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

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[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).

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[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

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[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.

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[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

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[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.

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[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

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[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.

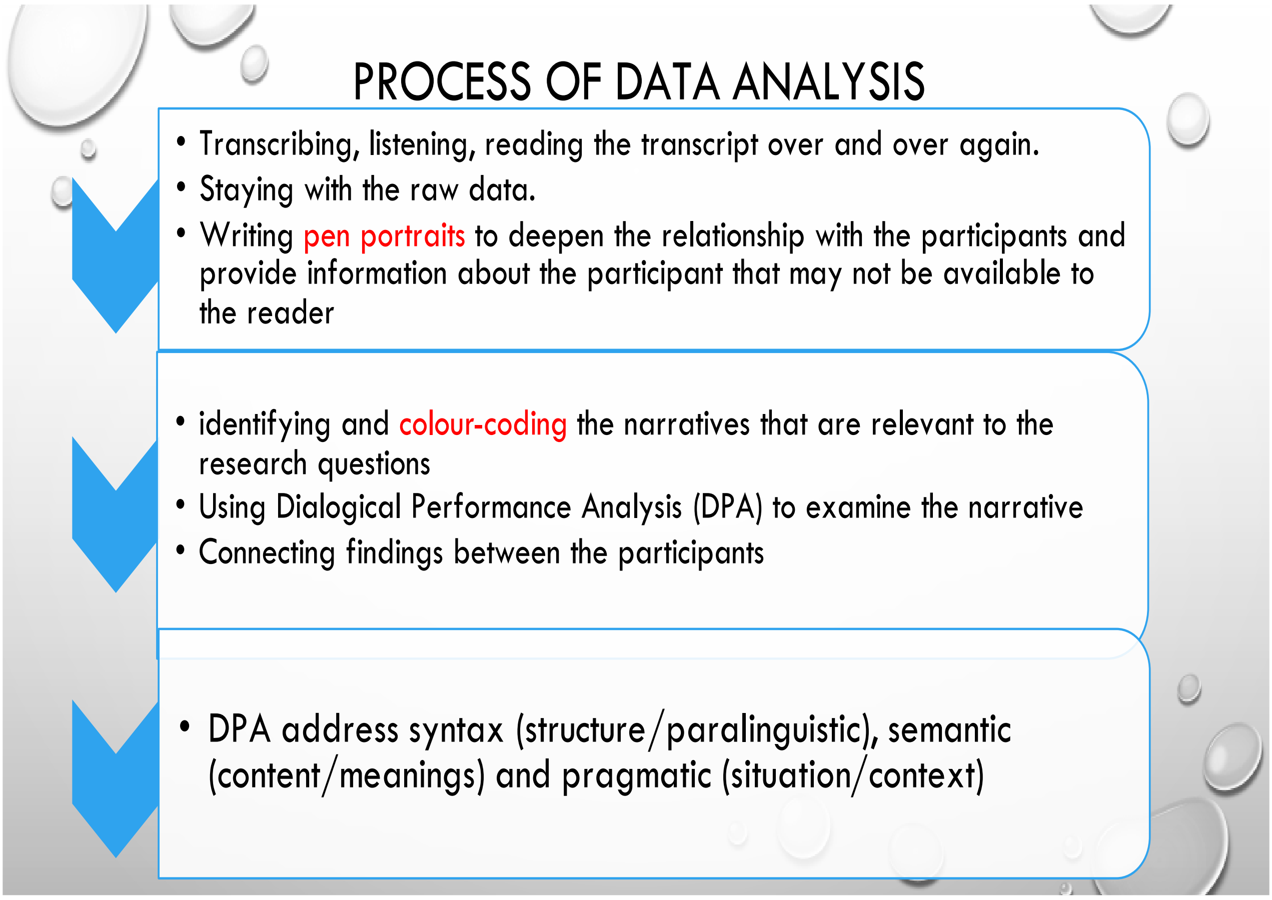
All participants were recruited by snowballing or as a result of advertisement in the AFT (Association of Family Therapy) newsletter or through their ED special interest Google group. This was to avoid any undue pressure from the researcher during the process of providing participants with an information 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:



PROCESS OF DATA ANALYSIS

- Transcribing, listening, reading the transcript over and over again.
- Staying with the raw data.
- Writing pen portraits to deepen the relationship with the participants and provide information about the participant that may not be available to the reader

- identifying and colour-coding the narratives that are relevant to the research questions
- Using Dialogical Performance Analysis (DPA) to examine the narrative
- Connecting findings between the participants

- DPA address syntax (structure/paralinguistic), semantic (content/meanings) and pragmatic (situation/context)

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.

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[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:

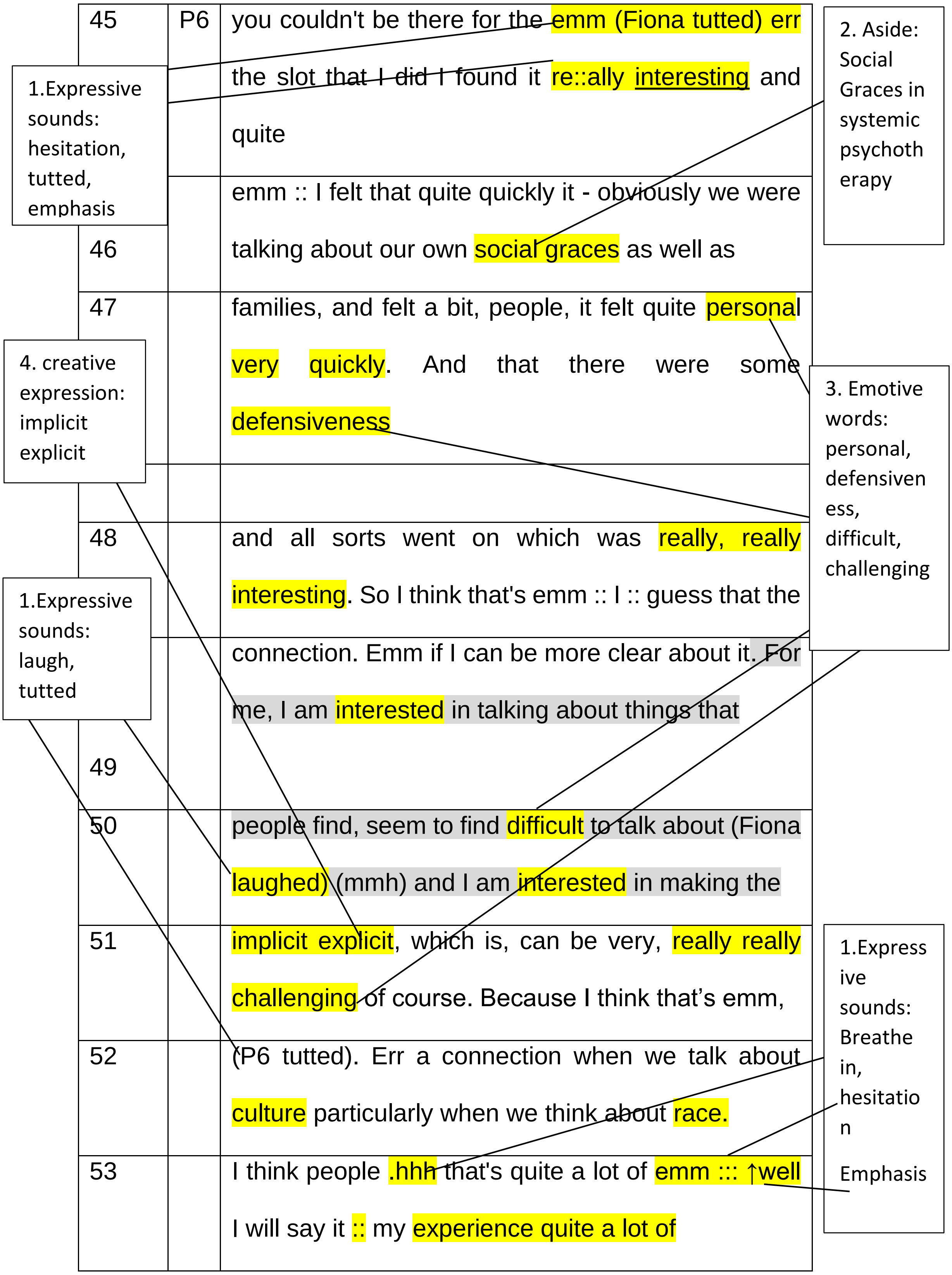
- expressive sounds, such as mmh, emm, breathing etc;
- repetition, to emphasise key moments or ideas;
- direct speech, including "I" or direct quotation of someone else to build credibility;
- verb tense and pronouns, to indicate the participant's position in their story telling (closeness or distance 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
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 (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 psychotherapy

4. creative expression: implicit explicit

3. Emotive words: personal, defensiveness, difficult, challenging

1.Expressive sounds: laugh, tutted

1.Expressive sounds: Breathe in, hesitation

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

8. Repetition /emphasis

(line 65 & 69)

5. 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
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 (Fiona laugh) not everyone. Emm but there was some of that. And yeah.

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
584	Cynthia	YES SS (Amy laugh)
585	Bella	with no set agenda there
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.
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
594		members in a different way.

2. Creative language

3. Emphasis and repetition; showing excitement

2. Creative language

4. Inaudible and expressive sound

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.

<u>Eve (P5)</u> 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.

<u>Fiona (P6)</u> 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 might 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 <u>this</u>, 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.

Resonance and Empathic Therapist

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

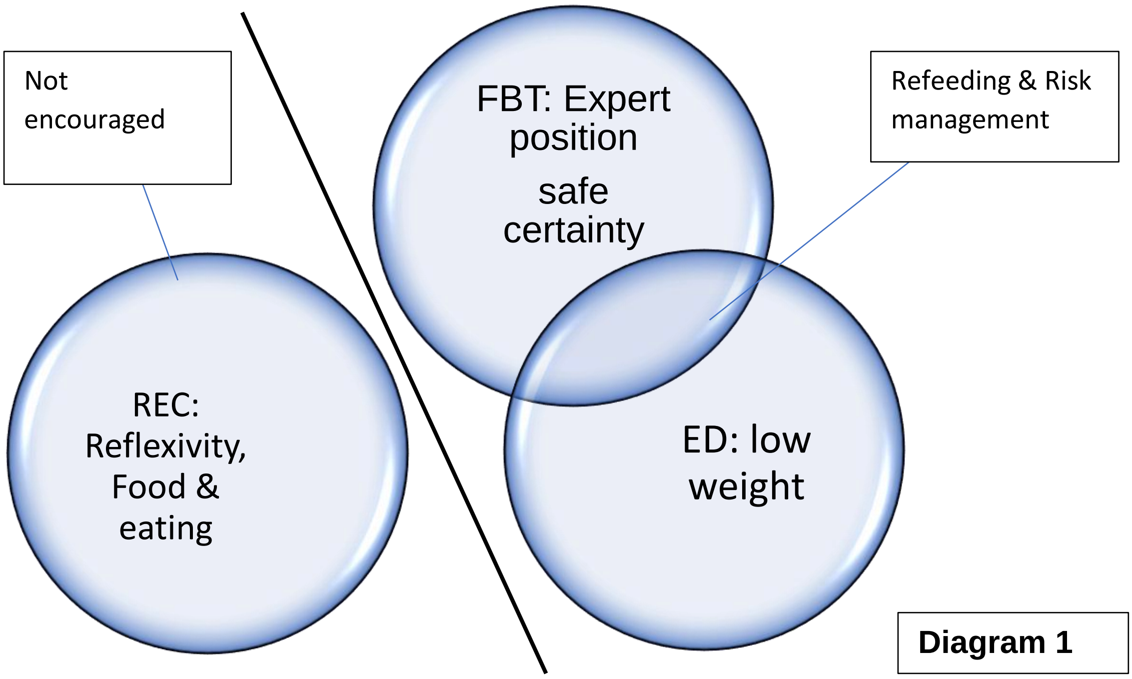


Diagram 1

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.

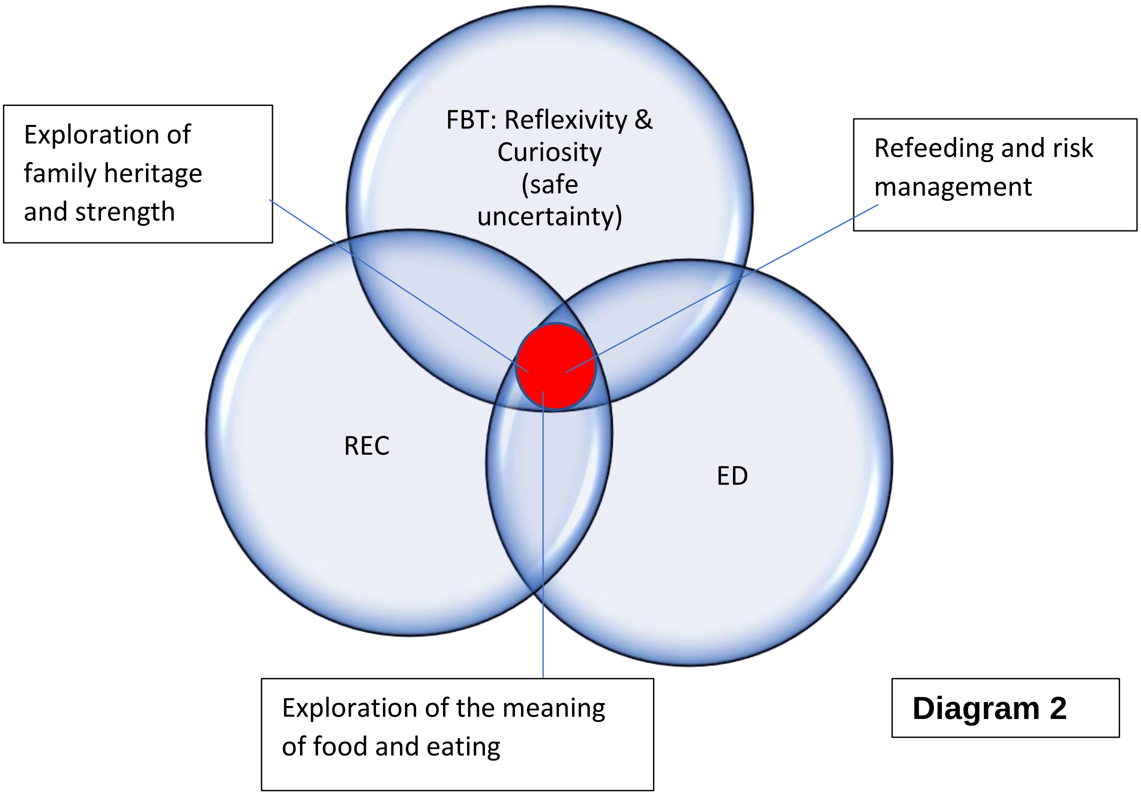


Diagram 2

FBT: Saving life and reflexivity

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

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[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

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[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.

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[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 haIelf 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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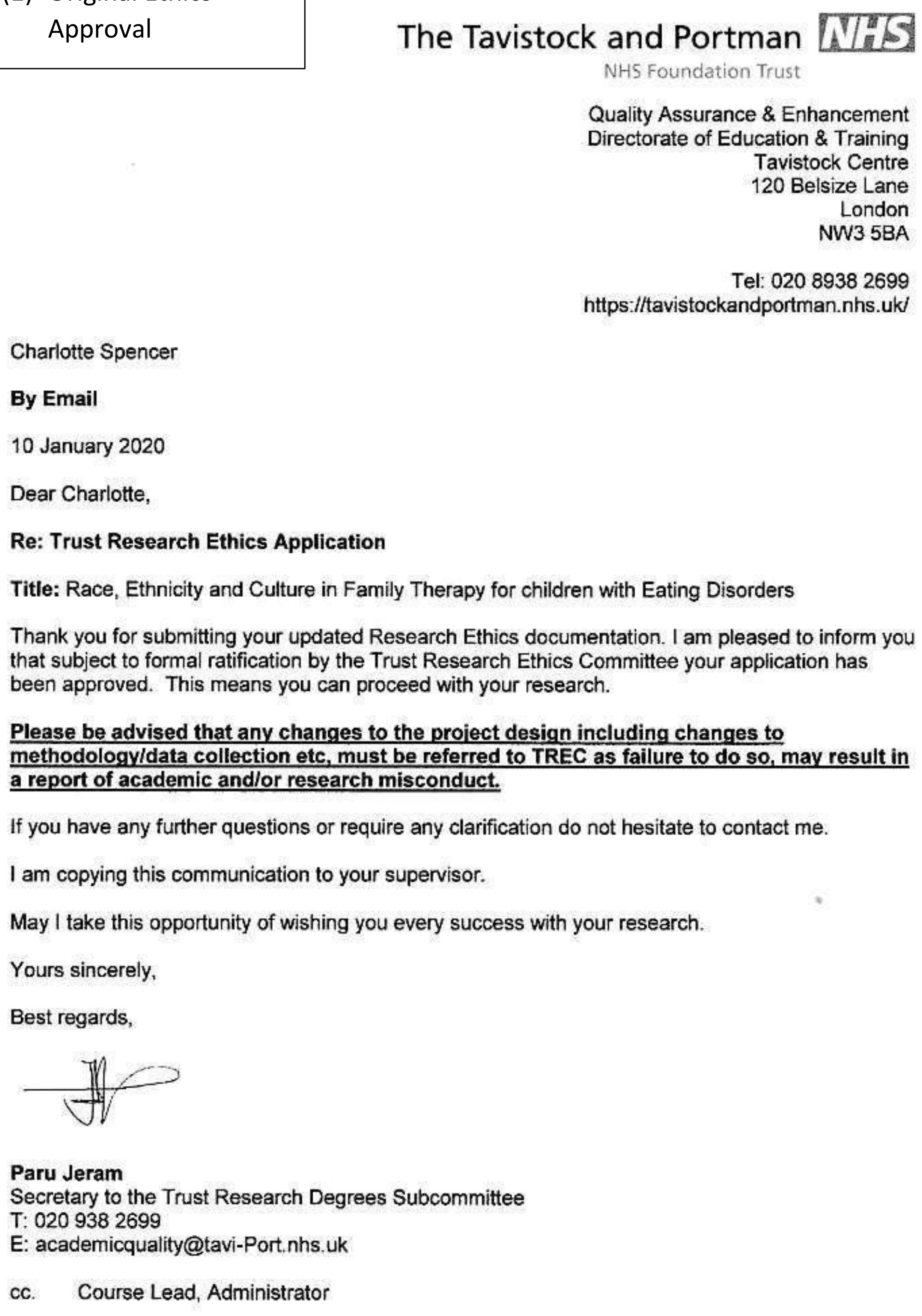
APPENDICES

Appendix 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)

The Tavistock and Portman NHS Foundation Trust

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London

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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
--------------------------	-----------------------------	------------------------------------
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?)

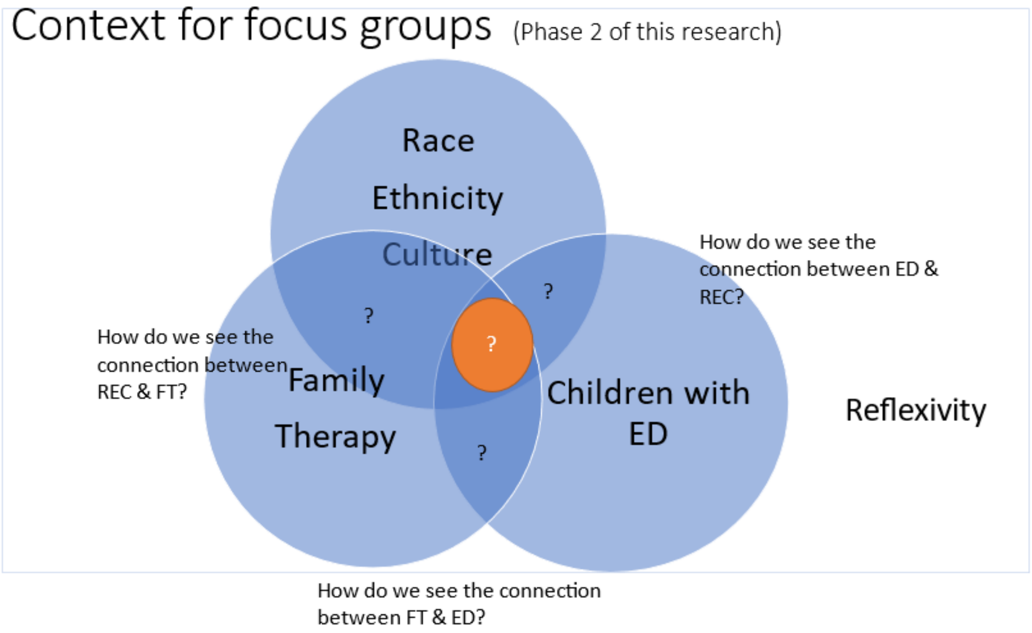
5. Do you think about your own eating when you are talking to family about this?

- 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. <u>Group discussion</u>

   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.

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.