).

Amy, Faith and Eleanor did not refer to any personal stories but spoke about their interest in REC. Amy is white British, works in a predominantly white area, and works with a team of staff from different racial backgrounds (841). She is interested in how to "unpick" family culture and other interconnected issues in the family such as gender and religion. Faith, white Irish, referred to her experience of moving between Ireland and London. She has increased her awareness of differences. Eleanor, white Latino, did not refer to her lived experience of migrating to UK. She talked about her interest in the subject and research into race, ethnicity and culture at her Master's dissertation. I felt Eleanor has an untold story but this is the part of her identity that she choses to share with the group.

<u>Emotional experience</u>

- Ivy and Gabby had very premature babies and were not able to be in the early life of the baby. Feeding is the only thing they felt they could do as a parent in the first part of their babies' lives. The experience of being at the "cusp of life and death" with their baby connects them with parents of children with an eating disorder who are desperate and in fear. Helen also talked about hearing stories from her mother, as she was a very premature baby (223-234). (Resonance with clinical parents)

- Faith talked about the shame that was brought on her family member who was obese in the 80s in Ireland, which wasn't common then (209-211).

10. Distraction from REC

- Amy talked about how the medical approach offers certainty in managing physical risk but also shuts down any curiosity and exploration of REC issues (340-345).

- Bella performed the power of the medical approach and described her frustration about the "five minutes" to speak at ward rounds (see details in Methodology Chapter page XX). Also, her clinical lead told her that there is no time for reflective space because the workload has increased during the COVID lockdown (703-706). These comments show the power of the medical discourse and how service is the priority when organising a multi-disciplinary team discussion. It reflects how staff are supported in the team. Bella is conforming to the team expectation at the ward round but also puts up a resistance by running a reflective space for all multi-disciplinary staff. I felt she would defend and negotiate the survival of this reflective space.

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systemic manual. So those conversation didn't happen as much because there are always other emergent events (727-748).

- Ivy and Helen described their concerns about safeguarding processes when families disengage because of "alienating" practice such as when anxiety arises from the team, there is ignorance of some culture or lack of understanding of the family culture (354- 357, 376). Helen felt this becomes messy and results in a loss of opportunities to work therapeutically with families and young people.

11. Resistance and Conformity to the grand narratives of treatment of Eating Disorders

- Helen performed a story in which she "blew up" the manual and did something different for a Muslim family. She called it the crystallising moment in her career when she realised that the manual did not fit the family and she was not going to try and make it fit. She previously worked in a white dominant area and they didn't have families from minority ethnic origins for a long time. Her actions led to a "massive kind of rumble in the team" being questioned why this family is so special. She defended her decision and questioned why difference is so dangerous (1037-1041). She acknowledged it was "hard" to be in that situation.

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- Bella emphasised the importance of self-care and prioritising a reflective space especially when it is not seen as a priority: “there is no time” for thinking or reflection. She is concerned that race, ethnicity and culture is becoming just more of “a thing”
- Both the need for safe certainty (managing risk) and safe uncertainty (exploring race, ethnicity and culture) are influencing their practice. They take different positions according to clinical experience, team and contextual influences.
- which does not meet the needs of the families: a lip service (723-727)

12. <u>Clinical Practice</u>

- Bella argued for the importance of being kinder to ourselves, not trying to perform at all levels but to stick with the "normative routine" of systemic enquiry. In this was REC issues will come out organically (903-904).

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13. Position of participant in relation to REC

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- Structure, routine and connection with class (Helen 144).
- Privilege, creativity, pleasure and sharing. It is harder if one eats alone whichwas perpetuated by the lockdown (Ivy 145-147)

15. **Contexts: power of medical discourse, team, FT-AN and societal influence**

- The medical discourse has the power to organise priorities and influence team functions. We heard from the narrative of "five minutes" to get one's point across at ward round. On another note, Ivy talked about the systemic position of a paediatric ward offering respite to families who are dealing with the situation "every minute of every day" (950-951), offering family in crisis support to manage their children's' behaviours. This highlights the both-and position of what medical power can hold.

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working privately with patients with eating disorder because it is too risky without support from the multi-disciplinary team (942-945, 957-958).

- Both groups talked about racism, white privilege and othering, and how these influence their relationships with power and their cultural practice.

- Davina and Bella spoke about the impact of COVID lockdown and the increase in workload, which made it even harder to be reflective when exhausted. Davina narrated in creative language “your brain is shredded” (671-672) and this leaves little space for complexity.

16. Influence of food narrative on clinical experience

Ivy described the importance of respecting a family’s culture, working round the “big block” rather than making them shift to a different paradigm (351). Gabby advocated that families should go back to their own ways of eating and their cultural position. However, feeding treatment might lean towards a western way of eating during eating disorder in order to accommodate the initial refeeding (297-305).

Appendix 5b: Examples of identifying themes from the two focus groups

Themes identified from DPA of group narratives

1. Identities and position of participants
2. Personal Stories
3. Eating Disorders, risks and families' responses
4. Reflection, Reflexivity, Resonance and Assumptions
5. Power and medical discourses
6. Team influences (structure, workload, support and constraints)
7. Discourses and wider context
8. Practice and effect of COVID on practice
9. Working cross-culturally
10. FT-AN

1. Identities and position of participants

- Davina identified herself as white British Lesbian and kick started the discussion by saying "*living in a racist society*" (83), showing her thoughts and setting the overarching context of racism in our society and that she is not afraid of talking about it.

  (Safe to talk about race, racism with me)

- Bella talked about as a black professional, she found herself a minority, BAME, "*I am not very comfortable with that word all the time*" (98). She often thinking about the affordances and constraint of having conversation like this in her work settings. She thought about BLM "*you know the Black Lives Matters movement and how we have to sort of RE, configure our service I suppose*" (102) in order to become a good fit for the family that are using the service.

  (Tolerate uncomfortable discourse and pondering on when she can have safe race and ethnicity conversation and looking out for opportunities for change)

- Cynthia described herself as white Scottish and curious about the lens of patriarchy and dominant culture (115). She talked about the pressure to be slim and of certain body type from her white privilege position. "*I heard all sort of ideas about how people should look. And particularly how women should look*" (123).

  (Gender discourse and dominant culture)

  Amy described herself as white British, working with white British families mostly as she works in a white British area. She wonders how to unpick culture, race, gender and "*all of those things*" as they are interconnected and overlap (132-135). She found her work "*is*

finding out about the individual family's culture" but also "finding out about how they have created their own family culture." (135-138).

(Family's culture and how it is created)

Eleanor described herself as white Latino and she echoed what Bella had said about welcoming the families. She is interest in how services are representative of the community that they serve, the workforce, the discourse and the medical discourses that become the barriers for these families (108-111).

(Barriers to family accessing services)

2. Personal Stories

- Cynthia described watching the Nepali meal video made her feeling "intrusiveness" (173) and reflecting on difference "*Lots of it was from my own, my own experience of family meals, as a child and in the here and now*." (176-177)

  (Resonating with the video, evokes feelings and made her reflect on differences and her own family meal experiences)

- Bella connected the Nepali family meal video with her own family meal and gender role in cooking. "*I was thinking of (.1) coming from quite a matriarchal, sort of family line of who did the cooking in our family. Emm, and my brother certainly didn't*." (213-214). Meal time is also sharing of food "It felt like eh, a sort of whatever else has gone in the day that time for everyone to come together" (216-217).

  (Gender story in Bella's family)

- Eleanor said she need a fork if she were to join this Nepali family for a meal. She described a similar experience in Egypt, sharing food after Ramadan. *"I don't mind sharing a plate with other people having the same. But I felt quite uncomfortable eating with my hands, so I wants a fork. And that was a real contrast in terms of culture*." (226-228).
  (Resonance and personal boundary)

- Bella talked about African culture, serving food first to visitor and possibly African carol as well (233-234).
  (Welcoming rituals to visitor)

- Bella also talked about her connection with table in which her family used to have a meal round the table every Sunday night when she was growing up (381-382). She thought it was a fun and lovely

space but years later she heard from her brother-in-law that it was *"torturous*".

(Difference in family rituals)

- Eleanor talked about her experience from her family origin in which they have lunch at noon. They catch up with each other but sometimes there is silence and tension (417-420).
  (Difference in family meal rituals)

3. <u>Eating Disorders, risks and families' responses</u>

- Amy said she always think about finding the culture of the family "*So the culture of the actual family, so it might be a culture that a based in their race, their faith or or other things*" (136-137)".

- Amy connected the Nepali family meal with difference and the family meal she had with clinical family. "*When I eat with family. It is, we all asking them to do something very different, you know*" (207). She wondered how family felt and what effect it has on them when they were asked to do something different.
  (Reflecting on practice)

- Bella felt she related to Amy's comment about difference and family meal at work place. "*How comfortable would that family from a*

similar background feel err, re-enacting that in our setting. I should think would be really really exposing and difficult." (237-239).

(Empathising with families experience of different culture eating family meal in the clinic)

- Amy noted how comfortable the Nepali family was at their meal time whereas the clinical family "*it's you know, SO HARD. It is really hard work*." (251-252). She was struck by how "*ex:hausting*" (256) the family are. Therapist are organised by "*well has it been forty-five minutes, have we done forty- five minutes, do we need to take the meal way*." (259-260)

  (Families with eating disorders struggled at meal time, pleasure and comfort at meal time has disappeared).

- Similar to Bella, Amy felt the tension in the Taiwanese family meal "*If you work in an eating disorder that's what you seeing every day, isn't it really*?" (328). This tension felt familiar and sometimes happened at her home at meal time, part of family life.
  (Tension can be part of family life but it is every day for family with eating disorder)

- Eleanor talked about tension in the Taiwanese family meal as invitation for feedback but not quite open to it at the same time. She

thinks this is something happens quite a lot in eating disorder "*not necessarily the meal time. But in, you know meal time all the time*" (370-371). So, she goes back to the idea of asking family how their culture around eating, before eating disorder.
(Tension is in eating disorder all the time; she dealt with it by asking their family culture around eating and before eating disorder.)

- Davina talked about when not familiar with something we should fall back on systemic principle of curiosity. In the context of eating disorders "*it is like a double block to curiosity, there might be the cultural issues of difference, but already the family are there in such an expose, tense ↑position because of eating disorder. So, I think that those sorts of double exposures might make me more even hesitant*" (435-437). Davina felt the therapeutic aim would be up curiosity and how to take risks in the context of "super sensitivity". (Risk of eating disorder and cultural issues is like double exposures to tension – super sensitivity, then double blocks to curiosity.)

- Amy connected with Davina's comment about risk and wonder "*how do you take risk and ask, and ask things about, things might not necessarily sort of seeing as being connected*" by the family (443-444). She talked about the different types of risk in eating disorders, both relational risk and physical health risk (450-451).

(Families relationship with risk and what help them)

- Davina responded to Bella's comment about safe space and how we make it safer for relational risks and cultural risk "*what are the factors in the team that can make that more or less easy*." (616-617).

  (Risks and Team factors in managing different kinds of risks.)

- Eleanor felt the context is a strong influential factor in race, ethnicity and cultural practice (862-864). Other than the challenge of supervising someone from non- systemic background in which she spoke about early on, she felt "*the context of eating disorders services and and how an eating disorders get expressed, in terms of physical ↑illness and the risk around this, that has, you know huge impact on how, how we work*" (867-869).

  (Context of Eating disorders in relation to physical illness and risks are organising the Eating Disorders Service)

- Davina felt this focus group conversation has stimulated her to think about relational risks with the family and what we need to put in place to do that. "*But then, thinking about the wider, more systemic issues of the team and staffing, and all, all those sort of sort of levels really*." (1044-1045)
- Meaning of food: Group two participated in a brain storming exercise about food and eating which generated a wide range of

meanings about food. Food is functional, for survival. Gabby and Ivy reflected on the importance of food in keeping their respective premature babies alive. Food is biological, if we do not eat, we die. It relates to our senses of taste, smell, sound and sight. Food is social and is a key element in parties, festivals, celebrations or when families come together. Food is cultural.

The group shared discussion about the role of food and how food practice offers structure, routine and connection for families: at funerals in the Muslim (Gabby187-194) and Irish cultures, at Christmas (Helen 144), and at the Friday Shabash. Food also shows the stereotype of gender behaviour: boys are encouraged to eat more to grow whilst girls are expected to eat less to keep slim. Females are responsible for cooking (Gabby 166-169). There is shame around obesity (Faith 208-217).

4. Reflection, Reflexivity, Resonance and Assumptions

- Bella resonated with “the tension and the sort of walking on egg shells” (309) in the Taiwanese family meal. She felt the body language is more laboured compared with the other video (317). Later on, she spoke her family meal and connection with table. (Tension; compare the two video clips)
- Amy talked about familiarity might shut down curiosity because you think you know what’s going on. Especially in eating disorder service, the familiarity with refeeding and medical intervention

"*that's not necessarily good thing because it might stop you being curious about, may be other things that might be going on.*" (343-344).

(Tension between certainty and curiosity)

- Amy talked about the families in the video clips were culturally different to her, so it doesn't resonate with her; (350-352). When I asked her about what does she do with that unfamiliarity or not resonate "*Nnn, I am not sure ↓"* (356).

  (Unfamiliarity, what does it do?)

- Davina said not resonated made it harder to be curious "*even though I might be inside, it : I : struggle to ask the question in case I cause offence*" (358-359).

  (Resonance made Davina more cautious)

- Cynthia felt "really frozen" and "kind of fear". She connected that with her own family origin. She sees those feelings as a way of giving her information "*it was in my body, the frozenness and it makes me, don't know↓, its information in a way. Emm, but it it it makes me wants to tread quite cautiously"* (364-366).

  (Resonance made Cynthia cautious)

- Bella resonated with the quietness and lack of conversation in the Taiwanese meal video. She thought "*Oh my Gosh*" (389) because

conversation made part of her family meal. She thought conversation in this Taiwanese family has a different place. (Difference between family and therapist's experience).

- Eleanor resonated with the Taiwanese family "*there were, the tension I can't put the finger on that I felt in this family, not necessarily to do with the silence*" (425-426). She connected this with other participants' comment about the risk of becoming "*less curious and make assumptions*" (428).

  (Tension and uncertainty create the risk of assumptions and lessen curiosity)

- Amy said works in a predominantly white British area and the young people who use the service are also white British. She is not sure what that does, whether she made assumption that she knows something as she has knowledge about them and their background (791-795). As white British "*So maybe you know emm, I don't, may be ask as many as questions or I am not, as curious, may be you know emm, I don't*" (796-797). She is not sure if she is less curious around race, ethnicity and culture (799).

  (Familiarity and sameness create assumptions and knowing, and lessen curiosity)

- Cynthia felt this research focus group discussion has deepen her thinking about sameness and difference. "*Something about the idea of knowing and not knowing and the middle position.*" (1080-1081). (Resonance, knowing or not knowing)

  She also connected with Bella's comment about "*still having the same conversations (Nh) and I feel like that more broadly about the Black Lives Matters tuff like, why has it taken that (Nh) for us to get to where we are. Okay, I am very, very frustrated. I just feel that we got so far to go and its about structures actually*." (1082-1085)

  Helpful to think about COVID effect, impact in our team and what actually matter. It raises her awareness (1086-1088)
  (COVID effect)

5. Power and medical discourses

- Cynthia felt "intrusiveness" when watching the Nepali family meal video. "*Did the people give consent and I don't know just all, a lot of discomfort really (ninth) and about watching :: watching through a western lens*" (174-`175)

  (Western privilege, people from poorer country are being filmed and watched)

- Bella felt less of the filming of the Nepali video clip, to her it was like "*Here we go again, you know. Like it might not been the first time.*" (218-219).

  (Switching off from noticing the injustice show the despair and avoidance from the pain or distress)

- Eleanor talked about "*competing agendas*" (653) in which "*the medical model taking very much, kind of priority, in front of err of, of the questions or what we need to attend to, and and some of those emm dynamic or, or experiences or or aspects like, you know like cultural and, and ethnicity and so on might emm not have the ↑time.*" (653-656). She connected with "*ONLY have few minutes*" (656) to discuss a case and get to the point, to get answer for what you need. There is no time to reflect, explore or think about the family in a systemic way (660)

  (Time, workload and solution driven)

- Bella said she "drove over the question" (699) about working with families of similar background. She described a work situation "*I just remember speaking to someone during coffer saying that, that the clinical lead was saying, no, no we haven't got time for reflecting space (Bella giggled) and I am like oh my God*" (703-704). She felt reflective time is what they need to have even when its is limited.

She felt the lead is saying "*its like bloody prioritise your time.*" (705-706).

(Time and workload prioritised over reflective time and self-care for clinician)

- Cynthia felt the question of what makes it difficult to consider REC niggling and not sure if there is something about the medical model (802). Amy tries to find out more about that but Cynthia is not able to elaborate (803-810).

  (Not sure if difficulties to consider REC has something to do with medical model.)

- Amy is troubled by the assessment and diagnosis process of her service. After one assessment session, in consultation of the doctor they have to put a diagnosis to the young person which Amy find it "really really difficult" (836-845). She felt "we have to do that for, for other reasons, for figures and things like that. And, and I find that really really troubling because I think that, actually you know we met somebody once and where we are portioning of this diagnosis to them." (846- 848). She is concern what is going to mean for the rest of their life, how people talk to them, how family members, etc. She wonders the experience of others in the group (848- 853).

(Assessment, diagnostic process is driven by statistical or performance measurement and the young person's life- meanings, identity, relationship and narratives)

Cynthia connected Amy's comment with care pathways. "What do they help us with and what do they stop us seeing?" (854-855). So, what is admitted in the process and what is not explored (856).

(Constraint and affordances of pathways)

6. Team influences (structure, workload, support and constraints)

- Bella talked about creating a safe space for difficult conversation "*almost like : responsibility to have, reflexive supervision spaces and : were people can be challenging and feel safe to be challenged as well*" (490-491)
  (Support)

- Bella talked about the weekly multi-disciplinary family therapy workshop she runs and its "*very very safe*" (510). She gave example of a clinical situation in which a young person with complex atypical anorexia were discussed "*may be some of the split in the team and how different professionals had felt, position*" (526-527). The psychodynamic team were pull into dilemma and how they manage the safety in their discussion, and for her to

remain curious. This facilitated a multi-disciplinary reflection and Bella felt the structure of routine safe space had allowed the team to take risk in this space (528-536)
(Structure and support)

- Amy related to the "tricky" and "vulnerable" situation mentioned by Bella. She described its "*really really tough, especially when sort of my colleagues will privilege something very different about the family*" (542-543). She will try to open something up and to think about it a bit differently because she knew she do get stuck sometimes. But it would be shut down and the idea of being vulnerable and showing the struggle is not possible (543- 554)
(Constraint: no space for honest feeling and reflection; openness is closed down)

- Cynthia talked about "humble story" in that people can express feeling of not good enough, whether other discipline would allow to say that (562-563). She felt "*we all have our own kind of our family story about that and the matrix of culture, culture lens we bring to that.*" (564).
(Difference, support or constraint within team)

- Amy talked about difference between professional, showing vulnerable can be seen as "*don't know what we are doing*" (567).

Colleagues from other professional background may not be able to connect with what she is doing (571)
(Differences and team discourse)

- Cynthia felt family therapy may be in "*a bit of privilege*" culture (579) because of the training and supervision structure which allows family therapist to be vulnerable, reflective and honest.
(Structure of family therapy profession)

- Bella said "*look, probably got five minutes to get your point across in that setting*" (583). This excited everyone as this is a shared experience of ward round. Bella continued "it's sort of like, almost like you are in, you are out, talk to the wall in some sense." (587-588). Amy echoed that as "hot seat" (589). Bella felt these five minutes slot is marginalising of patient as it is difficult to have meaningful conversation that put point across, or being effective, or being respectful or challenge conversation that are pathologizing to the parent (590-596).
(team structure, constraints and power of medical discourses)

- Davina gave an example about the importance of feeling safe in the team. She described working culturally with a Bengali family and being sensitive and going slow. She gained permission to talk with them about significant past events but few days later she received an email from the older sister who hadn't been in any of the session

"*saying how <u>dare</u> we talk about these painful issues that had nothing to do with the eating disorders, and why were you making it worse*." (645-647). Davina felt without the support of a safe team, she would have felt a lot worst. "*I mean it did still feel terrible, because it <u>did</u> make me think that I hadn't engaged the family enough before asking that question which cause I know it was hugely shaming, but I still think that it needed to be ask*." (649-651). (Safe team for sensitive work when trading through unknown family dynamics of family relationship. Even those in the session felt safe to talk but those not in the session didn't. There is a risk some family's culture felt obliged to go along with therapist, out of respect or their relationship with authority)

- Bella asked "*why other conversations still difficult to have within team. Emm, some of that might be about medical model, some of it might be about emm, I think the make up of the teams I think. I think for ME, right now I am very focus about race indicators and, who are we recruiting, services. Emm the race indicator you know on every level."* (885-888) She felt it is about how the services develop culturally in order to meet the needs of wide-ranging community groups within the eating disorders service.

  (Service recruitment to meet the needs of communities)

Bella felt curious about that but there is also a time she thought "*it would be really really easy to just walk away*". (892-893). But she knows there are a lot more somatising conditions that young people struggle with. She just doesn't understand why it is so difficult to have the conversation about race, ethnicity and culture (896)

(despair with lack of conversation about REC in the team, don't understand)

- Bella reiterated the importance of the team need to reflect the communities they serve. Some group member serves in area that are mainly white British. In her team, they are trying to work with families cross culturally. When patients or families come to the team, they need to see people that look like them, not just one version (1011-1015). "*I mean I work in a trust where they are really saying we need to get a look at the end in terms of our recruitment, our development, our retention of staff from different cultures*." (1016-1017). She thinks "*until our basic are really address, we are not structurally. Emm we need to address some fundamental areas before we can at it, or even attempt to get things better and get better outcomes on young people from different cultures, culture background.*" (1019- 1021).

  (Structural issues- recruitment and staffing- in addressing different culture backgrounds)

(Tired of the responsibilities for micro change which hasn't gone anywhere over the years. She is interested in structural contextual change).

Otherwise, Bella felt we are "*never ever, we always in that position where we always having the same conversations and the same reflections an it just become too safe and too, too certain and go back to the idea of, not* needing *to be curious because actually noting is challenging it.*" (1023-1024) Then, we are further and further away from meeting the community needs. When we are not developing, it is really wrong, and can't blame the staff if they never exposed to difference. She felt we need to be in places where we are pushing ourselves into different rings of comfort in our learning and development (1037- 1030)

(Structural racism kept our practice in the same place, not challenged, and just more of the same)

Amy thinks "I been a bit safe and may be I need to sort of start this conversation a bit more with the team, and not and not feel that OH yeah so everything else is more important" (1049- 1051).

(safety versus curiosity)

Bella values the group discussion and begin to think about her allies and use of power as a family therapist, to create constructive, meaningful and culturally sensitive change (1054-1061). She referred to Barry Mason's workshop and made her want to be part of change discourse (1070)

7. <u>Discourses and wider context</u>

- Bella asked "*who actually, being referred*" (90-91) and highlighted the structural issues of the primary health services (General Practitioners) where certain type of families being referred.

  Bella continued to say "*what other family script that informing people actually, turning up to, its support may be.*"(92-93), referring to family's script in "relationship to help".

  (Discourse about primary care, prejudice and assumptions of referrers or family's relationship to help)

- Eleanor questioned "*what is it about the service, about the workforce, about the discourse, the medical discourses that are emm, perhaps being barriers for these families to emm, to get the support that they need.*" (110-111).

  (Discourses in the health service context)

- Bella observed father's role in the Taiwanese meal video. "*it felt like there was stress and pressures, and burden might be on his shoulders*" (294). She recognised all the group participants and the characters in the video are female, except the father. So Bella is thinking about gender narrative and "whether he position himself as

the head of home and needed to be providing" (312- 313) or society put him in that position.
(Father role and gender narratives)

8. <u>Clinical practice and effect of COVID on practice</u>

- Davina (178-184) and Eleanor's responses (185-195) to the Nepali video tape were to work out what is going on for the family from a observer position, showing systemic practice.

- Eleanor talked about online family meal supervision because of COVID lockdown. "*doing much less interventions and and more like, emm participating in them, have conversation afterwards*" (272-273). This affects her interviewing and thinking more about the culture of the family and asked about family meal before the eating disorder (274-275).
(Consider family meal culture before ED)

- Eleanor connected with Bella's comment about supervision of team. Her position in the team is not only provide supervision but also support the team to develop a culture that supervision role for talked about her role in supervising the team and wonder how can she support the team to develop a culture of reflexive practice. She understood how difficult it is (600- 604). She quoted the difficult conversation she had with a person who is employed as family therapist but not trained in systemic psychotherapy. "*when I brought*

conversation about culture, and said what is culture has to do with it. It should be the same for everyone" (606-608). She said some psychologists think they are very systemic but actually come from a position of expertise. "*How difficult it is to introduce the idea, even the idea of curiosity and, and emm you know and being vulnerable*." (612-613)

Eleanor returned to issue of supervision (739-742), she felt she can have lots of conversation about culture and ethnicity with family therapist but it is harder with the rest of her team who don't come from the systemic background. She thinks "*It will take a lot of time to actually create those conversations that in a way that make them meaningful.*" (745-746). She wonders if its partly because of these factors: different background and needs a lot of time to make meaningful conversation but also because the model is quite medical (747). If the model is a family therapy model, then it is deliver by non-family therapist (748).

(-Medical or family therapy model; delivered by which profession and their background in talking about race, ethnicity and culture.
- Lots of time is needed for meaningful REC conversation and ended up happening less.)

(Team/ power : Eleanor in position of senior clinician (power) pushing against other professional discourse of culture and reflexive practice)

- Davina felt "*we have a responsibility, be it for a training role to sort of lead by examples I suppose. Emm, so to, to may be, be brave*" (617-618). She like Cynthia's comment about the "not knowing position" (620) an aware it is difficult if you are the consultant responsible for everything (622). She also "*think the not knowing position, can mask how difficult it is personally to be in a not knowing position*" (622-623).

  (Different in role and responsibilities; not knowing position can be a mask).

- Davina put forward "*a helpful middle position, in between knowing and not knowing, not quite knowing. Yean, I like that."* (628-629) when I asked her about how to go on when we are not quite sure.

  (Not quite knowing when we are unsure about something)

- Eleanor said she has resigned from her team after ten years. She finds the current situation challenging and wonder how someone from a different theoretical background or non-therapist manged and how they are being supported (662-668). Davina agreed with

the "*Huge*" challenge (666) and refer to the massive increase in referral since COVID. "*people are :: so overloaded and like you say this work is so challenging. If you see four or five families a day, err your brain is just shredded and you, how you can think about these complexity*." (670-672). She is worried her team and she can see them getting more miserable and "*BURNOUT*" (673). So "*sensitive to the cultural difference and the engagement and all that just, I think probably takes more time, but whats been really really squeezed at the moment is time and thinking space*." (674-676)

(COVID impact, increase of referrals and workload compromised time and thinking space)

- Cynthia felt emotional listening to Davina and Eleanor speaking and commented on the impact of COVID on relationship and what that means globally, in communities and in public services. She "*feel like :: this kind of challenge to attachment if you like. It means that. Yeah the, the need to be building secure relationship and doing that work.*" (688-689) Building secure relationship is never more necessary but is harder (690).

  (COVID lockdown effect on relationship and how therapist work with families)

- Bella also She related to the comment about five families a day and "*I think, we just like have a big things around like, Black Lives Matters and you know black history month. But also thinking about self-care as clinicians.*" (707-708).

- She felt everybody in the group has mentioned something to do with where self-care is positioned or doesn't get positioned. "*I think during COVID, It, it's the fact that demand and capacity issue (Bella laughs) just keeps, almost like its like the, the ballon gets bigger, bigger and bigger, until its ready to burst.*" (709-712). The safe or reflective space is an supportive space. It's time and the boundary. At the beginning of COVID, she was losing the boundary, going to twenty-three webinars every week and then she had to say no when she realised its' too much (715-718). She thinks the learning from the first and second lockdown were getting help from your institution and being boundary with ourselves (722).

  (Self care- boundary and supportive space)

- Bella commented on the issues of race and culture, ethnicity. "*If they are already taken a back seat role at the beginning of COVID, my worry is that it become even more of a thing*" (724-725). When she hears conversation like we haven't got time "*It's like oh my God, are we so, are we further away from meeting emm meeting these needs.*" (726-727)

(COVID pressure, time and workload pressure, REC become more of a thing)

- Davina agreed with Bella and talked about "big risk". "*I sometimes I say this in: the team. But it, it is quite a: a risky thing to say. Part of me feels I can't do family therapy emm on screen, on line. I can do parent work, I can work with some family, individual fine. But a very conflictual :: er whole family I can't do very effectively. And then thinking about putting cultural isues into the mix where one has to be slower and more sensitive and pick up cues you know. I don't know what all the difficulties are. I, I just, I just sort of feel I can't do it actually" (728-733).* Davina is not sure if she is allowed to say that. Her service still sees fair amount of people face to face, increasingly online because of the numbers. She felt it is more challenging to work online and working with difference (738).

(COVID has opened the challenge of working with complexity and working cross-culturally online, what is possible and what is missed?) (Who and what does not allow Davina to speak her view about online working?)

9. Working cross-culturally

- All focus group one participants commented on the large amount of food at the Taiwanese family meal. Davina said it "*could feed an army*" (289).

(No one wonder about the cultural meaning of excessive amount of food)

- Davina talked about silence in the Taiwanese meal video "*just make me think I might be in danger of mistaking silence round the table for tension. Whereas in fact, that might be a cultural norm*" (405-406) the danger of mistaken silence for tension, whilst that could be their cultural norm (403-406). She thought about an article that criticised about middle class template for how family should behave (409)

(Cultural consideration of silence)

- Davina talked about eating disorder is "more than a bundle of psychological or racial, not racial, relational issues" (811). Her team is very systemic and serves a diverse area. But there is a "*ponderous of white middle class. Yeah, young women and that, is that the stereotype of err a person with anorexia, or are they being err being referred to the services, more than another group. Because it is stereotype*" (814-816). And her team is "very err white team" (818).

(Stereotype practice, young white middle class woman being referred for anorexia, treated by a very white team)

- Amy described her team are from different racial and cultural backgrounds. So she felt lucky to have that in her team as they have a range of different voices (821-824). The young people are predominantly white middle-class females. Amy is not sure "*what that does, when, when there are families emm, that are referred that are from a different backgrounds as well*" (826-828). She is not sure if they think differently about these young persons from different backgrounds. "*I think this is particular to ED services actually. I think its you know (Cynthia nhh) emm because it is you know something very particular. You know, I think that its sort of may be invite that particular that stereotype as you are saying Davina*." (830- 832). So certain type of young people will be referred (833).

(Eating disorders invite stereotyping)

Amy emphasised there is no certainty when the white young person being referred to her service (834). She thinks the young person, with their parent or people around them presented themselves in a certain way when they see their doctor. This creates assumptions and a referral to her service. But this does not necessarily mean the medical profession, psychiatrist or doctors think it means eating disorder (836-839)

(Families and young people of white middle class presents in a certain way, trigger a stereotypical referral to eating disorder service)

- Bella connected with Amy who works in a diverse team and majority of young people are white British. She also works in a private inpatient service where young people are high functioning, academic whose parent "*knew how to beat the system a lot, if I am sort of saying, the white middle class families.*"(879). Their voices and narratives influence service provision and everybody knows that. It isn't discriminated against other culture but eating disorder is cross-cultural (882- 884).
  (white middle class privilege in beating the system and influencing service provision somehow maintain the challenge for non-white middle class to access service- equality or equity issues)

- Bella used the balloon metaphor which it's about to burst, to talk about pressure again (previous at 709). She felt we put too much pressure on ourselves about what we supposed to be achieving (899-901). "*We, it is some of it about being kinder to ourselves, about actually stripping back what our role and purpose going to back to that basic. And really, must starting from scratch from you know what is the normative routine and boundary with the families. What are their scripts, just asking those questions, rather than this*

expectations with we are support to be performing on all the levels" (901-905). The issues of race and cultural come out "more organicly" rather than putting ourselves in this where we are suppose to have all the answers (907-908).

(Advice on self care and stick to basic systemic enquiry and REC practice will come organicly)

Bella thinks its both about prioritise our time, what conversation we are able to have and whether we are developing on individual or team basis (909-910). Having consultation from external people to come in and help some of the cross- cultural thinking within teams (911-914).

(Views about priority, conversations and external consultations)

Bella then questioned and despaired about why we are not able to have conversations to sort out the needs of the families. "*Emm, for me this is a conversation that is a revolving conversation. Though whether it was five years ago, or two years ago. I think it is the same conversation, emm, systemicly we, we you know, we folk so much about the grace, etc. But (.1) yeah I, is emm.*" (916-918). Bella reiterate she struggle with why we are not able to have conversation

(Revolving conversation, GRACE hasn't helped much).

Eleanor connected with Bella's comment about conversation, the importance of safety. She thinka talking about race, bring up the idea of "*white fragility and emm there are so many kind of err, ideas around around that you know, put people emm off, the hook or arr or or people feel afraid of emm, of saying something might offend*." (925-926). Other things like religion, culture and "*its its **far** from over and I think that, there are going to be decades and generation, generation until emm, perhaps we feel a bit more comfortable and confident to have those conversations.*" (928- 930)

(White fragility and fear inhibit conversation).

I connected with Eleanor and others about safety and asked how we manage the risk of assuming when work cross culturally. Eleanor said she doesn't know but we make assumptions all the time which is something we had to accept and acknowledge. "*And and may be more active in, in questioning ourselves and the assumptions that we are making, and be more curious and ask more*" (934-935).

(Addressing assumptions through acceptance and acknowledge, question ourselves, curious and ask more).

- Cynthia talked about working cross-culturally makes her think about "*I think you can trip up just as much as with your own culture, as cross culturally, may be because of assumptions, don't know*." (971-972) She gave examples of different region in Scotland, they have completely different values, beliefs and religion, like Catholic and Protestants in Glasgow, football in London and Glasgow are very different.

  (Cross- region difference, different ethnicities in white British society)

  Davina said she is not sure if she would agree with Cynthia because "*the tripping up, and causing a trip up that taps into really deep racism isn't, isn't there, there is a bit more than*." (973-974)

  (Racism is not in cross-region difference)

  Cynthia reflected and agreed with Davina, she said "*as white therapist we do need to be incredibly mindul. Emm yeah*". (980-981) I asked mindful of what? Cynthia said "*white privilege*"(983) and other invisible privileges. Davina suggest "*class*" and Davina responded "*like class or or culture like my mother was English in Scotland. That was a very emm (Cynthia hissed) ehh very complicated thing actually to manage as a child that to, to people*

who don't understand the idiosyncrasies of the Wes of Scotland may not see." (986-987).

(Ethnic difference in Scotland or other invisible privilege like class)

Cynthia talked about managing white privilege in a therapy session as a response to my question about her description of white privilege. "*I think I would probably be more tentative and careful. And I would probably assume, I would be more likely I will be making assumption around sameness (nhh) and if I am honest, with a white family or may be a Scottish family*." (1000-1002).

(Managing white privilege through tentative and careful, assumption of sameness)

- Eleanor felt we had come a long way and we can't change institutional discrimination and racism overnight. She felt this research is important. She felt she can bring these conversations in all levels with families, in supervision, in training and in service development.
  She is thinking how she could be more open to invite families to contribute to their work, having more meaningful feedback and learn from them (1102-1112)

  (Feedback and Relational reflexivity)

10. FT-AN

- Eleanor think the FTAN model carries “judgement”, it close down some of those curiosity conversation. “*So there is something about us being a bit more skill and bringing those conversations into the mix*.” (937-938). When the model is delivered by non-family therapist, she thinks the more skilled conversation is completely missed (940). In terms of equality, the family will experience very different depends on who deliver the model (941).

  (FTAN inhibits curiosity and different professional deliver it differently.)

- Davina said she recently did the FT-AN training and was pleasantly surprised to find out they had gone back to systemic principle and emphasise on engagement, without that none of the subsequent phases of treatment will work (943-945)

  (Back to therapeutic process and basic systemic questions, rather than too heavy on goal driven approach)

  Davina believes engagement is particular important in cross-cultural work and connected that with Bella’s comment about going back to ordinary systemic question “why don’t we do that?” (947) She thinks the treatment frame is “*very goal orientated*”(948), focus on weight

gain quickly and speed things up. Similar to Eleanor had said "*If one stick too rigidly to the model you lost all those subtler engaging sort of questions.*" (949-950).

(Critique on the constraint and affordances of the FT-AN)

- Amy also talked about her work with a supervisee who recently did the FT-AN training. This supervisee was trying to do this and that and Amy said she is not sure if this is the work. The work is to get the family to sign up to the work and since then the supervisee's approach shifted. Amy acknowledged "*there is the, the come on, we got to do this, we got to get them restore, we got to get ↑this. We got to get the physical health. You know, its, its sort of takes away, isn't it, from* <u>*all*</u> *the other stuff we really value.*" (958-960). She thinks building a relationship with the family and the young person, the rest may be not as "tricky" (961-963).

(Joining Davina, Bella and Eleanor in the importance of engagement).

- Davina brought us back to eating disorders and the Maudsley model. She felt it invite us to take an expert position which is what a family wants when they are in crisis, needing advice and containment (1003-1006). "*Emm, but that might be particularly problematic if we are talking about working cross culturally and white privilege, because then that might feed into that.*" (1006-

1008) Davina is concern that the model reinforces something in those of us who are in the white privilege position (1009).

(Power and expert position of FTAN, constraint and affordances)