In the margins:
Black, Asian and Minority Ethnic women's narratives of recovering from an eating disorder

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Abstract

Eating disorders are associated with white Euro/American women and were initially thought of as a 'culture bound' condition; that is specific to a particular culture. However, research and clinical experience shows that Black, Asian and Minority Ethnic (BAME) women in the United Kingdom and globally, experience the distress of disordered eating. There remains a debate about transferring diagnostic categories across cultures and how similar or different the experience of eating disorders is for BAME women compared with white women from the United Kingdom. This inquiry is a small scale qualitative inquiry asking questions of race and culture, of idioms of distress and intercultural meaning making explored through narratives of nine racially diverse women recovering from an eating disorder, drawing on a dialogical approach to narrative analysis. Recovering narratives are explored both to bring forth untold appreciative stories where personal stories of recovering is under researched, and to make transparent that research addressing BAME women and eating disorders is limited and where studies are undertaken, they remain invisible in mainstream clinical texts or journal articles.

Individual/cultural and collective stories are identified through the analytic process drawing on creative non fiction writing techniques, weaving both traditional and dialogical methods of narrative analysis. The dialogical method centres on 'voice, embodiment and emotional volitional tone' of the storytellers, every voice contains multiple voices. The researcher is ready and attuned to listen to the emotional volitional tone, an active, embodied talk that invites reflexivity of the researcher who embodies and emotionally engages with the material creatively, contributing to the co construction of dialogical stories. In foregrounding storytellers' strengths, capabilities and talking back to the orthodoxy of biomedical narratives is a position or resistance.
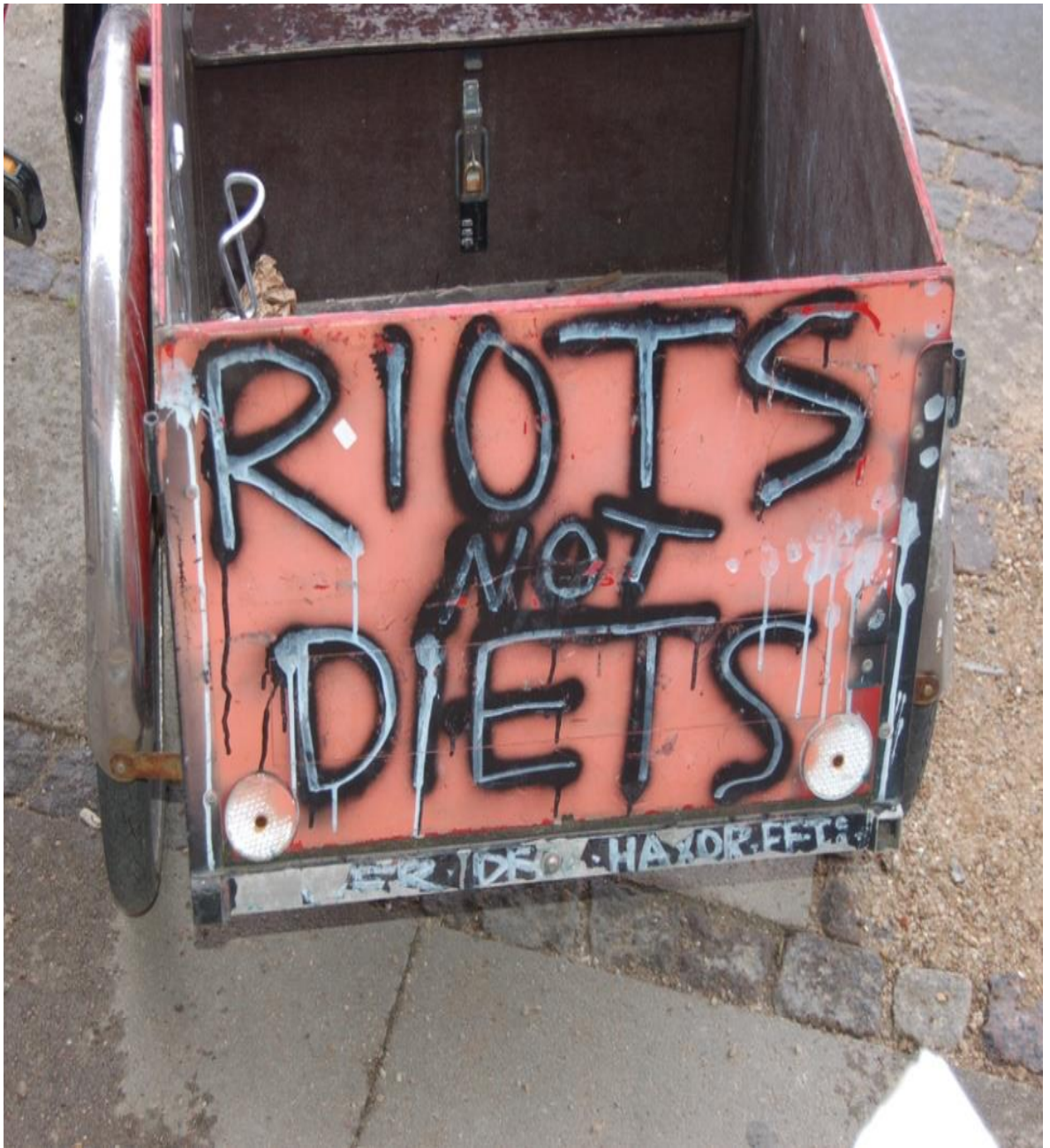
Dominant discourses of eating disorders marginalise BAME women, and represent a challenge to clinicians and services. The lack of attention to diversity is

shown to impede access to timely assessment and treatment. The ethnocentric narrative is further emboldened because racially diverse families are concerned about seeking help where services are seen as constructed for white persons leading to concerns about confidentiality and fear of stigma.

Key findings are summarised below: The first two findings concur with current, though marginalised knowledge; the remainder of the findings are unique to this inquiry.

- Eating disorders occur amongst BAME women and cause distress
- Help seeking remains problematic; when help is sought there are access to treatment issues
- Clinicians require training to challenge assumptions regarding BAME women and eating disorders
- Eating disorder experiences may appear similar to white females though clinicians should not presume the pathway to the condition is the same
- Migration, racism, colonisation, slavery, trauma, loss, bereavement, famine, war, starvation, the role of food, gender roles, family understanding of mental ill health and social change need to be taken into account in assessment and treatment
- BAME women are positive about their recovering from eating disorders
- BAME women co exist in individualistic and collectivist cultures and this may assist in recovering
- Culturally informed practice/training guides are produced to support clinicians in identification, assessment, treatment and training

In concluding, this inquiry interrogates the dialectic between mainstream and subjugated narratives, contesting assumptions that it is only white women who experience eating disorders and brings forth marginalised narratives that resist, stand up and talk back to dominant narratives. BAME women experience the distress of eating disorders often without adequate support in our communities. As clinicians we are positioned now to consider our ethical responsibilities towards this visible/invisible heterogeneous group.

'Stand Up, Speak out, Talk back'

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[1] The names are all pseudonyms chosen by the women apart from Esme who was unavailable after interview, to preserve confidentiality

Emily

Chapter 1: Introduction

Warming the context

I begin this inquiry[2] warmed up by literature, poetry and songs of racially diverse women and men; Maya Angelou, Toni Morrison, Audre Lorde, Nina Simone, Kamila Shamsie, Alice Walker, Arundhati Roy and John Agard; They are not only known for their words but for also for their political activism. They inspire me to take a liberatory and transgressive position showing through these pages how I work through the analysis to counter the dominance of objectifying and oppressive discourses that position Black, Asian and Minority Ethnic women (BAME) in the margins with their suffering. The current dominance of the biomedical model of eating disorders ignores the legacy and impact of colonialism and slavery through which we lose status, language, culture, food, identity and social positioning.

I discuss language use in detail below, but first I share why I choose to use Gunaratnam's (2003) term 'minoritised', rather than 'Black, Asian and Minority Ethnic' which is a more common term to describe the specific characteristics of persons of non white ethnic origin. 'Minoritised' draws attention to the active process of becoming a minority. When I attended the ethics panel at the beginning of my research endeavour I was asked to define 'minoritised' as they had not heard of it before. I struggled to find my voice then it came to me that my Zimbabwean nurse colleague would not be a 'minority' if she were back in her land. This helped me to embody how our specific characteristics are part of a process rather than being positioned as if these characteristics are our essence. Singh and Dutta (2010) draw on Brah (1996) who argues that ethnicity is not boundaried or fixed and is contingent on a range of factors including political, cultural and economic shifts in society. Moreover the minority/majority dilemma in terms of population,where persons of colour are the 'majority' globally such that ethnic

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[2] I use inquiry, study and project interchangeably

'minority' becomes a misnomer. I consider carefully this language use, concerned it may not be specific enough for some Black, Asian and Minority Ethnic persons. I am mindful of the dialectic between the uses of BAME in mainstream culture yet 'minoritised' is taking on a life of its own. Words are both a reflection and an action, (Freire 1993) I notice it being taken up by others around me and using it back to me. For example at a recent workshop event I introduced the term 'minoritised' and the feedback to the course organisers was 'Can we have more minoritised presenters next year?'. This beautifully illustrates how language is fluid, changeable, operates at the level of mutual influence and is inherently dialogical, (Frank 2012). I argue its developing 'voice' is standing up to notions of BAME being viewed as a fixed idea of describing racial characteristics. It remains to be seen over time how Black, Asian and Minority Ethnic persons identify with being described as 'minoritised' or whether there continues to be an argument for greater specificity.I describe myself as a minoritised woman of dual heritage where I am positioned both as *the same* as white persons,

'*I think of you as Western*',

And as *other*,

'.Yes but, *where do you come from originally?*'

In this study I show how the storytellers and I *Stand up* and *Talk back* to this dominance. From the storytellers I learn how services are ill equipped to offer culturally informed[3] practices. For me as a systemic psychotherapist, it becomes a responsibility to redress these inequalities. Moreover, the courage I now need comes from anger at how I have been positioned in my professional and personal life to not talk to my heritage, whilst minimising, ignoring and subjugating my experiences of race and culture. This study is borne of this felt reality as well as

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[3]Hay, P., Chinn,D., Forbes, D., Madden, S., Newton, R., Sugenor, L., Touyz, S., Ward, W. (2014), I borrow this term from the Australian and New Zealand psychiatrists who have devlloped the concept working with indigenous persons in Austraila and New Zealand

from intellectual rigour. I am in a liminal space where my cultural and racial identity is shifting but is not yet fully embodied. I am more political and angry and this impacts on my thinking. In turn an angry minoritised woman is likely to be overlooked in the echelons of academia so I try to critically attend when I am being preachy and to make transparent whether this is an affordance or a constraint, (White 1997, Lee 2012). This inquiry is a call to action, for more relational risk taking, risking being clumsy not clever and encouraging colleagues to do the same, (Partridge and McCarry 2017).

My work context

I work in the National Health Service (NHS) in a children and young persons eating disorder service in South East England. Specialist eating disorder services have been commissioned nationally by NHS England in recognition of the serious and life threatening consequences for persons if their eating disorder is not identified and treated in a timely manner, (National Collaborating Centre for Mental Health 2015). This has important resonance for this inquiry where minoritised women's eating difficulties are often misdiagnosed as a physical rather than mental health issue,(Smolak and Striegel Moore 2001, Wales, Brewin, Raghavan,Arcelus,2017). Current practice and protocols are designed to enable services to deliver specialist interventions, founded on modernist biomedical research as 'gold standard', an eating disorder is viewed as a mental disorder and as 'value free', (Lee 1995). The latest diagnostic guidance advises that anorexia nervosa (AN), bulimia nervosa (BN), binge eating disorder (BED) avoidant and restrictive food intake disorder (ARFID) and other specified feeding and eating disorder (OSFED) are the current nosological[4] terms, (American Psychiatric Association (APA) 2013). These categories are based on developed nations research and are then transferred to see how they fit in other cultures. If they do not appear to fit they are viewed as 'atypical' and side lined from data, (Littlewood and Dein 2000). I speak of 'developed' versus 'developing' nations to describe 'western' and 'eastern '

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[4] classification of illness

societies whilst recognizing the conundrum that Japan and China are in the east yet are also developed nations. Other terms include 'individualistic' versus 'collectivist or 'minority' versus 'majority' that differentiates according to population size. The point is to recognize that there is not a dichotomy, the dilemma is nuanced and there currently is no correct way to discuss the sameness and differences so I try to be as specific as possible as I go through the study.

The interest in eating disorders amongst diverse populations in Europe/United States of America and globally comes from social anthropology and cross cultural psychiatry who ask questions about the universality of disorders versus culturally specific disorders, (Littlewood 1995, Lee1996, Littlewood et al 2000). Kleinman (1987) speaks of a 'category fallacy' as,

> *"The reification of a nosological category developed for a particular cultural group that is then applied to members of another culture for whom it lacks coherence and its validity has not been established." (P452*)

In thinking about eating disorders in industrialised nations as well as globally, it is important that I keep these ideas in mind so that I do not fall into an overreliance on our diagnostic systems and replicate ethnocentric practices.

I see my task in this inquiry to demonstrate imaginative and creative ideas as well as intellectual rigour. I refer to Bateson's (1979) dictum,

> *'We shall know a little more by dint of rigour and imagination, the two great contraries of mental process either of which by itself is lethal. Rigour alone is paralytic death but imagination alone is insanity' (P219).*

This means using creativity to bring forth ethically responsive, reflexive research practices into the public domain. Imagination and creativity are liberatory forces, enabling, even demanding that we resist taken for granted ideas of power and control through the political structures within which we all live our lives. As I challenge dominant narratives, I connect with ideas of resistance and standing up and speaking out as a way of disrupting this hegemony. bell hooks(1989) urges

minoritised women to 'talk back', meaning to talk about oneself, ones writing, one's identity, to speak up and out, disclose our experiences and not stay quiet. bell hooks moves from silence to speech as a gesture of defiance, a liberated voice. Talking back is aimed at dominant discourses that marginalise us, (Holmes 2016).

As I contemplate this inquiry, drawing on the social constructionist paradigm, I embody uncertainty though excitement as I face the tension of undertaking a postmodern inquiry in a modernist field. On the one hand I seek to counter the orthodoxy of the medical model by critiquing taken for granted language use, for example drawing on the narrative therapists use of 'a/b' to refer to anorexia and bulimia (Epston and Maisel 2009) and I introduce 'eds' to disrupt the use and hence meaning of 'disorder'. Moreover, I use abbreviations to deconstruct the professionalisation of human problems increasingly becoming viewed as psychiatric disorders, (Katzman and Lee 1997, Warin Turner, Moore, Davies 2008, Warin 2010, Harper 2012). This dialectic is present daily to me because 'disorder' is used in clinical practice. Its constant usage becomes taken for granted and in turn through talk, 'disorder' is talked into being and it is important that I use my self reflexivity so not to be positioned by mainstream language.

Resistance

Resistance nestles within the narrative paradigm, where constructs of re-membering and outsider witness practices are tools that enable dialogue of recovering as a counter to illness, victimhood and individualisation. Re-membering trauma, rather than a simple posttraumatic stress model, invites conversations about important people in our lives and enables a shift from problem-saturated discourses to discourses of hope, (White 1997). Outsider witness practices help not only to validate and sooth but to make transparent and public the hurt so that we can be accountable. In this inquiry I engage with, and amplify stories of hope, resilience and within this, articulate that if we begin to come to 'reasonable terms' with our past, that our futures become more meaningful, (White and Epston 1990, Denborough 2014).

Resistance is defined by Wade (1997) as:

> *"Any mental or behavioural act through which a person attempts to expose, withstand, repel, stop, prevent, abstain from, strive against, impede, refuse to comply with, or oppose any form of violence or oppression (including any form of disrespect) or the conditions that make such acts possible, may be understood as forms of resistance"* (p25)

Resistance is counter to being unfavourably or negatively positioned by the power structures of our histories, the health service, media and politics. As the storytellers[5] embark on storytelling, they enter a different space where they hear their words out loud, contemplating questions of what it means to recover from eating disorders. In articulating this, the storytellers are able to reflect how it is that they have the potential to increase their abilities to lead productive and enriching lives, (Frank 2002, Pearce and Pearce 1998, Wade 2014).

Why I choose this area of inquiry

This inquiry came into being following my lack of knowledge of minoritised women with eds. The realisation that I had internalised the dominant narrative that eds are commonly associated with white middle class women followed the poor outcome some six years ago, of a clinical case involving a young woman, Hana[6], aged 16. The family came from the Middle East. Hana was referred for treatment of 'anorexia nervosa' a condition where the individual restricts her calorific intake, often struggles with body image and fails to recognise she is emaciated. It strikes me now that this lack of awareness of diversity and eds is symptomatic not of my personal ignorance but of wider trends in society that discursively construct eds as a white female disorder, (Bordo 2009).

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[5] I use storyteller, narrator or collaborator to convey the active contribution of storytelling undertaken by the women in the study (Holstein and Gubrium 1995)

[6] A pseudonym

This research is conducted in a postcolonial context, which means that the historical processes of colonialism, and power structures are omnipresent yet remain hidden, and need to be exposed, (Fanon 1963). As my inquiry is centred on the experiences of minoritised women, I turn to minoritised scholars, researchers, poets and authors for inspiration and guidance, though I recognise my work will inevitably reflect the works of white 'dead man's writings', (Merrill 2011), alongside white male and female American/European researchers, systemic authors, philosophers and psychiatrists, (Eisler 2013, Nicholls, Lynn and Viner 2011, Schmidt and Asen 2005, Treasure, Claudino and Zucker 2010).

Aim of this inquiry

I aspire to conduct ethically transparent research by bringing forth and disrupting taken for granted power structures that appear objective and unassailable, for example the medical model and the relationship with ed research. I do this by using my self reflexivity, which means sharing my own stories, co constructing new stories and making them transparent so that new meaning can be generated, (Harper 2013). I speak in the first person to emphasize my subjectivity as part of the research process. I strive to make the work accessible though it is important to remember that as a first-person narrative the complexity and rigour will not be sacrificed in the process, (Gunaratnam 2003,Wetherell and White1992b, bell hooks 1989). I draw on my own experiences *and* aim to bring forth previously unheard, untold, unknown stories to a wider audience. I use an autoethnographic approach, which reinforces the importance of storytelling in the human and social sciences, enabling the reader to hear personal narratives and also how these connect to the wider sociocultural context, (Grant, Leigh-Phippard and Short 2015).   This practice fits well with the narrative approach, a postmodern stance that recognises the problems of unseen power and allows for multiple stories rather than one Truth. Attention is paid to how the storytellers make meaning of their situation rather than privileging diagnoses or causation. Thus, 'the problem is the problem, not the person', (White 1997).

The research questions are:

Question 1:How do minoritised women construct narratives of recovering from eds?

Question 2: How can the process of research amplify and elaborate the experiences of those co-producing the research?

Question 3: How does the talking back and resisting victimhood enable the taking back of knowledges and performance of not yet heard stories?

In this final section of the introduction I outline chapter headings. The next chapter, Chapter 2 is the literature review, followed by Chapter 3 which is the method; that is the steps taken to bring the study into being; this is followed by Chapter 4 outlining how I choose my methodology. Chapters 5 -8 detail the analyses, findings, critique of the study, future research possibilities finishing with a series of practice guides for clinicians and the unfinalised words of the storytellers.

This introduction is designed to set the scene of the inquiry. I now move to the literature review for a more detailed examination of the literature that has helped to inform, provoke and shape the study.

Chapter 2: The Literature Review

This chapter is divided into three sections. The first section focuses on epistemology, exploring my thinking on language and knowledge acquisition. The second section explores my subjectivity as it connects to the inquiry and the third section addresses ed stories from a number of positions including historical, biological/treatment, sociological, critical feminist/poststructuralist/narrative, systemic and recovering stories. This is a non-systematic and small-scale inquiry. It is neither possible nor necessary to review all the ed literature. I generate the arguments that unfold in this study based on the literature and the analysis as it connects with my research questions. I take a political position, meaning I review contemporary dominant literature in parenthesis, whilst affording additional attention to literature that is often subjugated so I look at '*some'* literature' *in a particular way',* (Richardson 1990).

Epistemological Stories

Here I develop my thinking on epistemology, how this scaffolds my ideas on knowledge, language, critical theory and the intersection with a dialogical, affect and embodied approach to intercultural qualitative research. I draw from a pool of diverse critical social thinkers from the movement that Shotter (2011) calls, 'practical philosophy'. A social constructionist approach within which postmodern/poststructuralist and contemporary hermeneutic philosophies sit, means I take a critical stance towards taken for granted knowledge on language, commonly known as the 'linguistic' or 'narrative' turn. This paradigm represents a turn away from a classical view of bringing individual experiences into the political realm, (Gergen 2002, 2011, Gunaratnam 2003,Belsey 2002). A social constructionist lens views mental health as constructed by humans within specific cultural contexts and thus brings forth opportunities for deconstructing the medical model, its pathological labelling and its rhetoric, (Afuape 2014).

I draw on three philosophers to scaffold the epistemological story; Foucault (1965) for his insights into modern psychiatry, labelling and self surveillance; Bourdieu

(1993), for his ideas on habitus; that is our daily routines of commensality, the practices and habits we adopt including our taste and his exploration of embodiment, (Wainwright 2000) and Bakhtin (1984) for his dialogical ideas on language.

Foucault's written works are influential in poststructuralist feminist discourse and narrative therapy, (Madigan 1992). Foucault's (2001) key theory centres on the indivisibility between power and knowledge. He challenges notions of universality and neutrality of dominant discourses such as the power of global versus local knowledges and the use of biomedicine over alternative approaches to mental or physical ill health. His thesis on madness, on prisons and the hegemony of psychiatry scaffolds a context for eds as discursively constituted, not individual pathology. He calls this dominance of discourse 'dividing practices'. He provides a way of deconstructing assumptions that come to be taken as 'the truth' in our clinical fields. His ideas of the 'critical gaze', that is how we constantly self survey and compare ourselves unfavourably to others, are referred to by Foucault as 'Subjectification'. In the field of ed and diversity, the notion of self surveillance or critical gaze resonates as women struggle with the idiom of food as both a pleasurable, 'natural' activity and as frightening, guilt inducing and punishing one, (Ramazanoglu 1993, Madigan 1992, Flaskas and Humphreys 1993, Bordo 1993, Simon 2007).

Bourdieu (1979) is interested in power, inequality and countering dualism. He offers concepts of 'capital', borrowed from Marx' terminology, 'field' and 'habitus'. Bourdieu includes 'symbolic capital', for example the white coat of the doctor. Wetherell (2012) adopts Bourdieu's ideas on capital referring to 'emotional capital', for example those who have emotional awareness and sensitivity. 'Field' goes beyond geography and is about having authority within a specific discipline, for instance within the field of psychiatry where there are permissions to label and classify. 'Habitus' is central to Bourdieu's theory of social inequality and embraces ideas of embodiment that goes beyond developing knowledge through language. It is through the body that we learn the taken for granted aspects of everyday life, our food preferences, our accents, our tastes, and gestures come from 'socially

informed' bodies, (Warin 2006). Bourdieu (1979) suggests that eating, embodiment and our bodies are a performance of gender, class and identity. Bourdieu's concepts are drawn upon both by anthropology in the eating disorder field, (Warin 2010) and in dialogical narrative research (Frank 2010,Wainwright 2000, Lupton 1996, Bourdieu 1979).

The dialogical systemic field draws on Bakhtin's (1981) ideas on language. In particular how it is a social living language known as 'heteroglossia'. Heteroglossia refers to how stories are generalised within cultures and refer to codes we use in our talk such as our professional language, and the genres we use to tell our stories, (Frank 2012, Couture and Sutherland 2004). Not all language nor the social groups that use their voices are equal in terms of power. Bakhtin speaks of counter hegemonic voices that stand up to the more powerful voices and this has important resonances for this inquiry as minoritised women are positioned to speak out about the lack of interest shown to diversity and eds. Bakhtin (1981,1986) considers how the personal use of language is interconnected with identity development in a person's cultural world.

> *'From a Bakhtinian perspective, narratives are externalised; multivoiced utterances that originate from the author's internalisation of past and imagined dialogues and encounters in the social world. As such they become a primary site for analysis of the mutual constitution of self and the social world, of meanings at the personal and cultural level'. P3 (Skinner, Valsiner and Holland 2001)*

For Bakhtin (1986) words are not just signs, they contain meaning and we use our words with affect and emotion, what he calls the 'emotional volitional tone'. This tone refers to our utterances as we make them, in the moment, we are relating to and expecting certain utterances in return, for example, how we finish others sentences. It also refers to how we attune ourselves emotionally to others emotional positioning, (Shotter 2006). It is this dynamic, the bringing together of thinking about our words/utterances and the affective resonances we have as we enter into dialogue with one another. We feel something when others speak and

we feel something when we speak and we embody these feelings in our conversation. Moreover, the dialogical approach, considered part of the affective or corporeal turn, goes beyond language, (Wetherell 2012). Dialogue described by Bakhtin (1984) in Seikkula et al (2015) is 'embodied action', meaning we dialogue throughout life, before we can speak; we use our hands, eyes, spirit and our whole body.

Epistemology: Language Stories

Language within social constructionist epistemology is a discursive activity between people. Language constructs the person and the relationship and it is through language that we construct our understanding of the world, (Burr 1995). In this study I use language to challenge dominant narratives in the field of eds to bring forth how our language can appear neutral yet hide dominant negative discourses about those whom are on the receiving care within our services, (Willig 2010, Barge 2012). Language in this paradigm is a precondition for thought and this view is in contrast to traditional psychology that argues that thought comes before language, (Gergen and Hoffman 1996). The idea from Heidegger (1978) that as humans we are 'born into a sea of language', that we absorb and take in to ourselves is a beautiful and powerful image conveying how language pre exists us and lives on after us. Put another way, 'we are said into being,'(Griffith and Griffith 1994, Harper 2012, Gardner 2001,Wetherell and Potter 1992a, Merrill 2011).

I privilege 'woman/girl/female[7]' over 'patient, sufferer or service user and use 'person' as a generic term if I am referring to male and female, (Epston 2007, Nicholls and Yi 2012). By bringing forth these alternative descriptions, I notice how biomedical language of eds are privileged, obscuring the relational, social, cultural and historical aspects of their construction, (Maisel, Epston and Borden 2004, Hepworth and Griffin 1995). I view '*anorexia as having the person'* rather than a person having anorexia, in other words separating the problem from the person,

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[7] I privilege female over male due to the nine to one female to male ratio of sufferers

(Epston et al 2009). The 'anti anorexia/bulimia league', 'anti a/b' is a place of resistance that counters traditional ed stories. Within this position is the powerful idea that a/b/eds are a moral rather than mental health concern, (Hepworth et al1995, Lock, Epston , Maisel and De Faria 2005).

Feminist literature prefers 'eating problems' or 'eating distress' both as an acknowledgement that the eating concern may not be 'disordered' and as a counter to the dominance of psychiatric categories, (Thompson 1994, Burns and Tyrer 2009, Hepworth et al 1995). Women with a diagnosis of 'anorexia nervosa' say that they have 'anorexia' so the idea of erasing it from dialogue is problematic, (Malson, Finn,Treasure, Clarke, Anderson 2004, Warin 2010, Garrett 1998, Chernin 1986). Warin (2010) argues instead of the debate around labels we should disrupt the exoticisation of thinness, the critical gaze upon women and the female body being continually under public scrutiny.

Epistemology: Towards a Critical Race Perspective on Race, Culture and Ethnicity

As part of the process of scaffolding, I bring forth critical theory highlighting how social and historical contexts shape the way diversity is obscured and marginalised in research and public discourse. This approach helps reduce the risk of rampant relativism by doing something with our knowledges rather than merely acknowledging which is a common critique of social constructionist ideologies, (D'Arrigo-Patrick, Hoff,Knudson-Martin,Tuttle 2016,Nieboer and Partridge 2000). Critical theory is further developed as critical race theory where intersectionality, embodiment and corporeality are theorised beyond language yet remain within the social constructionist paradigm, (Frost and Elichaoff 2014, Cromby and Nightingale 2002, Watt Jones 2010, Delgado and Stefancic 2013). Within this epistemological frame, I discuss the implications for undertaking reflexive qualitative research across social diversity. What this means for minoritised women with eds is that diversity as a topic of study can reduce the risk of obscurity by bringing stories into the limelight.

There are two main approaches to systemic practice and race. The first is the social constructionist approach where practitioners attend to race and diversity collaboratively, exploring multiple view points with families and colleagues. The second approach to exploring diversity is critical theory where social justice, liberationary and activism are centralised, (D'Arrigo-Patrick et al 2016). I have not previously acknowledged this distinction as I assumed I was doing both in my practice. I think now it is a useful distinction to consider as researcher/clinician. I critically reflect on my own practice as I read; what is it that I do or say that disrupts taken for granted cultural narratives that families bring to therapy? I draw on critical feminist literature and ask how it is that young women make an association between body image and success or how it is that body image talks to them about who they are as young women; I ask parents of the pressures they are under and how this can impact on their daughter's beliefs about achievement and success. This is why I now bring forth this perspective in this study to show how I privilege action alongside theory.

With any inquiry involving social diversity it is important to examine the historical processes through which race, ethnicity and culture come to be constructed and how colonialism is implicated in this. Donald and Rattansi (1993) begin the introduction in their book '*Race, Culture and Difference,*' stating the paradox that confronts us when we try to explain the complexity of race and racism. Until the Second World War, race was viewed as an essentialist category based on physical appearance and genetics. Despite being discredited as a theory, racism persists in different forms, invoking the rhetoric '*I am not racist I just do not like their culture*' as if this is more acceptable than overt racism, (Wetherell et al 1992a, Brah 1996, Hardy 2008a, Donald et al 1993). I critically contextualise race as a 'precarious' discursive construct; it is not an epiphenonomen, in other words, it is not a side effect of something but holds significance in its own right, (Gilroy 1993, Larner 1995, Wetherell et al 1992a). I have not put race in parenthesis in keeping with Smaje (1997) who refers to 'the use of scare quotation marks' arguing that race is not afforded serious analytical status. Where such analysis does take place, it is in academic circles and not within clinical practice. This critical lens informs the ebb

and flow of the study as I weave the ed literature as it intersects and connects with systemic literature and research methodologies. I resist the pull to define and categorise race, culture and ethnicity as I view them as socially produced categories. The risk in definition is that they are essentialised as categories, frozen in time, objectified and unified whereas I view them as troubled, contested and therefore partial, (Gunaratnam 2003). Race is discursively hidden, marginalised or denied such that 'race is an absent presence', (Hardy 2008a,Gunaratnam 2003, Pendry 2017). In viewing race this way, I argue that race/racism is at the heart of British politics actively shaping history, impacting on us even if we are unaware of this, (Gilroy 1993). It is through this lens that I critically evaluate the impact of race on the storytellers and their stories. Within conversations about diversity there are intersections with gender and class and other diversities, (Watt-Jones 2010, Frost et al 2014). Moreover, our ability to understand these categories is hampered by many conflating ideologies such as a culturalist conception of race and ethnic identity where race is seen in terms of culture rather than political history where culture is rendered superficial, static and exoticised within a multiculturalism framework, creating the so called, (Donald et al 1993)

'Saris, samosas and steel band syndrome' (p2).

As with any contested category, culture needs to be scrutinised to ensure it is not masking as a western liberal definition of culture, that is 'a set of individualised beliefs and preferences, as free choice', rather than as a *social* frame of norms, rules and taboos. Talk of 'cultural difference' risks minimising power and inequality within this multicultural framework.

There is a culture of mistrust between mental health services and minoritised persons, the so-called 'circle of fear'; with mistrust comes underutilisation of services impacting on later presentations often in crisis, via the criminal justice system, (Pendry 2011, Smolak and Striegel-Moore 2001, Abbas,Damani, Malik, Button, Aldridge, Palmer 2010, Kirmayer 2012, Malek 2011). Delay in presenting has an impact on the course of the condition with a similar picture emerging in adolescent mental health care, (Fernando and Keating 2009,Raleigh, Irons, Hawe, Scobie,

Cook, Reeves, Petruckevitch, Harrison, 2007 Luepenitz 1992,Smart, Tsong, Mejia, Hyashino Braaten,2007,Pakes and Roy-Chowdhury 2007, Huey and Polo 2010, Malek 2011, Commander,Dharan, Odell, Surtees,2007,Tolmac and Hodes 2004).

There is growing recognition that health services must consider culture[8] to be ethically sound and clinically effective, (Kirmayer 2012, Shweder and Bourne 1991, Campion and Fitch 2015). In the ed field this is endorsed in NICE guidance (2017). This mirrors my experience of understanding eds amongst minoritised women, that they are marginalised and denied a discursive reality, (Hardy 2008a,Chowbey, Salway and Mubarak 2012, Wales et al 2017). This happens because white dominant persons view persons of colour with suspicion even before words are spoken. The problem is systematic and based on inherited power relations between white persons and persons of colour. This narrative still permeates psychiatry, health and educational provision. Hardy (2008a) calls this the 'racial stain' whereby skin colour is signifier of a reductionist strategy in British society. It creates an 'invisible fence', a hidden barrier faced daily between those who have power and those who do not, (Burr 1995, Hardy 2008a,Gunaratnam 2003, Littlewood 2001, Currin et al 2007). Moreover, as Gunaratnam (2003) puts it, there is the paradox of the 'hyper visibility of race and the embeddedness of race;' in other words our skin colour is the visible 'stain' yet race cannot be spoken of. A good example is how the National Health Service disproportionately recruits white job applicants. Not only is this problematic for minoritised staff to reach senior positions, research has shown how this lack can adversely impact on provision of services because without minoritised voices in position of authority, diversity drops of the agenda, (Kline 2014). Within the ed field the problem of a lack of diversity amongst staff creates a context where diversity amongst the client group is absent and not considered. I am the only minoritised person in a large team.

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[8] I would add, 'must consider race'

Epistemology: Dialogue, Emotions and Embodiment

Emotions and embodiment are often not theorised in social constructionist research, (Pocock 2010, Krause 1993). My understanding of the dialogical approach is that it enables an integration of language, emotions and embodiment. Wetherell's (2012) 'affective practice' bridges the divide between poststructuralist language paradigms, theorised as a space where the body, embodiment, the visceral and the social come together. Eds cannot be understood unless language, embodiment and emotion are privileged. In the ed field, emotions are expressed in therapy as either intense anger, rage or sadness or by an absence of affect or emotion. In this inquiry it is not uncommon for storytellers to speak of highly emotional material then to back away from the associated experience or display of emotion, (Reissman 2008,Piran and Teall 2013, Shotter 2005, Gergen et al1996, Warin 2010, Wetherell 2012, Malson et al 2011, Anderson 2016, Hall and Du Gay 1996, Seikkula et al 2015). There have been papers on embodiment (Hardham 1996) but I find Afuape's (2017) definition of embodiment most useful. She speaks of embodiment in her family as a tactile way of relating and simply as,

> '*Being present and alive to our bodily felt experience'* (p90)

More importantly she highlights cultural differences in developed individualistic cultures, Afuape (2017) calls this the 'minority' world, little time or attention is given to bodily feelings and sensations. She goes on to say that oppression and emotional wounds impact on our bodies and can interfere with our ability to feel in touch with our bodies. This makes important sense when I think of women suffering with eds. From a dialogical perspective, we embody ideas of knowing how to go on, in each unique situation, reflecting in action (Schon 2016) rather than reflecting on action; the moment-by-moment experience that Shotter (2015) calls 'anticipatory' guiding. These ideas resonate in my study where storytellers contend with issues to do with their bodies and bodily experiences through the taking in or rejecting of food, as well as bodies that may have endured trauma, racism, oppression and dislocation (Warin 2010, Kaye, Wierenga, Bailer, Simmons, Bischoff-Grethe 2013, Frank 2010, Lee 2012).

The 'basic emotions' paradigm where emotions are located in the person is questioned by cross cultural research and dialogical thought, (Malik 2000, Fredman 2004, Wetherell 2012, Krause 1998, Gunaratnam 2003, Olson 2000, Wetherell et al 1992b, White 1983). How emotions are performed across cultures is important. For example, in eastern paradigms the mind and body are interconnected, unlike western/European nations where the Cartesian logic of mind-body split tends to be privileged. Historically social constructionist/poststructuralist ideology has privileged language above emotions and affect. In minoritised eds the body becomes a site for showing distress. For example a minoritised woman may speak of feeling bloated or full and not report body image issues, (Malik 2000, Krause 1998, 2012,Fredman 2004, Hardham1996). Embodiment is the connector between mind and body and between the body and the world we inhabit. It encapsulates a range of experiences from 'enjoyable embodied agency' to disembodied experiences of poor body image and lack of affect. Piran (2010) asks how it is that young girls are expected to be 'polite, nice and small', or the immigrant girl whose visual difference places her as a subject to be critically gazed upon as 'other'. This connectedness between embodiment and language is especially significant in intercultural and eating disorder research and practice because not every experience can be languaged (Malik et al 2005). This epistemological position does not ignore the body or the person; it is the *categories,* not *the individual* that are deconstructed. The storytellers are not disembodied from the text but are an integral part of the story. The corporeality of the body is positioned alongside language, (Weedon 1987,Burns et al 2009, Belsey 2002, Hepworth et al 1995, Wetherell 2012).

The Storytellers and my Subjectivity

This section explores commonalities in my story and the storytellers' from the perspective of colonialism and migration. The storytellers are from a range of collectivist cultures[9] that is cultures where family and community are privileged

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[9] Including Japan, the Caribbean, South Indian islands, Central America, the Middle East, East Africa, India

over individual need, (Littlewood 1995). There are tensions for minoritised families: should they assimilate to the host culture or remain loyal to traditions, whilst first generation minoritised persons are faced with adapting to peers, school, and community. These are powerful social forces experienced both by the storytellers and myself, (Smolak et al 2001). Eds sit within this historical, sociocultural and structurally unequal context with little attention afforded to minoritised women and eds whilst research on eds amongst white women is continually updated.

I am the eldest of four siblings; my brother Alan, sisters Seeta and Shanta and I live in the South East of England. I have an older half sister Sandra who lives in Germany. My father Herman, now deceased, was born in Guyana, South America, previously a British colony. His ancestors, along with many poor Indians, were brought from the East coast of India as indentured labour. They were taken to British colonies to continue the work of slaves and had no more privileges than their slave predecessors. The impact of colonialism diluted their religious and cultural identity and this coupled with the challenging relationship between the indigenous persons lead to hostility and strife. My mother Valerie is white, born to working class British parents. My grandmother met my grandfather who was looking for factory work, travelling from Wales where he worked as a miner. Valerie was born and raised in post war London. Her marriage in the late 1950's caused outrage, yet she held her head high, her loyalty to my father and talking back, provided a secure foundation for us all. I was born and raised in London and Scotland; my dual heritage has always been a central part of my identity. I have lived all my life in the United Kingdom surrounded by stories of race, whether that was being asked in the school playground,

'*Where do you come from*'?

Or being called a 'Paki', or how my father was overlooked for promotion as other younger white men rose in the ranks of the Civil Service, or how my brother

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and Pakistan.

changed his Indian name by deed poll to counter racist abuse, or my mother being called racist epithets for marrying an immigrant. I know now that I have been trained to be a GEMM therapist, that is a 'Good Ethnic Mainstream Minority' and I find I trouble myself with concerns about having been successful professionally due to being too good a GEMM therapist, a minoritised woman who does not challenge the status quo, (Hardy 2008b).

Being called a 'Paki' renders me constituted as an outsider, a postcolonial subject that marks me out as inferior. It is not just a personal racist insult but is recognition of the power of the discourses that are exercised through us as minoritised persons, (Brah1996)

My Subjectivity: My Racial/Cultural/Systemic/Ed Knapsack and the Interconnection with the Storytellers

The knapsack metaphor resonates on this research journey. I use the 'white privilege knapsack' as a metaphor for this study where I collect ideas, techniques and knowledges and store them in my knapsack for safe keeping, (McIntosh 1998). I have unearned privileges in my knapsack; I am fortunate to have been born in a country relatively free from social and political disturbance; I have been born healthy into a supportive family, I am socioeconomically stable. I reflect on similarities and differences of my knapsack and those of the storytellers. One significant difference between is the issue of identity where through the process of migration, the individual occupies a liminal space that is betwixt and between as one leaves behind their old identity, yet the new identity is not-yet-known as they begin to adapt and adjust to a new environment, (Lee 2012). Moreover, the place a person/family arrives at might not be the place where they will settle. The migratory experiences are a contemporary tale of trauma as we witness daily of the movement of the Rohingyas facing ethnic cleansing in Myanmar, (Judah 2017) or those forced out of the Calais "Jungle", or the millions of displaced persons from Syria, Afghanistan and Iraq. These journeys become visual maps in my mind. I refer later to 'migration maps' as a way of visually conceptualising the journeys of persons as they look for safety and sanctuary and suggest how such a map can be

used in intercultural therapy with eds, (Partridge 2017).

I reflect now on how race is performed in systemic therapy and specifically in systemic work with eds. I remember a special edition of Context, '*Sowing the seeds of Cultural Competence'* at the turn of the century and it seemed to herald a new beginning where I imagined race taking centre stage in our day to day conversations (Dwivedi 1999). On the one hand there are open invitations into conversations about race for example Laszloffy and Hardy (2000) who note that race is not discussed in systemic therapy. A number of techniques to support systemic clinicians, are offered to bring forth and make transparent these concepts in therapy, for example the Cultural Genogram where we can reflect on the pride and shame issues of our cultural heritage/s, (Hardy and Laszloffy 1995) The Genogram with attitude (Halevy 1998) which allows us to explore origins of prejudice in our families), However Laszloffy et al (2000) do not refer to the broader *sociopolitical* context within which political structures uphold essentialist categories of race. Whilst it is vital that therapists develop race awareness and sensitivity to be able to discuss race with families and in teams, there is a risk that these conversations occur only when a minoritised person raises the dilemmas, (Hardy and Laszloffy 1992, Cardemil and Battle 2003). Despite Burnham, Palma and Whitehouse (2008) assurances that as systemic and narrative therapists '*we have a rich history of considering diversity'*, in clinical practice there remains uncertainty about 'how', 'when' and even 'if', to talk about race, as if to invoke the category implies covert acceptance of race as a biological category, (Gilroy 1993) I think Burnham's (2008) point is unhelpful in this context because the idea that we are too afraid to talk of race is symptomatic not of a 'rich history' in diversity but of our unwillingness to think of race being an organising principle in everyday life, (Hardy 2008a, Brah 1996, Lawless, Gale and Bacigalupe 2001, Karamat-Ali 2007).

Within eds there remains a universalist focus, with little attention to diversity. Treatment focuses on systemic therapy's use of manuals in the treatment of eds, (Lock, Le Grange, Agras and Dare 2001). This directly privileges white persons over persons of colour as there have not been any studies to explore the usefulness or otherwise of a manualised approach to minoritised persons with eds.

There is little consideration as to whether the models based on research studies with white participants are suitable across cultures. This includes material in the family therapy journals, (Smolak et al 2001, Downs and Blow 2013). I am frustrated at this late moment, after reading the latest Journal of Family Therapy with a special edition on eds, to read of the celebratory work of systemic therapists only to find that the majority of authors in this edition are either psychiatrists, clinical psychologists or academics in universities in the United States. There is no mention of culture, the articles are predominantly quantitative studies, the dominant narrative remains unchallenged which I think links to the non acceptance into the Journal of my own paper where I provided counter stories.

My Subjectivity: Reflections on the Reflexive Process

Reflexivity is a process or strategy that mediates the effect of myself on the research process. Reflexive dialogic attention is paid to each step of the research, including the formulation of the research questions, the choice of methodology, gathering and analysing the material, collaborating with storytellers. Russell and Kelly (2002) suggest that the researcher;

> *'Return the fruits of the research to participants'*, (p1)

This involves a process where I turn the gaze on myself to make sure I differentiate my self and my story from the storytellers. By centralising all aspects of reflexivity, including self, relational, dialogical, gendered and cultural reflexivity as overarching concepts throughout this project, I acknowledge I am intrinsically part of the study. I strive to bring forth my use of self, my transparency, my privilege and power and to take steps to redress the balance where I can. As I state in the Introduction, this inquiry has brought forth emotional waves for me that need time to become embodied practices, where instead of feeling angry, I learn to language my anger, talk back to myself and others, to not be silenced, a journey that has already begun and is illustrated at various moments on these pages, (Burck and Frosh 1994, Watt-Jones 2007, Roberts 2005, Hardy 2008b). Navigating this position may invite additional scrutiny as a constraint despite my efforts to be transparent. This is in

contrast to a quantitative researcher who performs as a neutral, objective scientist, writing herself out of the script. In my discomfort I am reminded of the need to transgress, to stand up and speak out.

Building on Foucault and Bourdieu's work, this is a study that problematises power and knowledge as traditionally held by those with symbolic capital. Power and knowledge are not held by persons accessing/or in need of the mental health system. Therefore I attend throughout, alongside self reflexivity, to the issue of *micropolitcs*, that is how power is manifested in the research relationship at every level of the study from the conduct of the research, to the write up and the sharing of findings, (Bhavnani 1993). Now that I recognise how I have been positioned as a GEMM therapist, for year's fuels me to push further in my exploration to bring minoritised women with eds from the margins, (Hardy 2008b).

Ed Stories

I divide the ed literature into historical, biomedical, including treatment, sociocultural, feminist/poststructuralist/narrative, systemic, and recovering stories before moving onto Chapter 3.

In the early part of the study, I was drawn to the 'demedicalisation' movement to channelling my energy by denouncing psychiatric labels, (Montcrieff 2010). I then reflected on the idea that diagnosis is not always being a 'disaster', that for some persons the clarity for them around diagnosis can bring relief and a sense of knowing how to go on, (Gergen et al 1996) so I began to turn my gaze, recognising the tensions for systemic clinicians working in psychiatry in what Strong (2016) refers to as a '*discursive monoculture*[10]*,* or '*a discourse of legitimation*' (Lyotard 1984). There are realisations that follow from this position. I note the tensions and contradictions working in a modernist context holding a social constructionist/poststructuralist frame and also acknowledging the existence of eds

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[10] Meaning how within-person individualist medicialised explanations are offered for persons' distress based on the American and European diagnostic guides, (Strong 2015)

as a condition affecting girls and women, increasingly men and boys and minoritised women in both developed and developing nations. I highlight the totalizing discourse of the medical model in the ed field; acknowledge the historical colonial implications for this dominant narrative and look to ways to transcend and counter its treacherous bind by privileging the social, the political and continuing to problematise the over medicalisation of persons in distress, (Avdi 2005, Belsey 2002, Gunaratnam 2003, Kinderman 2011).

From Saints, to Sickness, to Culture, to Talking Back

Eds were first seen as an ascetic religious phenonomen becoming a medical condition during the late nineteenth century. There is evidence of eds in the twelfth and thirteenth century Europe where women were revered as saints, known as 'Holy Anorexia', (Bell 1985, Bemporad 1995, Garrett 1998). These women did not display a fear of fatness, associated with modern European/American 'anorexia'; rather they were seen as expressing spirituality through the body, (Lee 1996). By the fifteenth and sixteenth century, women were no longer revered for self starvation but were viewed as manipulative and deceitful by the ruling clergy. By the seventeenth century hysteria and related conditions were seen as witchcraft and in the eighteenth century starvation without organic cause lead to definitions of madness, (MacSween 1995, Bordo 1993). 'Anorexia Nervosa' positioned as a medical disorder was viewed as a feminine problem due to the irrational nature of women, (Hepworth et al 1995). The first presentations of 'anorexia' were European/American women and it is on these case studies that the first diagnostic manuals were formed, (Smolak et al 2001).

Bruch (2001), a psychiatrist from the United States was one of the first to write of a/b/eds. Her research identified that eds emerge as a consequence of young girls striving to be successful and pretty yet are victim to parental, peer and media pressure. This formed the dominant understanding of eds that remains prevalent today, (Hepworth 1999). There followed a surge of ed presentations in the 1960's, coined a 'modern epidemic', coinciding with increased consumerism, fragmentation of the family and individualism, (MacSween 1995, Nasser, Katzman and Gordon

2001, Lee 1996). The death of Karen Carpenter, part of the popular brother-sister singing duo, in 1983 of 'anorexia' related difficulties, fuelled a media surge that enabled 'anorexia' to be seen within the values of the family, underpinned by the social and political neoconservative era in the United States during that period, (Saukko 2009).

Several theorists of the late 1960's continued to theorise that over compliant daughters developed 'anorexia' as 'a failure in separation-individuation', (MacSween 1995). Palazzoli (1977), of the Milan Associates, argued 'anorexia' arises from a disturbance between the mother and daughter, referring to this as 'arbitrary and unempathic mothering', (Schwartz, Thompson and Johnson 1982). Crisp (1995) viewed 'anorexia' as a 'biological regression' emerging to avoid puberty (Schwartz, et al 1982). Minuchin, Rossman and Baker's (1978) work with the family and 'anorexia', argue that the family appear nice yet hide pathology including enmeshed relationships between parents and children. Parents are described as rigid and overprotective. The idea of the psychosomatic family emerged at this time and has permeated to the present day.

I have described a historical path leading to the naming of eds as a medical condition. There is further discussion of the systemic paradigm below. I turn now to current biomedical research literature.

Ed Stories: The Dominant Biomedical Modernist Discourse

In this paradigm, eds are viewed as, 'highly distinctive disorders at the brain–body interface' and as 'relatively common, serious and treatable disorders', (Schmidt and Campbell 2013, Wildes and Emery 2001, Nasser et al 2001, MacSween 1995, Keel and Klump 2003, Cummins and Lehman 2007). At the core of the condition is eating disturbance, body image and weight concerns. Fat phobia is a central diagnostic indicator for a diagnosis of 'anorexia' with a core psychological feature of an overvalued idea of body shape and size, (Treasure, et al 2010, Treasure and Russell 2011). Women with 'anorexia' are described as having specific personality

traits including perfectionism, anhedonia[11] are ego-syntonic[12], show inflexibility of thought and are 'harm avoidant'. Eds can follow after a period of anxiety in preceding months, (Kaye et al 2013). The features of rigidity, ritualised behaviours with food and resisting treatment are viewed as evidence for an underlying neurobiological contribution where hormonal changes at puberty are presented as evidence to explain why there are more females to males, (Culbert, Racine and Klump 2015). Eds are associated with significant physical, psychological and psychosocial consequences in terms of long-term health, mood and other mental health complications, (Lock 2015, Nicholls et al 2011, Kakhi and McCann 2016). There is evidence amongst males delaying help seeking because eds are seen as female disorders, (Räsänen and Hunt 2014). Neurobiological studies form a backdrop to the outcome research studies. The research task is to explore how psychosocial factors interact with biology. Outcome studies sit within the biomedical paradigm even though systemic theory, operating in the modernist and social constructionist paradigm, has been integrated into the studies, (Nicholls et al 2011).

Most research into psychosocial treatments operate within the modernist biomedical paradigm and are positioned alongside dietetic and medical management across the age range and include the following: in patient, out patient, day patient, community based, specialist and non specialist services, multi family groups (Asen 2002, Fairbairn and Eisler 2007), cognitive behavioural therapy (Fairbairn, Cooper and Shafran 2003), feminist therapy, (Piran 2010) cognitive remediation therapy, (Tchanturia et al 2010), family based therapy (Lock et al 2001) and group work, (Nicholls et al 2012, Malson et al 2004). There is a limited role for psychopharmacology although anti psychotic medication is occasionally used, (Morris and Twaddle 2007, Schmidt et al 2013, Dold et al 2015). Outpatient specialist treatment has been found to be as effective as in patient

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[11] Display lack of ability to experience pleasure

[12] A psychoanalytical term applied to persons with anorexia nervosa: lacking in insight to their condition

treatment and costs one tenth of the price, (Schmidt et al 2013, Gowers et al 2007, House et al 2012).

There have been ten randomised control trials into adolescent 'anorexia' that have included family interventions though only one, the family based treatment model, also known as the Maudsley Model, has been systematically investigated, (Le Grange et al 2014, Jewell et al 2016,). Outcomes of treatment are variable (Simmons, Milnes and Anderson 2008, Malson et al 2004, Holtom-Viesel and Allen 2014) and in a systematic review of dropout from family based treatment, figures range from 4% to 27.6%, (Lock 2015). Downs et al (2013) conducted a methodological review of the past 25 years of family based ed treatment and concluded that family based treatments are the treatment of choice, especially for early onset eds. It has been argued that psychosocial interventions plus brain directed interventions in the form of neuroimaging studies might be a way forward, (Schmidt et al 2013, Gowers et al 2007). From the perspective of the biomedical model, with a sprinkling of systemic theorising, the recent NICE guidance (2017) offers the latest guidance on treatment. It is not too much of an exaggeration to say that I am thrilled that the guidance in its first section, General principles of care, note that we should;

> *'Ensure that all people with an eating disorder …have equal access to treatments.. regardless of: ….gender or gender identity, sexual orientation, religion, belief, culture, family origin or ethnicity..* '(2017, p5)

This enables me to talk of diversity in the ed context, not as a personal project but as 'recommended in NICE guidelines', affording and bringing forth increased visibility to minoritised persons.

In concluding this section, eds remain poorly understood; there are divides in the research community about how and where to target research; neurobiologists look at appetite pathways, other scientists explore brain imaging, whilst others are investigating psychological changes. Despite the many research studies, the paradigm of biology means that the understanding of eds remains within a

modernist frame, obscuring newer or alternative models, (Hoskins 2001). Whilst the biomedical research is valuable and sheds light on causes and reasons for eds it remains reductive because it fails to take into account wider social cultural influences aside from a brief acknowledgement that they are 'implicated' in aetiology, (Eisler 2002).

Ed stories: Sociocultural

In this section, I privilege an extended reading of the literature to counter the dominance of the biomedical paradigm. I highlight how social, cultural and political factors are theorised in ed research. The interest in eds amongst diverse populations in Euro/America and globally arises from social anthropology and cross cultural psychiatry asking questions about the universality of disorders versus culturally specific disorders. The diagnostic categories found in the diagnostic manuals are routinely taken to countries the world over to see how the classification of illness[13] categories fit for different populations, (Littlewood 1995, Lee 1996, Littlewood et al 2000, Becker 2007, Miller and Pumariega 2001).

There are two key areas of exploration relevant to this study; one area of study draws attention to a rise in eds globally amongst diverse persons; the other area is research that shows first and second generation minoritised women are experiencing eds in the United Kingdom and Europe, (Pike, Hoek and Dunne 2014, Nasser et al 2003). As all diverse families in the United Kingdom and Europe will have been at some point in their history been involved in moving across continents, the idea of an established link demonstrating that moving from one culture to another can trigger the development of disordered eating is an important finding and should remain in our collective thoughts when working interculturally with eds, (Anderson-Fye 2007, Nasser et al 2001, Littlewood 2002, Wales et al 2017).

I am interested in how eds are similar /different globally. Is there correspondence

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[13] Nosology

between eds in Fiji where eds are not viewed as illness but as seen as poor appetite and treated with herbs, with eds in Europe? (Becker, Burwell, Gilman, Herzog and Hamburg 2002). To what extent these questions raise the further questions of indigenous illness categories that 'look like eds' but are not as in the Fiji study, remain outside the scope of this inquiry but important questions are raised because it highlights the key issue of the intersection of culture and medicine. Watters (2010) addresses this conundrum of the idea of universality of conditions. He reports how eds in China were unheard of until two significant developments were reported in conjunction with one another. One was the case of a girl who died of self starvation, thought of as a 'rare, true anorexia', the other development was the case of Princess Diana suffering with bulimia. This story went global and created a symptom pool for girls in China to draw upon to express their distress. As a consequence the numbers of cases soared. What this tells us, in much the same way that hysteria of the nineteenth century told us of women's distress brought on by surveillance, restrictions, in all manner of ways, socially, sexually, politically and emotionally, is that when we are distressed, we need an expression and this expression needs a name that is coherent with a specific time and place, a cultural storying of distress yet instead we/those with symbolic power reach for a label, in this case the ed label.

One study exemplifies the questionability of routinely using universal outcome measures in other cultural contexts. Le Grange et al (2006) used the Eating Attitudes Test (EAT) (Garner and Garfinkel 1979). with South African school children to see if these children also experience eds. One hundred black young people were then excluded from the trial after answering the question '*how often do you think about food*' they answered '*all the time*' because they were hungry and not 'eating disordered'.

Mumford, Whitehouse and Platts (1991) surveyed South Asian schoolgirls and white schoolgirls using the Eating Attitudes Test (EAT). Whilst they found no difference between the thinking of body shape they found that the South Asian girls average score was higher than the white girls, in other words, the scores reveal an increased risk of ed pathology compared to their white counterparts. Moreover, the

South Asian girls of the study were 'traditional' girls rather than 'assimilated'. This contradicted previous studies that had argued that an increase in eds amongst minoritised women was due to increased exposure to developed nation ideals and the pressure to assimilate, (Nasser and Malson 2009, Bhugra and Bhui 2003).

Smolak et al (2001) discussing the diversity of women in the United States, make the point that the majority of cross cultural studies focus on differences between 'black' women and 'white' women in terms of symptom presentation. They note that the dominance of this focus leads to the implication that it is 'white' versus all other minoritised women. Their argument is not only is there is an under representation of studies of other groups for example, Asian and Latina women, we also need to be aware that Latina and Asian women differ from African American women in presentation as much as they differ from white women. So for example, binge eating was found to be more common amongst Asian women whereas less common amongst Latina women highlighting heterogeneity between minoritised groups. Moreover, Cachelin, Phinney and Schug (2006) found that Mexican women were not only more at risk of binge eating disorder than their white counterparts, there was evidence that a strong ethnic identity protected against purging. The team hypothesised that the more acculturated to the host culture, the more at risk they were of developing eds. This was confirmed in the study and in addition that these at risk women were facing heightened pressure towards thinness as they continued to take on developed nations beauty ideals, (Tareen, Hodes and Rangel 2005).

Some studies report less eds amongst particular minoritised groups whilst others report the same incidence as white populations and in some studies, there is evidence of a disproportionate number of cases in diverse versus white populations, in particular for 'binge eating disorder and bulimia', (Nasser et al 2001, Watters 2010, Striegel-Moore and Bulik 2007, Franko 2007, Mumford et al 1991, Feinson 2011). This is an observation made by Littlewood (1995) that is, increasingly, as minoritised women have become acculturated to dominant modernist values including body image ideals, they too present with 'fat phobia', (Podar and Allick 2009), Fat phobia refers to the intense fear of gaining weight or

becoming fat and is part of the diagnostic criteria for 'anorexia nervosa'. The point here is that women from diverse cultures and ethnicities may not speak of 'fat phobia', rather they may speak of stomach ache or no appetite, the symptoms then viewed as physical, (Becker et al 2009).

There are studies identifying higher ratios of 'bulimia nervosa' amongst South Asian women compared to whites (Mumford et al 1991), higher rates of 'bulimia' in Trinidad (Bhugra et al 2003) and higher rates of 'binge eating' amongst Asian women compared with white counterparts (Bhugra et al 2003). There are studies arguing that the more acculturated the woman is, the more at risk she is, because she is trying to assimilate, (Cachelin et al 2006, Dolan 1991). Yet other studies report that women who are considered as remaining loyal to family traditions and who are not absorbing developed nations thin ideal, are also experiencing eds, (Mumford et al 1991, Lake, Staiger and Glowinski 2000, Striegel–Moore et al 2007). One small study revealed evidence of eds being triggered by Ramadan (Akgul, Derman and Kanbur 2014).

There is broad agreement that social, culture and biology play a part in the emergence of an eds, (Anderson-Fye 2007,Winchester and Collier 2003, Feinson 2011). Studies show that women who migrate to developed nations, or second generation minoritised women as well as women globally[14] may be at risk of eds. Sociopolitical factors impacting on the development of eds include migration, cultural beliefs about living in two cultures, power inequalities, gender roles/stereotypes, cultural beliefs and practices about the body, food and eating, racism and discrimination in work and education and language as well as stereotypes about minoritised groups, (Wildes et al 2001. MacSween 1995, Nasser and Katzman 2003, Keel et al 2003, Chowbey et al 2012, Lee 1995,1996, Cummins et al 2007, Becker, Arrindell, Perloe, Fay and Striegel-Moore 2010b,Cachelin et al 2006, Le Grange et al 2006, Smolak et al 2001, Tsong and Smart 2015). However, of all the social factors that are implicated in body image

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[14] Including Nigeria, South Africa, India, the Middle East, Malaysia, Japan, China and Hong Kong, Fiji

and shape disturbance most research focuses on cultural beliefs and practices about body shape and size whilst neglecting other social/political forces, for example of history such as the impact of slavery and colonisation, of power inequalities and of racism. By ignoring these wider factors we risk not identifying cases, (Smolak et al 2001). Moreover, fear of fatness and distorted body image is not always present in minoritised women, (Lee 1995, Lee 1996, Becker et al 2010b, Dolan 1991, Anderson-Fye 2007, Littlewood 1995, Littlewood 2002, Becker, Thomas and Pike 2009,).

Wider sociocultural factors are important in marking trends that may explain the rise in eds across the century but it may also obscure localised and specific issues. By studying across cultures researchers hope to learn how social influences become risk factors. The Fijian study by Becker et al (2002) shows that between two time periods, one before access to American/Dutch television, and one after three year access to television, the incidence of eds changed dramatically implying that exposure to modern body shape ideals lead to the increase, (Gilbert 2012). However, Becker repeated the study this time using qualitative rather than quantitative research, and found that thinness was a requisite for getting a job in the tourist industry and, therefore, desire for thinness was viewed as an economic factor, a demarcation of poverty, rather than an emerging mental disorder, (Becker et al 2010a).

The use of qualitative research in these studies provide a more nuanced conclusion; both the recognition that mass media is hugely influential in the dominance of body ideals whilst also recognising that it is not only mental health that is impacted upon, that economics are also an important factor in minoritised women changing their food intake for the sake of work. This finding was replicated in a study of women from Belize, who were pressurised into dieting for the sake of work, (Anderson-Fye 2007). A study in Curacao, a former Dutch colony by Hoek et al (2005), also undertook a quantitative study followed by a qualitative study had similar findings. In the Curacao study the socioeconomic changes appeared to show an increase in 'anorexia' amongst white and mixed race populations but not in the indigenous black population where no cases of 'anorexia' were identified. No

explanation was offered for this though I reflect that the black indigenous women are less likely to be eligible for work in the tourist industry due to other discriminatory pressures. There are other risk factors to be considered, not just the pressure to be thin. For example racism and acculturative stress may also impact on minoritised women's self esteem and emotional well being and act as a trigger for eds, (Gilbert 2012). Nasser et al (2009) argue that women get caught between two different types of culture. She argues it is more helpful to theorise eds as, Individualised solutions to sociocultural problems', or, 'A loss of voice in an oppressive world'.

Whether or not it is 'traditional' or 'assimilated' women who are more at risk of eds, there are few minoritised referrals to services. Studies highlight that the lack of referrals are because of family issues of shame and stigma about mental ill health, concerns about confidentiality and lack of knowledge in their communities as well as a lack of knowledge about eds amongst minoritised communities, (Chowbey et al 2012, Wales et al 2017, Waller et al 2009). These factors are compounded further by primary care providers being unaware of eds amongst minoritised women and in particular that the atypical presentation contributes to poor detection and access to specialist help, (Waller et al 2009, Chowbey et al 2012, Wales et al 2017). In one study, general practitioners were given a case study with the same symptomology but the ethnicity and gender were manipulated. Overwhelmingly minoritised women were not diagnosed as suffering from eds whereas the white females were. This ethnocentric bias in primary care warrants appropriate training of doctors who are the often the first point of contact for identifying eds, (Currin et al 2007, Williams, Turpin and Hardy 2006).

A/b research continues to be based on clinical descriptions of white American/ European patients and these case studies have formed the foundations of the diagnostic manuals, weight and height charts, and outcome measures, (Wildes et al 2001, Feinson 2011, Malson et al 2004, Striegel-Moore et al 2007, Smolak et al 2001, Cummins et al 2007). Both the biological and the sociocultural theorists, share the belief in the idea of a/b/eds as pathology. Sociocultural theorists focus on how social dimensions influence pathology and this paradigm remains subsumed

within psychiatric discourse, (Hepworth 1999).

There have been increases in eds across the twentieth century, said to be associated with society's increasing desire for thinness, (Keel et al 2003). Littlewood (1995) hypothesises that with increased modernity, industrialisation and technology, previous collectively organised societies are increasingly under pressure to migrate and to marry less, leading to increased individualisation. These changing processes are thought to impact on the development of eds, (Littlewood et al 2000). This rhetoric reinforced by notions that minoritised women are protected against eds because of perceived different values about body image, which has conspired together to create a context of colour blindness, (Chowbey et al 2012, Franko et al 2007, Franko 2007, Striegel-Moore et al 2007, Smolak et al 2001,Dolan 1991, Le Grange et al 2006, Cachelin et al 2001).

In summary, though presentations amongst minoritised women appear similar to white women as well as evidence to suggest there are disproportionately higher ed rates amongst some minoritised communities, as practitioners we need also to be mindful that presentations may not be typical, (Feinson 2011), and note that minoritised women may not be appropriating developed nations ideas of the thin ideal. Moreover, though the myth that minoritised women are protected from eds because of a cultural preference for larger bodies is largely discredited, a positive racial 'identity' rather than 'race' per se, is viewed as a protective buffer against body dissatisfaction, (Capodilupo and Kim 2013, Trepal, Boie and Kress 2012). Eds amongst minoritised women might more usefully be thought of as (Littlewood 1995);

> "*A reassertion of an instrumental strategy of self renunciation in situations of experienced constraint".* (*P45*)

Littlewood argues that minoritised women face complex pressures to both be seen to uphold family traditions whilst simultaneously being expected to assimilate to the host society, (Smolak et al 2001).

Ed Stories: Feminist, Poststructuralist and Narrative

I begin here with early feminist understanding of eds and contrast their position with the poststructural feminist/narrative position, (Orbach 1985, Lawrence 1989, Wolf 1994, Chernin 1986). These pioneering women were influential in putting gender at the forefront of thinking, highlighting how patriarchal structures directly impact on women's lives. Feminist authors argue that the social role of women and structural inequalities create oppression within patriarchy that lead to eds, (Hepworth 1999). MacSween (1995) argues that 'anorexia' is an extended example of how women both resist and are constrained by cultural concepts of the female body. The early feminists argued that the mother/daughter relationship is central to the disorder within the context of patriarchy, the term 'anorexic' is still used and recovery is viewed as the responsibility of the individual. However, the feminist writers maintained binary divisions in terms of gender and did not explore class and 'race' in their theorising, (Saukko 2009, Hepworth et al 1995, Bordo 1993, Thompson 1994). The rhetoric of a biological basis to eds continues to prevail over other explanations, (Bordo 2009, Orbach 1985, Chernin 1986, Piran 2010). Hepworth 1999).

The dominant narrative that sets womens bodies as a site of struggle where the feminine ideal of the thin, androgynous body is unrealistic and unattainable is explored in Wetherell's (1992b) discourse analytical study. The study interviewed non-clinical women about their ideas on body image and eating issues. Three main repertoires[15] for women were identified;

- 'Eating and dieting is associated with an idea of a 'natural self'
- 'To succumb to eds is a weakness'
- 'Resistance to the dominant story is undercut by the fear of society's lack of acceptance of being 'a bit overweight'.

This study shows us how 'non clinical' women construct what it means to be a modern "natural" woman in society; namely to be conscious of our eating behaviour, to dismiss the notion of being obsessed by body image whilst

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[15] Repertoires are a way of understanding the content of discourse Potter and Wetherell (2001)

simultaneously being afraid of being judged for being overweight. This positions women in a double bind where eating is both natural but to overeat is to be feared and to under eat is to fail.

Thompson (1994) discusses both the 'contributions and the limits of feminist theory' when considering eds amongst minoritised women. She argues that feminist analysis has been the clearest amongst the various models of explanation of eds, foregrounding patriarchy as an agent of power and control in the management of women's bodies and appetites. However, she also argues that we should not presume that minoritised women have the same struggles as white women. Whilst white women privilege the effect of sexism in their lives, additional oppressions may prevail for minoritised women, (Burman and Chantler 2003).

Holmes (2016) writes that it is hard to see how eds are not a feminist issue, where the feminist position is to ask how it is that the female body has become a site of struggle for women who are required daily to manage their appetites and deny themselves the comfort of food. Feminist/poststructural and narrative explanations of eds remain peripheral to the medical and sociocultural models, (Wetherell et al 1992b, Hepworth 1999, Malson and Burns 2009,Waldegrave 2009). Poststructural feminists, those who focus their critical gaze on institutions and practices that appear neutral, take sociocultural findings as a *starting point* for the understanding of eds, (Besley 2002). Their point of departure from earlier feminist and sociocultural explanations of eds is an important and nuanced one. They argue that it is not that the sociocultural environment *influences* the emergence of eds, rather it is how industrialised cultures discursively construct eds; that is, how culture is a *site* for the development of eds. It is the hidden power structures, the symbolic, economic capital and dominant narratives within which eds are constructed, (Malson 1999, Guilfoyle 2009, Hardin 2003, Bordo 1993, White 1983, Epston et al 2009, Maisel et al 2004). A woman becomes at risk of eds due to historical, colonial, political, social/cultural pressures yet it is the discursive structure that privileges individual biological and cultural explanations, such as the repertoires of Wetherell's et al (1992b) study above, over all other hypotheses, (Maisel et al 2004, White 1993, Malson 1999, Bordo 1993, Burns et al 2009,

Hardin 2003, Carolan et al 2010). From a poststructuralist perspective Malson (1999) sums this position well by stating that anorexia should be understood not as an individual pathology but as,

> *"A combination of embodied subjectivities, experiences and body management practices, embedded and constituted by contemporary discourse and practices of late 20th century postmodern culture."* (P137)

Poststructural researchers say little of biology and argue that sociocultural explanations are not enough in themselves to provide a complete understanding of eds. To adopt a sociocultural explanation creates the illusion that women are obsessed with shape and size, that they are vain and preoccupied with body image. Instead, we ought to look at wider social and political processes that are implicated in the position of women in contemporary society. Thus eds can be understood as both an expression of distress and an expression of how patriarchy, capitalism and modernism construct a context to amplify this distress, (Malson 1999, Holmes 2016). Feminist theories of eds are competing and overlapping. For example, a/b is a method of control over female lives that appeared to have no control, or the child-like body of women with 'anorexia' is seen as a response to rejecting traditional feminine roles, or resisting conformity to heterosexual identity, (Malson 1999). There remains a tension between postmodern/feminist conceptualisations of eds as a discursively constituted and the dominant biomedical and psychological paradigm that locates psychopathology in the individual woman with little focus to the gendered and sociocultural aspects of these issues, (Burns et al 2009, Fallon, Katzman and Wooley 1994).

Narrative therapists, influenced by poststructuralist and feminist thinkers, argue that developed nations cultural norms are the site for a/b to take root. They have worked to counter the strong moral tone of a/b, their anti a/b can be thought of as part of the externalisation technique but also about challenging a way of life that has been constructed for young women to be obedient, good girls. The anti a/b league affords women the opportunity to talk back to a/b. A/b is conceptualised by Epston et al (2009) as;

'A heinous morality of personhood capable of exploiting many dominant cultural values such as thinness, self discipline, individual achievement and plays on young women's hopes and fears.' (p210)

The a/b sufferer hears an inner voice with a 'strong moral rhetoric' and it is the task of the therapist to bear witness to help sufferers to separate themselves from the tactics of a/b. The narrative approach provides an approach to eds that recognises the problem is the problem not the person and therefore liberates women from a sense of failure and self blame, (White 2002, Churven 2008). As developing populations increasingly adopt cultural norms associated with the west, where the female body is on display and is emphasis is placed on competition and achievement, it is these norms that narrative therapist's argue put immense strain on young women, (White 1983).

The technique of externalisation, borrowed from narrative therapy, where the ed is viewed as an external figure, uninvited into the family system, where the family must work together to get rid of anorexia, is a widely used technique in the Maudsley treatment models and in my practice, (Epston et al 2009,Lock et al 2001). Dallos (2003, 2004) uses an attachment narrative approach when working with families with an ed member. He notes the difficulty in developing preferred narratives and this leads him to explore other domains to increase his understanding. He argues that insecure attachments impact on the production of thinly described stories. Foucault compares the analysis of modern power as a 'chilling analogy for anorexia', (Maisel et al 2004). Madigan (1992) utilises externalisation techniques and also puts the client at the heart of the encounter; so rather than holding the view that the sufferer has personality deficits he asks how the individual came to be recruited by a/b, (O'Shaughnessy, Dallos, Gough, 2013).

The collective narrative therapy approach of Denborough (2008) work with trauma can be an additional useful approach, taking the work out of the therapy room into schools and local communities, where the 'tree of life 'or 'team of life' are powerful tools for the bringing forth of stories of empowerment, using sport metaphors of 'coach', 'goals' and 'teammates',(Eames 2018).I think this approach may sit very

well with communities not accustomed to help seeking or who may be anxious about mainstream services or in schools.

As a final note in this section, whilst there seems to be a paradigm clash between the biomedical and the feminist/narrative approaches, Holmes (2016) found that her participants did not see the two groups as antithetical, suggesting conversations about gender could be brought into mainstream treatment. Piran's (2010) feminist approach towards prevention of eds, involves working in school based feminist inspired groups where she suggests it is not about change at the individual level but at societal level. Piran (2010) centralises gender as a risk factor in eds, her work involves dialogue about inequality and how this is played out in young girls lives, including discourses about violence, discouragement of sport of in order to be 'feminine' and the emphasis on appearance. She explores all aspects of being female and the implications for this within developed nations culture. However, there also is the critique that some feminist analyses do not bring forth working class, minoritised or lesbian women for whom eds are also in evidence but much less acknowledged, (Holmes 2016).

Ed Stories: Systemic

Family/systemic therapy for eds came into being following the recognition of poor outcomes following hospital treatment. Although good weight gain could be achieved in hospital, long-term outcomes were found to be poor, (Dare et al 1995, Eisler et al1997, Downs et al 2013). Before this recent period, clinicians, often psychiatrists, across Europe and South America were beginning to theorise eds systemically, learning from studies of other mental health conditions for example schizophrenia, where persons with schizophrenia recovered in hospital only to relapse once in the family environment. More over, psychoanalytical psychotherapy was also proving ineffective, (Palazzoli, 1977, 1985, Minuchin et al 1978). Following Palazzoli's dissatisfaction with the psychoanalytical approach, she set up the Milan team and began working with families where she argued that there were two commonalities in families with an anorectic member. One, that did not allow for conflict in the couple relationship and two, in order to manifest this

harmony, typically the mother invested in her daughter creating a dependent and immature yet compliant daughter. She described the parents as appearing super competent yet failing to allow for adolescent individuation. She sets this in the social context of modernism, which acts as a trigger for the emergence of the ed, that food abundance paradoxically creates a context for restriction unlike during the war in Italy when she notes there were no anorexics, (Palazzoli 1985). When the Milan team split, Palazzoli and Prata continued to work together and developed their 'Invariant or Universal prescription' method which creates a structural boundary between parent and child subsystem addressing enmeshment (Palazzoll 1977). This was designed to disrupt unhelpful patterns evolving between parents and their child with 'anorexia'. It involved parents being told to take a trip out of the home, to leave a note saying when they would be home, not to explain beforehand and not to say what they would be doing. The effect was to disrupt any unhelpful coalitions between family members and place parents back as a cooperating united couple, and in so doing to reinforce the hierarchy within the family through increasing separation between the generations, (Tomm 1984). Minuchin et al (1978) observed something similar, noting enmeshment and superficial harmony amongst family members, where beneath the façade, was rigidity and perfectionism. These models helped to shift the focus from individual to family pathology, highlighting the disturbed interactional patterns in families with an anorexic member (Stern et al 1981). Stierlin and Weber (1989) family therapists working with eds, practicing and conducting research in rural Germany helpfully remind me that the therapist is part of the system, a factor often not referred to in the manualised approaches. They were interested in common factors amongst ed families and in long term follow up of treated families, what happens after treatment ends? Their systemic approach reminds me of the post Milan style of therapy that I practiced in my earlier career, paying attention to life cycle transitions as triggers for problems, (Dallos and Draper 2000). Whilst both the Milan, Minuchin and Stierlin teams offered a family perspective, representing a change from individual psychological theories before this, the view that families were to blame for their child's ed pervaded the field for decades. The problem of the 'psychosomatic family' was said to 'confound correlation with causality'. (Depestele, Claes and

Lemmens 2015, Holtom-Viesel et al 2014, Minuchin et al 1978, White 1983, Dare et al 1995, Eisler 2005, Eisler 2002). Ed theories aside from the poststructural/narrative theories placed the individual or the family as pathological; causes were linked to biology, the family or psychodynamic issues, (MacSween 1995). Controversy about family role in aetiology remains, where the orthodoxy of the current research is challenged by Dring (2015) who revisited notions of causality, though his thesis is presented as 'either' genes 'or' family', neglecting to note the complexity and multifactorial nature of the emergence of eds, (Dodge and Simic 2015,) Recent outcomes evidence places systemic therapy at the heart of treatment, where families are collaborators in treatment is the latest position outlined by the Le Grange, Lock, Loeb and Nicholls 2010 of the Academy of Eating Disorders who draw a line under the negative positioning of families, viewing them as a treatment resource, (Schwartz et al 1982, Downs et al 2013, Eisler et al 2016).

The current approach to treating adolescent eds is founded on systematic research with techniques come from Haley's Strategic therapy (1987) where the clinician is agnostic to ideas of causation and from White's (1997) ideas on externalisation enabling the parents to take charge of the condition by collectively working to rid the system of the ed, (Lock et al 2001, Eisler, Le Grange and Asen 2003). Post Milan ideas are drawn on, parents are seen as the experts, refeeding advice is not directly given, parents draw on their own knowledges. The structural therapy techniques of enactments and sculpts are also widely used. For example, a useful sculpt is to invite the family to show the family structure, before during and after ed entered the family, (Rhodes 2003).

The Lock et al (2001) treatment manual has been updated with a more systemic collaborative focus, for example on the therapeutic relationship, (Eisler et al 2016). The bringing together technical and relational skills in the form of evidence-based practice is a hopeful move, though I notice a semantic polarity between systemic colleagues regarding manualisation. At one end of the polarity is intuition, and relational expertise; at the other, manuals represent 'technical non-systemic scientific expertise,' (Ugazio 2013, Fruggeri 2012). The point is that as systemic

practitioners we should critically challenge positivist research viewing randomised controlled trials as 'guides in need of interpretation', (Larner 2001). Eisler (2002) accepts that research in systemic therapy is important, but goes on to say there is more research in the field than people are aware of and that it is not research but an academic structure that is missing in systemic therapy compared with other disciplines, (Rhodes and Madden 2005a, Barker, Pistrang and Elliot 2016).

Whitney, Currin, Murray and Treasure (2012), recognise the contribution of qualitative studies in ed research arguing that the clinical realities are not picked up in quantitative studies and can help to improve medical understanding. They explore the impact of family based therapy on carers with families reporting what is helpful and what more they would like from services.

The question of what constitutes evidence in psychotherapy remains narrow but systemic research has had to demonstrate a keeping up with the times by showing what works in therapy whilst also having to critique positivist research' impact on systemic practice, (Larner 2004). My day-to-day working practices are informed by the modernist paradigm as I navigate between neurodevelopmental ed studies, (Schmidt et al 2013), psychiatric ed studies, (Peterson et al 2016) and family therapy ed studies, (Eisler 2013, Rhodes et al 2005b). This paradigm affords a good fit with a manualised approach to working with adolescents with eds and their families, (Lock et al 2001).

In my clinical practice, we offer 'a family based approach to eds, contrasted with the notion of 'generic family therapy'. Eisler (2013) asks whether ed treatment is

'Family therapy with eds as a specific form of family therapy',

 or is it

'Family therapy with a specific focus'?

Eisler answers his question in a typical both/and way, suggesting that yes, these specific approaches *are* family/systemic therapy *and* they are very specific

treatments aimed at mobilising parent/s capacities to re-feed their child. Within this model eds are viewed as the paradigmatic mental health concern warranting a family approach, (Eisler et al 2016).

There is no systemic research on culture and eds. However, there are numerous systemic qualitative studies exploring culture in a variety of ways. For example, Pakes et al (2007) analyses family therapy sessions for their culturally sensitive practice in recognition of the inequality of access for minoritised persons to therapy services. Singh (2009) compares and contrasts the construction of family in intercultural and intracultural family therapy. These qualitative studies, whist not ed specific, can help prepare for ed research by attending to family life cycle differences; by not privileging the 'nuclear family' over other forms of family and deconstructing taken for granted ideas about family and intercultural therapy.

Ed stories: Towards Holistic Ideas on Recovering[16]

The process of recovering from eds remains poorly understood, studied mainly within the biological paradigm. Recovery is viewed as the return of biological health such as a healthy weight and menstruation. Within these narrow parameters, between fifty and seventy per cent of sufferers with ed recover. (Kaye 2011, Eisler et al 1997, Kakhi et al 2016, Davidson et al 2005*).* There is little to draw upon in the literature that specifies how recovering is constructed amongst culturally and linguistically diverse persons. As professionals working interculturally we need to,' understand that recovery and its principles are not universal concepts' (Mental Health in Multicultural Australia 2014). Minoritised women in the UK face the ubiquitous pressure alongside their white counterparts, to be slim, differentiating their experiences from their mothers and grandmothers, who may have been encouraged, even revered for plumpness, usually a sign of wealth, for example those of Chinese and South Asian heritages, and thinness can be taken as a sign of a physical illness such as AIDS,(Littlewood 1995, Chowbey et al 2012). With

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[16] In this study I have referred to recovering though the literature refers to recovery- my view is that there is a process of recovering involved rather than a fixed notion of recovery, partial recovery, no recovery

increased globalisation this reverence is changing and fat is viewed as problematic, (Lee 1995, 1996). In conversations with the storytellers and from the literature, racially diverse families have a range of knowledges and understanding about what eds are or what mental ill health is in general. In the same way we should not presume the pathway to ed is the same as white women, nor can we presume recovering is within narrow biomedical parameters. The poststructural feminist writers are the first authors to write of recovering beyond biomedical explanations, invoking patriarchy and modernism as cultural constructions creating a context for the expression of eds. Once the ed is experienced, recovering sits within the same paradigm of patriarchy and modernism and the limitations of this are discussed above. The literature that is interested in minoritised eds, focus on access to services and identification of eds with little to say about recovering, (Becker et al 2010b). In the same way that minoritised women are not asked about the story of food in their family, or about religious or spiritual connections with food, (Becker et al 2010b, Chowbey et al 2012) nor is the notion of recovering afforded conversation. Yet another 'shy' story' (Partridge 2017) that is brought into being within this inquiry that new ideas of recovering are constructed in the dialogical conversations and are discussed in the findings below.

I turn both to memoir and to ethnographic writing for stories of personal recovering (defined as a form of research of a particular social experience, in this case, eds and diversity). A typical ethnographer immerses herself in a community as a participant observer gathering an insider view over a period of time, (Suzuki, Ahluwalia, Mattis and Quizon 2005). Within the researcher/participant relationship it is possible to develop a relational ethnographic approach, involving writing and dialogical talking within that relationship, (Simon 2013).,(Elliot 2010, Garrett 1998, Hornbacher 2010, Chernin 1998, Saukko 2009, Kleinman 1987)., Poor recovery is in part related to a/b being constructed as 'within individual' pathology and therefore it is down to individuals to rid themselves of their 'perfectionism' and other deficit traits. If recovery is constructed in this way, that is as within the 'essential self', 'anorexia' is 'one's identity' and to give it up is a frightening prospect, (Malson et al 2011). Hardin's (2003) study goes beyond the

individualistic focus of many mainstream studies. She explores recovery, arguing that ideas of recovery are embedded in social/cultural narratives and neo liberal values such as individualism, health and fitness and dieting rhetoric and the ongoing critical self surveillance of women. Both Hardin (2003) and Malson et al (2011) studies show that recovering leaves women feeling outsiders to dominant narratives about the need to lose weight or the need to go to the gym. Recovering is both biological and social and highlights the importance of dialogue with the ill person about their stories of pain, worry and fear. It is these ethnographic explorations that Kleinman (1987) found helped with the recovering process; the sense of being listened to, engaged and connected with rather than treatment is being done to you, (Holmes 2016).

In summary though the biological and sociocultural paradigms do not to overlap theoretically, both view eds through the biomedical lens. It is argued that there is a co evolving process between biology and culture that is contributing to eds in societies where it had not been previously seen, (Pike 2013). The poststructural literature by contrast makes transparent the historical and societal conditions that create a site for the development of eds, as distinct from a within-person pathology. Importantly from the narrative perspective, the idea that eds are a moral rather than a medical concern adds a useful counter position to the dominant narratives, (Malson et al 2004, Hardin 2003, Garrett 1998, Hepworth 1995). It is within the narrative/systemic/dialogical frame that recovering can be seen as an act of resistance, of talking back to a/b/ed; the anti a/b/ed position and in so resisting, that women talk back to the historical and social legacies that created the context for eds to thrive, (Epston et al 2009, Bordo 2009, Hare-Mustin 1994).

It is in this spirit that I have sought marginalised literature and discourses as a stance of resistance and to counter mainstream ideology. It was the frustration of having no answers, of having little literature or theory to draw upon that lead to this journey and the next chapter sets out how methodological issues were thought about and decided upon.

I move now to the methodology stories.

Chapter 3: Methodology Stories

In this Chapter I continue to scaffold the inquiry developing coherence regarding methodological choice, different research paradigms, intercultural and doubled research and the question of 'othering'. I critique the dominant research paradigm then I explore why we study stories within the narrative research paradigm. I explore methodological plurality and 'doubled research'. I show the dialogical potential of stories and I introduce the dialogical narrative approach to research (Frank 2010). Finally I end with a particular type of story, the collective story, a shy and infrequent visitor in qualitative research, (Partridge 2017) yet arguably a powerful construct to bring forth the politicisation of subjugated stories, (Hawes 1998,Harper and Thompson 2012). This chapter maps the story of how I interrogate the material co produced in this inquiry, (Ponterotto 2005, Harper 2012, Reicher 2000).

What do I mean by Methodology?

Methodology centres on assumptions about how knowledge is produced and thought about. I explore the assumptions that methodology makes about the world, and about how I am understood in the research process, (Willig 2010). There are several consequences of embracing a social constructionist research perspective. I view human experience as mediated through history, culture and language. Central to this position is awareness that my chosen methodology will produce 'knowledges' rather than one overall, unifying 'knowledge'. I question taken for granted assumptions about the world and the acquisition of knowledge/s. For example, within this study, I view a/b/eds as a social construction rather than as an internal medical/psychiatric condition, (Willig 2010).

I do not seek to disentangle what there is to know from how we can know, by that I mean to make the distinction between ontology and epistemology. For poststructuralists it is not *what* exists, but what we can *say* exists, in other words what claims can we make about the world, (Belsey 2002). We 'are', that is we exist, and we 'know' in the same space, it is not split off. From this position, we are

material, embodied human subjects. I take from Butler (1990) that social categories exist in the material sense. There is no binary split, two aspects of humans are their ability to tell stories and their ability to talk of their bodily experiences. This philosophical perspective not only fits with dialogism, itself anti binary, it is suited to systemic, narrative and intercultural inquiry. Dialogue is not only about language, words, discourses or narrative but is also about lived, felt experiences. It is this lived experience of embodiment and the stories that unfold through our bodily experiences, the material and the discursive and the inseparability of both that I explore, (Malik 2000, Afuape 2017).

The Quantitative Research Paradigm: Boastful[17] Voices in Ed Research

This research paradigm, also referred to as 'outcome' 'realist, 'positivist', 'modernist' or 'essentialist' research has dominated the scientific community for some four hundred years. Drawing on the natural sciences, 'objectivity' and 'rigour' is sought via the scientific method. Knowledge production is viewed as value free, uncontaminated by the researcher and can be characterised by the 'lab experiment'. In this paradigm there is a reality out there waiting to be discovered, this is the ontological reality. The knowledge produced is independent of the researcher's awareness and the findings of the study should be 'valid, generalizable and reliable', (Barker et al 2016). In her exploration of this, Willig (2010) asks, *'how can we be sure that our data collected will help to answer our research question/s? Why should the reader believe the findings?* This is the question of 'validity' or what Reissman (2008) calls 'trustworthiness'. The issue of 'generalizability' is interesting in how it may be understood in qualitative research. Can I generalize my findings from this study? Do I want to generalise my findings? Generalizability relies on the use of standardized methods, designed to *minimise the influence* of the researcher and is a common practice creating an illusion of objectivity, (Guba and Lincoln 1994, Breuer, Mruck and Roth 2002). By contrast, in qualitative research, the subjectivity of the researcher is centralised not minimised.

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[17] Partridge (2017)

Reliability is about someone else replicating the study and is said to be reliable if the same answers are found in a future study. Willig (2010) suggests this is of less concern for qualitative researchers who often research one phenonomen in great detail. Thus it is possible that it cannot be replicated, moreover it may not be desirable to do so.

Qualitative Research: The Shy[18] Voice in Ed Research

There has been a shift to qualitative research in the social sciences due to dissatisfaction with ideas of objectivity and of obtaining reliable knowledge, (Ratner 2002, Madill, Jordan and Shirley 2000, Breur et al 2002). Within the qualitative paradigm there are disciplinary and theoretical differences bringing forth ideas about the nature and production of knowledge, (Willig 2010, Madill and Gough 2008, Barker et al 2016). For example, Madill et al (2008) divide methods for analysis into 'discursive, thematic, structured, and instrumental'. 'Discursive' includes discourse analysis and conversation analysis focusing on the study of talk; 'Structured' includes methods that help to convert qualitative data into numbers such as repertory grid analysis; 'Thematic' includes grounded theory and 'Instrumental' includes participatory/cooperative inquiry methods and narrative analysis. It is possible to undertake narrative research from a discursive/language-based epistemology or from a phenomenological perspective, where participants are viewed as experts on their experiences; in other words, it is possible to apply different epistemologies to the same methodology, (Kemmis and McTaggart 2000).

Implications For Research of the Different Methodological Choices

In this section I discuss the methodological possibilities that I considered in this study. When I was developing the research proposal, I was attracted to discourse analysis because of its political, poststructural feminist insights with its application of discourse theory to the study of talk in interaction, (Weedon 1987). Discourse

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[18] Partridge (2017)

analysis problematises talk and text; what a person says is not a mirror to an experienced reality but is constructed from a range of repertoires available to her in her talk, (Gough and Madill 2007). I read Emerson and Frosh's (2009) critique of a discourse analytical study of white New Zealander's 'racism', where participants were seen as 'judgemental dupes' and I felt uneasy. I found discourse analysis' emphasis on text over the subject problematic as the participant appeared subjugated in favour of the text or discourse, (Madill et al 2008,Potter and Wetherell 2001, Tseliou 2013, Georgaca and Avdi 2012). In reflecting on the subjectivity of the participant, I realise I neither view her as 'uncomplicated', in other words, where the interview material is viewed as the Truth and therefore 'objective', nor do I view her as passively constituted by discourse, a blank subjectivity as in discourse analysis, (Gough et al 2007).

The Cooperative Inquiry paradigm has its roots in several philosophies and parts of the globe drawing on liberation and social activism approaches in Latin and South America and Asia, (McArdle and Reason 2008, Freire1993, Afuape 2016). The introduction of this paradigm highlights the cross fertilisation of ideas and the influence of different paradigms shaping the literature, (Cooperrider and Srivastva 1987,Guba and Lincoln 2005, St George, Wulff and Tomm 2015). I relish the idea of sitting amongst 'co researchers', affording transparency and a commitment to the shared research endeavour though I knew I did not have access to a group of participant/collaborators, (Cooperrider et al 1987, Reason and McArdle 2008). In this paradigm storytellers are not positioned as subjects or as 'other', fitting with my epistemological frame. The idea of the nine storytellers coming together to develop the research questions based on their collective experiences, for us to collaborate on an exploration of their questions, I think would have been very exciting, (Reason and Heron 2001).

Ethnography is increasingly used in the social sciences, involving immersing oneself, not only in 'exotic/native' cultures but also in local cultures such as the 'ed' culture, (Grant et al 2015). Warin (2010) spent several months in in patient ed facilities making relationships with women and engaging on a very personal level with their stories. The idea of prolonged immersion in the community being studied

appeals to me but the limits in terms of availability of participants prevented this methodology from being suitable, (Potter and Hepburn 2005). Instead, I have drawn on 'autoethnography' as I bring forth connections and distinctions with my own history, (Suzuki et al 2005).

When choosing a methodology I have to first consider what it has to offer the research question. For example, if I were to test a new drug I would not choose a qualitative methodology, whereas I would choose a qualitative methodology to explore patients' experience of the new drug, (Bryman 1998). In the ed field the majority of studies are within the quantitative paradigm though there are also a number of qualitative studies, for example inquiring into parent to parent support and parent support groups, (Krautter and Lock 2005, Nicholls et al 2012, Rhodes et al 2005b).

It is possible to operate within the positivist paradigm and undertake a qualitative methodology, for example in some types of grounded theory, (Corbin and Strauss 1990). Data can be analysed from different epistemological positions, for example a realist and a social constructionist position, or it is possible to undertake a content qualitative analysis to include numbers. Qualitative and quantitative methodology can both be used in narrative research, (Harper 2012, Burck 2005b, Barker et al 2016). The choice then is to think about what do the different paradigms have to offer my research questions and the kind of knowledge I hope to produce.

Many researchers now argue for permeability and plurality between the paradigms rather than approach them in a binary, either /or fashion, (Madill et al 2008, Sprenkle and Moon 1996, Maracek 2003). Not only are researchers thinking about pluralism in methodologies, advocates of the participatory action/cooperative/appreciative inquiry paradigm wish to avoid the dualism of research versus practice and indicate that the merging of the two is more harmonious, ethical and a galvanizing force for social action, (Oliver and Barge 2002, Browne, Chien and Cawthorne 1998, Piercy and Thomas 1998). Whilst methodological pluralism is argued for, McNamee (2014) argues that the research

worlds are not yet well connected. The first research world she refers to is the quantitative world of science, of measurability, of validity and generalizability; the second is qualitative research that McNamee further divides into two; 'traditional/interpretative' and 'relational constructionist' world. Modernist research can be both 'quantitative/qualitative' and constructionist research is referred to as 'relational inquiry'. McNamee argues we should not dismiss one type of research as better or worse, that instead we see each research world as a construction, rather than as a truth, and that we question our taken for granted beliefs about research, (Barker et al 2016, Sprenkle et al 1996, Smith, Hare and Van Langenhove 2001).

I am drawn to researchers who effortlessly and harmoniously appear to bridge divides that appear contradictory. It is becoming possible to bring practice ideas from the systemic setting, to talk with commissioners about embracing empirical studies and to maintain ongoing relationally engaged conversations, rather than the often one sided conversations about evidence only, (Simon and Chard 2014, Tilsen and McNamee 2015). My clinical practice relies on my ability to keep in mind both modernist and postmodernist practices and the relative influence of each.

Coordinated Management of Meaning (CMM) and the Systemic LUUUTT model

I came across the LUUUTT model some way into the study. The acronym stands for, stories **L**ived, **U**nknown stories, **U**ntold stories, **U**nheard stories, stories **T**old and story**T**elling, (Pearce et al 1998). This model is taken from Coordinated Management of Meaning, CMM where CMM is a practical theory for the exploration of communication. Within CMM, the world is context dependent, where our experiences are mediated through a number of contexts including the political, cultural, family, event episode, dialogue and embodiment, (Hannah 1994, Afuape 2017). I see the links between CMM and dialogical theorists who ask similar questions both drawing on important questions about 'how we can live better lives' and 'what patterns of communications are most conducive to living with dignity, honour and joy?' and resonates with Frank's (2010) ideas of authenticity, that is

created within the process of storytelling. The model helps to engage with stories by inviting the co construction of stronger richer stories to be brought forth, Stories told, are those that we tell of our lived stories. There may be tensions between how we wish to live and how we are living, so that when we tell our stories, we do so in the way we best know how, to perform our desired sense of self in the stories. The unknown stories are the ones we are not capable of telling. The untold ones are those that we *can* tell if we want to but we choose not to. Unheard stories are those that have been told previously but have not been listened to by those who ought to have listened. Stories of eds amongst minoritised women fall into all of the story categories. In this inquiry I ask that stories are told. I presume the storytellers tell the stories they want to tell and that they want me to hear. This involves a tension between the stories lived and the stories told. Part of telling stories is to enable the teller to make sense of the lived stories in the retelling, (Pearce Associates 1999). It strikes me as I end this inquiry that I could have furthered my analysis by drawing on CMM given its social constructionist sensibilities and how it embraces embodiment and culture, (Afuape 2017). I have not embodied CMM in training or in clinical practice. Yet in some ways the CMM paradigm is intuitively how I think and feel, I am immersed in and recognise the hierarchical processes around us, the contextual systemic frame bearing down on us and the implicative forces of resistance that occupies all our endeavours be they individual, personal, community or cultural.

Why Study People's Stories[19]

This strikes me as a fundamental question. Storytelling is universal and occurs throughout time. Often there is a moral component in our storytelling about who we are as a family, as a community, who we are and who we are not. For Frank (2012) the narratives of persons and their ill health, their 'personal troubles' become

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[19] Frank (2002) asks this question. (P109)

'public issues' once out in the open creating the potential for change. Personal stories or personal troubles can be seen as 'trivial' in research terms. Bourdieu (1993) quoted in Frank (2002) calls this reduction of stories as trivial 'symbolic violence.' In my clinical work symbolic violence occurs when young women tell us that the treatment is challenging or unhelpful; that we are more interested in their parents stories than theirs. It sharpens my awareness to ensure that I hear those stories too. The process of telling stories are dialogic through which we come to make sense of the world through our lived experiences. Frank (2002) argues that just because stories are drawn from a conventional pool, meaning cultural stories, they are still authentic stories. My task is to unpack cultural assumptions embedded in the narratives and to bring forth the preferred rhetoric within. I look for precious hidden, shy discourses buried within conventionally told stories, looking for pots of gold within the dominant illness narratives, (Kleinman 1988,Partridge 2017). I am not interested in looking for within person explanations that is individual responsibility for illness. Rather, I look more broadly at minoritised womens' experiences of embodying growing up in a multi cultural society, (Warin et al 2008).

Intercultural Research: The Process of 'Othering' in The Context of Colonization Practices

Research sits within a historical and postcolonial context. It does not matter which methodology is chosen, it comes from a historical context within which some research has harmed, belittled and pathologised its participants, (Bhavnani 1993). For indigenous persons, research is a dirty word, where knowledge is collected *about* them, classified and written up in the developed nations, (Tamasese 2000). This is called 'othering', a term coined by De Beauvoir (1953) who referred to woman as 'other'. Said (1979) applied this concept to non-whites. 'Othering' is a process by which dualities of power and powerlessness, of dominance and subjugation can unwittingly be played out in the research process and therefore requires that I, as researcher, reflexively attend to these factors, (Ayo 2012). Being 'othered' is to position a person outside of discourse and therefore deprives them of the ability to answer back or disagree with research findings.

Whilst the intention of early anthropologists was to find out about 'the other', what happened was that indigenous persons were rendered exotic, seen as less capable of abstract thought, of being less developed, subjected to the colonisers gaze and the othering process creates a context for racism, (Denzin and Lincoln 2005, Bourne 1991, O'Brien 1990, Fine 1998, Tamasese 2000).

Research is more than the task of interviewing and analysing but involves contextualising research in epistemology and politics including the debate about meanings of the categories of race, culture and ethnicity, (Gunaratnam 2003, Dickerson 2014). By not paying attention to these processes we end up with is the domination of developed nations health systems to the exclusion of traditional systems. Even the desire of slaves to escape captivity was given a mental illness label of Drapetomania.

Before colonization, many cultures had their own health and healing systems but increasingly these were replaced by the health systemic of the dominant colonial societies and research followed, suppressing traditional practices in favour of 'modern' ones. Folk therapy, traditional and spiritual healing based on oral traditions became increasingly restricted as psychiatric asylums took their place, (Bhugra and Littlewood 2001).

As I reflect on these dominant contextual forces, I consider my own positioning. At first, I wanted to create a context for giving a voice to those who are not in a position to bring forth dialogue of ed experiences to the wider community. However, I now counter this with the idea that I am the one who prepares and asks the questions, I set the agenda, and I have control over the analysis. Reflexivity helps by demanding that I give an account of my processes and biases. I practice a 'hermeneutics of suspicion' (Kvale 2006) in other words, resisting ideas of truth and finalized knowledge, being sceptical of any claims I make and acknowledging I am writing of others. An example of how this lack of reflexivity can impact is an example described by Fine (1998) when she comments on a study where an able bodied researcher researching disabled people wrote up the study 'as if' there was no impact on her as the researcher; no fear or dread that she might become

disabled.

A counter to these unconscious biases in the dialogical research approach is that I work to ensure the storyteller is not effaced. I am mindful that anything I say about a storyteller is something a storyteller would or could say about herself. As a researcher with privilege, I act as a curator of stories so it is incumbent on me to maintain my reflexivity and transparency. (Roberts 2005, Frank 2010). The tension is about speaking or not speaking of other. White (1997) was known for not speaking of others but with others, (Denborough 2014). If I speak of others I risk colonising their words, passing them off as my own, if I do not speak of others, I risk positioning the other as being unable to speak of me (Richardson 1990). I choose to speak of others, whilst asking how it is that the storytellers of this study are not in a position to tell the stories for themselves, (Kitzinger and Wilkinson 1996, Richardson 1990, Fine 1998). To manage the risk of othering, I ask questions in a tentative manner to enable the storytellers to choose whether or not to answer. I expressly make this clear at the start of the interview. I choose not to delve deeply as this was a one off meeting. I share personal information both of the visible and invisible social GGRRAACCEESS [20], referred hereafter as the SG's, with storytellers, (Divac and Heaphy 2005, Totsuka 2014). I also enable opportunities for storytellers to ask me questions. By affording this degree of reflexivity and transparency I hope it has the effect of militating against the effects of power, (Burnham 2012, Frank 2010).

Intercultural Research in practice

I reflect on the meaning of my similarities and differences with the storytellers in terms of skin colour, age, ethnicity, race and culture. Ethnic matching was prevalent in 1950's United States survey research. On the one hand, as exemplified by some feminist studies, insider status, for example both being women, can enhance the research process. Whereas attempts to ethnically match

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[20] The acronym stands for 'gender, geography, race, religion, ability, age, culture, class, ethnicity, education, sexuality/orientation, size

was found to be problematic in Gabb's study; that is when confronted with 'what is Asian?' is there a homogenous group that an 'Asian' researcher could be matched to and be therefore seen as having insider knowledge? How is privileging one social difference afforded over other social differences such as age, religion, or class? (Gabb and Singh 2015). The SG's are not fixed and final and are subject to interpretation. The idea of ethnic matching or any other sort of matching carries within it modernist connotations and therefore whilst these factors should be considered in postmodern research, they should not define it, (Crozier 2003).

In this study, I have no expectations of insider knowledge. I am a researcher of dual heritage. I belong to many overlapping and distinct subjectivities. Though I share commonalities with other dual heritage researchers, there are also differences. Interracial research is complex whether there are observable similarities in terms of skin colour and recognising that whiteness is a racial category also. Assumptions of sameness and difference need to be reflexively considered, (Nolte 2007).

One Size does not fit all: Critiquing the Quantitative Research Paradigm

One important critique of the quantitative paradigm is from a cultural perspective; Outcome research is not sophisticated enough to cope with difference, rather it actively seeks to minimise difference. Its Universalist principles reject findings that do not quite fit and are either dismissed or viewed as 'atypical' 'local' or 'accidental', (Littlewood 2001). The fact that it does not work, or is not tested on a percentage of the population is of little regard in this worldview. It becomes a self-fulfilling prophecy where as clinicians we are guided by these findings, we generalise our practices across cultures and in so doing, we perpetuate patriarchal structures by ignoring issues of power and control, (Tilsen et al 2015, Flaskas et al 1993). Moreover power continues to be held, for example, by drug companies who provide funding to show their product is effective and thus add fuel to the notion that there is only one form of respectable research and is the only way to achieve scientific validity, (McNamee 2010, Tracy 2010). Moreover, quantitative research has been criticized for its narrow repertoire of measurement at the expense of the

less tangible concepts such as emotions and experiences, (Barker et al 2016).

Reason et al (2001) use the term 'orthodoxy' to describe the quantitative methods of research and suggest they are a divisive form of research where the knower is separated from the known, a political event where the researcher is in charge of all aspects of the study and the subject is a passive recipient of observation. Their Cooperative Inquiry model by contrast emphasises that the participant 'participates' more fully in the research and is not a passive recipient.

Outcome studies nevertheless provide important insights, appeal to service providers and have been essential to ensure that systemic psychotherapy continues to be relevant in the world of commissioning arrangements and what constitutes best evidence. However clinicians often report a poor fit between research findings and their own clinical practices, (Simmons et al 2008, Eisler 2002). As systemic therapists we need to look to outcome studies to see what works in therapy whilst continuing to critique the overreliance on a positivist science model on systemic practice where the question of evidence relies on very narrow parameters. The concept of practice based evidence, emphasizing clinical practice that gathers data in a systematic way and analyses the outcomes, so 'continuously examining our curiosities', is argued for by Larner (2004).

Doubled Research and Doubled Listening

Historically, research communities tell many competing stories where some stories are privileged as a consequence of the sociopolitical and colonial context, whilst others are subjugated. This is a central strand of the study as I seek to bring subjugated stories to a visible position. In order that reflexivity in a study attending to race culture/ethnicity and gender can be enshrined, I find the practice of 'doubled research' enables a both/and methodological approach to this study. It is a reflexive practice for undertaking qualitative research where social identity is being explored. Using this concept helps with the tensions, contradictions and challenges within research, clinical work and personal life. On the one hand there is the issue of the lived experience of storytellers as 'racialised, embodied,

gendered, minoritised women and on the other, the essentialisation of such categories. We need both in order to disrupt essentialism, (Gunaratnam 2003, Brah 1996). Doubled listening (White 2003, Marlowe 2010) allows for a dominant troubled story to be put alongside a more hopeful story within the therapeutic relationship and in research. The notion of 'double' has a particular resonance for me. 'Double', 'two', 'dual', 'binary', 'dichotomous', are all connected to a world I inhabit. I have a dual, mixed race/ bicultural identity; I have a tendency to 'see both sides' in my clinical, personal and research contexts. Whilst occupying this double space, I sometimes fail to see one side as being preferable to the other. I have felt positioned and at times, have positioned myself, subjugating my cultural heritage, often not foregrounding it where I perhaps ought. I mentioned this example in the introduction; I did not respond when a colleague said to me, following some training I offered on culture and eds,

> *"This is your own political agenda, Kamala"*

I felt upset and marginalised, my voice not valued, my message lost. I flag this up again because it is both a strength and a constraint at different points in the research journey. Burck (2005b) is interested in the 'double self' concept. Her study was with participants living in two languages. Her study resonates with mine; migration leads to disruptions in the 'narratives of self' and as a consequence Burck argues by constructing her participants as 'doubled, enables a sense of coherence as replacement for the incoherence and disjuncture of their lives. In this way, I may position the storytellers of this study in such a way to enable increased coherence of their stories and life experiences.

Narrative Research Methodology: A Good Enough Fit

The choice of narrative methodology is a good fit between my world view, my love of narrative in literature and because the storyteller is at the heart of the analysis. The integrity and authenticity of the narrator is honoured, every effort is made to ensure their stories are not reduced to themes or disembodied from them, or rendered as text without *embodiment* in a social and historical context, (Squire

2009, Reissman 2008). This research paradigm looks at experiences and is interested in the every day lives of people, (Gough et al 2007, Smith et al 1995, Guba et al 1994). The idea that 'research tells a story', appeals to me, yet such a simple idea hides much debate about what constitutes good research or a good story.

Narrative research derives from the hermeneutic phenomenological tradition associated with Heidegger and Gadamer, (Murray et al 2012). This tradition is interested in interpretation. Narrative in the developed nations tradition is a *particular sort* of story, the key ingredients are that narratives have structure, plot and time sequence, in other words, a beginning, middle and end. Narratives can be spoken, written or visual and can be a whole life story or the answer to a single question. Reissman (2008) talks of 'narrative being everywhere, but not everything being narrative'. She distinguishes between 'a story' which 'speaks for itself' and 'narrative' as requiring interpretation, often having more than one meaning. She acknowledges that narrative and story are used interchangeably though for her, a story is just one kind of narrative. She cautions against offering a 'catch all' definition arguing that its diversity across disciplines, epistemologies and history makes this difficult.

There are several versions of a narrative research approach across disciplines. Contemporary narrative research has emerged from two parallel paths. Whilst there are some commonalities, for example narratives are viewed as opportunities for resisting power structures and discourses, the biggest division is how language is conceptualised, (Andrews et al 2009).

One tradition is the humanist tradition, where storytellers narrate their life histories. There is a 'single agentic storyteller'; what they say is a transparent window to their inner thoughts. This is in contrast to the poststructuralist tradition where narratives perform certain social functions. In this paradigm, language is not a means to express attitudes or feelings; instead language discursively constitutes the world, (Tseliou 2013). The poststructuralist tradition is not interested in 'self, the individual or agency', because they recognise these categories as varied and troubled

subject positions. The split can be thought of as, 'Internal/Humanist', a reflection of inner states contrasted with, 'External'/Social production of stories, (Tamboukou 2009, Phoenix 2009).

Reissman (2003) reminds us of the performance aspect of narrative. Narrators perform,

'*Dramas to an audience, not information to a recipient*' (p7)

I am interested in common factors across the narrative influences preferring to borrow from several ideas, positions and styles. The Critical Narrative Analysis position affords a useful link with Discourse Analysis, a methodology, even 'movement' that appealed as I wrote the proposal. Discourse Analysis, especially Foucauldian is concerned with the role of language in constituting everyday life, (Willig 2010). Emerson et al (2009) suggest holding onto the gains of discourse analysis with its roots in social understanding and to combine it with a focus on the meaning making processes by which we attempt to account for our lives. They go on to say that narrative analysis is 'a specific discourse methodology'

'Capable of critically contributing to the interplay between personal and social change'. (p 10)

For the purpose of this study, given the multiple and at times competing or contradictory definitions, I use Richardson's (1990) five categories of story. These are;

- 'The everyday; what we did, how we order our lives, temporal markers'
- 'The autobiography: relationship between past and present'
- 'The biography: a point of view from another's perspective'
- 'The cultural: narratives from one's particular culture, stock narratives'
- 'The collective: highlights voices marginalised by the cultural narratives'

I link together these story types with the concept of 'antenarrative', described as an improper story telling', (Boje 2001). I like the idea of a story being improper, rather than proper, conveying something more rich, exuberant and lively whilst also being messy. I find the idea that some interview material is not suitable for narrative

analysis to be a question of judgement rather than a fact, (Emden 1998). Who decides on the merit of what constitutes good enough material? This is why I am attracted to the idea of antenarrative because at times the stories appear fragmented, non linear and unplotted yet I feel are no less worthy than the more ordered stories. Boje's (2001) thinks of storytelling as a;

> *'Postmodern and chaotic soup of storytelling that is somewhat difficult to analyse'. P1 (2001).*

I undertake a Narrative analysis and I thread it with antenarrative, critical and dialogical thinking, these are the ingredients in my chaotic soup. I have been party to the constitution of the stories but they are not my stories. A hermeneutic dance takes place where the storyteller and I dialogue with one another. The storyteller emphasises certain events and experiences whilst she also thinks what it is that I would like to hear. It is this reflexivity, knowing that as a researcher that I contribute to the co production of stories and it is about acknowledging that I have power and privilege in the relationship. I have an ethical responsibility to do something with the stories. This means actively checking my interpretations, what Wren (2012) refers to as 'double hermeneutics', that is to be able to give an account of my interpretations, biases and suppositions.

I have not witnessed or experienced the types of trauma, dislocation, illness and loss that have been performed to me through the interviews. I do share a history of colonisation, slavery/indentured labour and racism. In the storylistening, I learn of stories previously unknown to me and I am enriched by these experiences. What I learn is handed on in my writing for others to also learn, take in and pass on.

Bringing Forth the Dialogic Potential of Narratives

The dialogic approach began with the Russian philosopher, Bakhtin (1981), who said, *'the words we use are only half our own,'* (Couture et al 2004). I find this an inviting idea. If the words are only half our own we need others to make meaning of our words, (Rober 2005). When we speak we give the audience our words, they

appropriate them and give them back to us in a renewed form. The process is both languaged, embodied and a shared emotional experience through which we form our identity, (Larner 2015). Andrews et al (2008) speak of the 'dialogic potential' of narrative research. What I notice is that the words on the page, once transcribed, do little justice to the multidimensional living, breathing human beings who story-share with me. Seikkula in Shotter (2015) remarks that there is a paradox regarding dialogue; it is both simple and complex, it is as easy as life is and as hard, but it is not something we can escape, it is like breathing, working, it is life. So although we learn of dialogical approach as a way to analyse data or as a therapeutic style, I remind myself of the simplicity of dialogue, not as a method but as a way of life, (Anderson 2012).

As I begin to interpret the material, Frank (2012), in recognising the capacity for storytellers to 'hold their own' in their storytelling, proposes five commitments in the practice of Dialogical narrative analysis:

Commitment 1: That each individual voice is a dialogue between voices. It does not mean two persons but that each person speaks from a multiple of voices, for example, as their parents, friends and teachers and therefore, from multiple points of view. This is known as 'polyphony' or the polyphonic voice. The speaker, through the process of 'ventriloquation' embodies these multiple voices and speaks through her own voice, (Rober and De Haene 2013). Another type of talk is 'heteroglossia', the cultural stories people tell as part of their narrative habitus. Narrative habitus is the collection of stories we embody as we grow up, they become second nature, showing as our tastes and preferences and shape our lives, (Bourdieu 1983). 'Paralinguistic' aspects of dialogue, for example pauses, silence, laughter, and experiences are also analysed, (Skinner et al 2001). Bakhtin (1981) pays attention to the 'emotional–volitional tone'. This refers to our utterances as we make them in the moment we make them, we are relating to and expecting certain utterances in return, for example, how we finish others sentences, (Shotter 2006).

Commitment 2: Frank (2012) urges us to be wary of monologue. This does not

refer to a binary split between dialogue and monologue but when, between persons, there can be monologue. Monologue is about a lack of curiosity, finalising what a person is saying, concluding too early. It is within this commitment I am, as the analyst, afforded the opportunity to hear multiple stories that the storyteller assumes belong to her, yet in the multiple listenings, there is a shape-taking place whereby I begin to hear collective stories.

Commitment 3: This commitment extends commitment two, where as the analyst I begin to notice repeated stories. Frank (2012) suggests that the stories have independent lives. I hear this as connecting to a social constructionist view of language. Stories and language exist before and after us, we grow into the stories and our experiences gain exposure by telling them to others as stories.

Commitment 4: This commitment is about recognising that as analysts we need to guard against finalising our analysis as if it is finalising the person. The story may be finalised as part of a study but also the storyteller goes on developing and changing so the stories will not be the same in the future.

Commitment 5: This commitment is related to commitment 4. Whist the dialogical narrative analyst recognises the need to finish the study, it is 'undialogical ' to summarise findings; rather the dialogical process of storytelling enables persons to increase possibilities for reflecting on their stories and deciding how they would like to take them forward. When we speak of co construction, in dialogic terms, this is not about turn taking but about the multiple voices we all have within us, that are drawn upon in the moment of the qualitative interview and therefore are unique moments of dialogue and as the stories unfold, they become a corpus of stories available in the public domain.

The Collective Story

I introduce here a particular kind of dialogical story, the collective story. A collective story is the gathering together of individual/cultural stories. By putting them alongside one another I begin to increase visibility and accessibility of narratives previously marginalised or unspoken. Through collective rather than individual

dialogue, we can look for possibilities for a shared understanding of the stories as well as creating opportunities for hearing diverse voices through this process. I think of the stories as a collective tongue, louder and more vocal than the individual/cultural stories, (Gilroy 1993). There are many collective stories in social history, for example the Civil Rights movement, Slave narratives, Holocaust survivors, Indigenous Persons narratives. Contemporary narratives include the multiple stories of ethnic cleansing, of forced migration, of war and traumas. These entire collective narratives act as a collection of tropes brought together with the purpose of resisting cultural stories that present as normative and true, (Daniels and D'Andrea 2007). This link to sociopolitical concerns came into being in my writing. It feels fitting to connect this inquiry to wider political structures. The reader can see beyond the individual storytellers and their individual narratives, to a broader, sociopolitical context. The storytellers can see how their stories are important and connect with other storytellers. The collective story attempts to resist culturally dominant ways of how we as a society respond to distress in our communities. The coming together of clinicians and 'service users as citizens' is an example of how social activism, by inviting social action can bring about social and political change. Groups such as 'Psychologists against Austerity', 'The Public Conversations Project', the 'Open Dialogue Model' and Liberatory approaches of Freire (1993) are testimony to this desire for political and social collective change, (Harper 2013). It is within this context that I place the collective stories of this study. Frank (2002) argues that change can occur when stories are narrated in the public domain and that they have the capacity to bring about political change.

Caddick, Phoenix and Smith (2015) study of veterans with posttraumatic stress disorder formed a 'physical' collective. The participants knew each other and findings reveal that the camaraderie, buddying and the feeling of being accepted is shown to alleviate their symptoms. Unlike the Caddick study, this inquiry is not a 'physical' collective, as the storytellers do not know each other. If they had known one another, perhaps the acceptance, camaraderie and connections may also have helped with the experience of ed. The storytellers do not have the opportunity to learn from the experiences of others recovering from ed. In creating 'virtual'

collective stories, I am attempting to bridge this gap, putting the collective stories into the public domain for future minoritised women.

Stories can be said to do work and we get caught up in our own as well as other peoples' stories. As we grow up we collect stories that become second nature to us, we do not question the why of the stories, and we just know they are in the story chest. They become our disposition, habits, and taste helps us understand why we have preference for certain tastes, food or otherwise. This is what Frank (2012) calls our narrative habitus. We are disposed to certain stories in the same way, he argues, we are disposed to certain foods. The gathering of stories comes together as a corpus of stories that connect with the ideas of one's narrative habitus, that is, a repertoire of stories that people share. My storytellers may not know each other yet tacitly their stories are vivid, similar and share a collective narrative habitus, (Frank 2012, Smith 2012).

It is through collective storytelling that political change can begin, (Andrews et al 2009, Richardson 1990). Collective stories are dialogic when we are mindful that no voice is on its own, every voice is made up of multiple voices. I produce dialogic collective stories by bringing together voices that are not yet in dialogue. Through careful analysis, it is possible to recognise the potential and capacity of stories to enable theoretical and methodological points based on both the questions asked of the stories and of the exemplars they become, (Smith 2013, Rober 2005,Frank 1995).

In summary, this chapter has addressed a range of methodological options and research paradigms, I have shown how the shyer cousin, qualitative research affords a good fit with systemic dialogical inquiry and that narrative research and I have explored why we study stories, intercultural research and the risk of 'othering' in the context of narrative research.

I move now to Chapter 4, the Method chapter.

Chapter 4: Dialogical Narrative Analysis: Analytic Practice

This Chapter shows the setting up of the study referred to as the 'method'. Method involves explaining what I did and how I did it with a clear account of the procedures involved. This includes ethical issues, the issue of piloting, transcription notation, recruiting storytellers, question design, qualitative interviewing, beginning the analytic process and questions of reflexivity, (Willig 2010). Each chapter builds on previous chapters forming a strong and flexible scaffold for the analyses to be brought forth in Chapters 5 and 6. I reflect on Frank's (2012) unease with the term 'method' as if it is a finalised step-by-step guide. I use his term 'analytic practice' instead.

Setting Up the Inquiry

How I set up the inquiry has implications for all aspects of what follows in terms of interpretation. Initially I was curious about how clinicians take culture into consideration whilst working interculturally with eds. As I developed my research protocol I realised that I wanted to collaborate with minoritised women about their experiences of eds. It was my 'failed' attempt to help Hana that sparked the idea for this inquiry, so it seemed fitting to talk with those who have insider knowledges, (White 1992).

Ethical Issues

The issue of ethics appears to be about what Swim et al (2001) call content ethics. This type of ethics has been formulated as a consequence of previous ethical violations. Content ethics form the current codes of conduct that we work to, the principles, standards and guidelines to ensure the safety and well being of participants and to ensure that they come to no harm in research or in therapy. The application for ethical approval for this study is an example of content ethics. From a social constructionist perspective, content ethics is neither relational nor collaborative. I reflect on both aspects of ethical accounting; content and process.

My first consideration, from a content perspective, is to ensure that the inquiry, based on one to one qualitative interviews with minoritised women who may be vulnerable, is safe and centralised. I attend to all aspects of the study to consider how or if it may be harmful by for example, carefully planning the questions and sharing drafts of questions with young service users. I reflect on the questions I develop, I consider confidentiality, ensuring that I explain the limits of confidentiality; I make sure breaks and refreshments are offered. I ensure participants are able to have follow up support from their care team if required after the interview. This traditional form of ethical thinking does not involve collaboration with the participant. Process ethics on the other hand embraces ideas of collaboration and co production, (Swim et al 2001). The idea of relational connectedness, my use of self, self disclosure and transparency are all aspects I draw upon.

The National Health Service Ethics approval process, known as the Integrated Research Application System (IRAS) guided me through this complex process. To prepare for the ethical approval necessary to conduct a study such as this, I produce posters[21] to advertise the study, a Letter of Invitation[22] to take part in the study; a Consent form[23] and a Participant Information Sheet[24]. In an effort to maintain this ethical position in relation to my research, I align myself with what Denzin et al (2005) calls the 'eighth moment' in research, which asks that,

> *'The social sciences and the humanities become sites for critical* conversations *about democracy, race, gender, class, nation states, globalisation, freedom and community'. (P3)*

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[21] See Appendix C Poster advert

[22] See appendix F Letter of Invitation

[23] See Appendix B Consent Form

[24] See Appendix A Participant Information Sheet

To Pilot or not to Pilot? : That is the Question

The question of piloting happens early on in the design and planning stage of the study. The purpose of piloting is to trial a small scale version of the study questions, in other words a pre study of the fuller study. Piloting implies I have something to find out that will be illuminated by the answers to my questions. As this is a dialogical social constructionist inquiry, each interview is a unique occasion; there is nothing to pre study because each interview is a co construction between the storyteller and myself, (Frank 2012). Instead of piloting and in the spirit of collaboration, I invited a group of young service users to help develop the Participant Information Sheet, Consent Form and Study Poster. I asked them to help me with drafting interview questions[25]. I wanted to know if they think any of the questions may be too challenging for vulnerable participants. This conversation was energetic and helpful. The young people offered constructive advice to ensure that the language I used is age appropriate and easy to understand. One service user asked me what a 'systemic psychotherapist' was, and we agreed instead I would use 'family therapist' as it was felt easier to understand. The group also asked how I would share information at the end of the study. They suggested I make sure the 'findings' are age appropriate and written in accessible language. One service user suggested I do a 'warm-up' with participants before going straight into the interview questions, which proved useful in engagement. One service user thought I had too many questions and I agreed with this feedback. In addition, one service user suggested I make a poster to illustrate the findings. All the young people were white British.

Transcription Method

There are a number of ways to transcribe depending on the choice of methodology. In keeping with a dialogical approach my intention is to notice voice as a performance and this involves listening to the 'emotional volitional tone',

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[25] See Appendix D Examples of interview questions

(Bakhtin 1993, Shotter 2015). One of the storytellers, Sarah, radiated humour, warmth and intelligence as she narrated her experiences. It was not the content so much as the pace and tone of her storytelling that left you in no doubt of her love for her family and her recognition of their suffering. I transcribe the conversations verbatim using a simple textual style. I highlight extended pauses, shown in brackets to the nearest second[26] as I argue, these represent significant dialogical moments for the storytellers, as they pause to reflect on questions, reflect in the moment and show their responsive understanding to the questions I ask, (Burck 2005b, Shotter 2015).

Recruiting Storytellers

I chose minoritised females because being female is the number one risk factor in eds and thus seemed fitting to explore this gendered condition, (Piran 2010). I collaborated with one London NHS site. I sent emails for an expression of interest to systemic psychotherapists in several London Trusts and surrounding areas. I asked how many minoritised cases they see in their clinical work. One senior clinician at a specialist centre in London told me that, '*Surprising as it may seem, Kamala, we do not see women from minority backgrounds in our service'.* This is not a surprise now. The literature recognises that issues of timely identification, referral to specialist services and barriers to treatment continue to be problematic, (Wales et al 2017, Currin et al 2007, Becker et al 2010b). Adverts for participants were placed with the 'Black and Asian Therapy network, BAATn and the national eating disorders charity website, B-EAT. I made two visits to the London trust. I met the clinical team to present my study and to answer questions. Following these visits, some amendments to the protocol were made:

- Participants would be:
- Current cases in later stages of treatment with staff available if there was need for clinical follow up after the interview

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[26] See appendix E Transcription Notation

- Minoritised women aged 16 and over, in a recovering phase *without additional mental health conditions*, would be eligible.
- Pregnancy would not preclude taking part.

I obtained permission to recruit participants from my trust where the same conditions applied. All participants were contacted by letter, telephone, or with help from the local collaborator to make arrangements for interview. I attended an ethics panel to discuss my study proposal and answer questions. A favourable opinion[27] was made after a couple of amendments to the layout of the 'Consent Form' and the 'Letter of Invitation'.

The Storytellers[28]

Storytellers[29]: (details at the time of interview)

All storytellers are minoritised women from a range of culturally diverse families. Minoritised in this context means 'members of non dominant groups of non European descent' (Smolak et al 2001). I did not use the broader census definition of minority, which also includes 'white other', for example travelling people or Europeans, as I specifically wanted to focus on the experiences of women of colour.

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[27] See appendix G Letter of favourable Opinion

[28] I use storyteller rather than participant to convey an active process rather than a passive one

[29] All names are pseudonyms to protect identity

Table 1 The Storyteller's names, ages, cultural heritage, work, living arrangements and profession

Name and age	Cultural /Racial heritage	Religion	Work/study	Living arrangements	Profession
SARAH 28	Jamaican	Seventh Day Adventist	Full time work	Lives with sister and brother in law	The Charity worker
ESME 17	Jamaican/Irish	Not disclosed	Full time student	Lives in foster care	The Beauty therapist[30]
TAMARA 19	Somalian/ Arabic	Muslim	Full time student	Lives in supported lodgings	The Paramedic[31]
TARA 48	African/Bermudian	Buddhist	Full time work	Lives alone	The Psychotherapist
HARRIET 22	Jamaican/South African	Not disclosed	Full time work	Lives with partner	The Literary agent
NICOLE 19	Mauritian/Irish	Catholic	Full time degree student	Lives with other students	The Degree student
PREETAM 24	Indian	Sikh	Part time work	Lives alone	The Assistant psychologist
LILLY 18	Japanese/ British	Buddhist	Full time A-level student	Lives with parents	The Tattoo[32] Artist
EMILY 26	Pakistani	Muslim	Full time work	Lives with a friend	The Environmentalist

The women chose their pseudonyms or agreed with my choice apart from Esme who was not available to choose a name after the interview.

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[30] Esme is studying beauty therapy

[31] Tamara is not yet a paramedic but it is her ambition

[32] Lilly is not yet a tattoo artist but hopes to be one day

Choosing Individual Interviews

I had originally hoped to interview minoritised families about their experiences of living with a family member with eds. I imagined and it proved correct, that there would be difficulty in recruitment, given how few minoritised women we see in services. A second and more compelling reason to decide to interview individual women came when I received an email from a prospective participant who wished to have assurances about confidentiality and anonymity as she did not want her parents to know she had suffered from eds. This was further borne out in the analysis as not all storytellers tell their parents of their struggle with eds. Moreover, the literature lends weight to this position as minoritised families may perceive that suffering from ed is something shameful and should not be discussed, or is not understood to be a serious condition by family members, (Chowbey et al 2012, Waller et al 2009). I decided that one to one interviews afford a detailed focus on individual minoritised voices, and allowed for privileging of the marginalised voice, (Papathomas, Smith and Lavallee 2015).

Developing Questions

As a systemic psychotherapist, used to the art of questioning, but a novice researcher, I wanted to make sure the questions were research oriented not therapy oriented questions, (Burck 2005a). My role in the research context is not about affecting change, instead I view my task as an ethnographic inquiry designed to create a context for artful storytelling, (Frank 1995). Table 2 below gives examples of my questions.

Table 2: Examples of Questions

Individual, family and cultural stories	*Can you tell me something about growing up in your family? What place did food have in your family? What are the family stories of migration?*
Cultural Food genogram	*What do you know of your ancestor's food? Does you family still eat this food? What kind of foods do you eat that are associated with your heritage?*
Emergence of ed/seeking help	*Who was the first to notice you were struggling? Who did you tell? How did you access treatment?*

Recovering stories	*What did you draw on to help with your recovering? Can you say something about your cultural heritage and your recovering?*
Future stories	*What are you most looking forward to as you continue to develop your skills?*

The cultural food diagram referred to in table 2 above is further developed below in figure 1.

Figure 1 Visual diagram of questions and the Cultural Food diagram
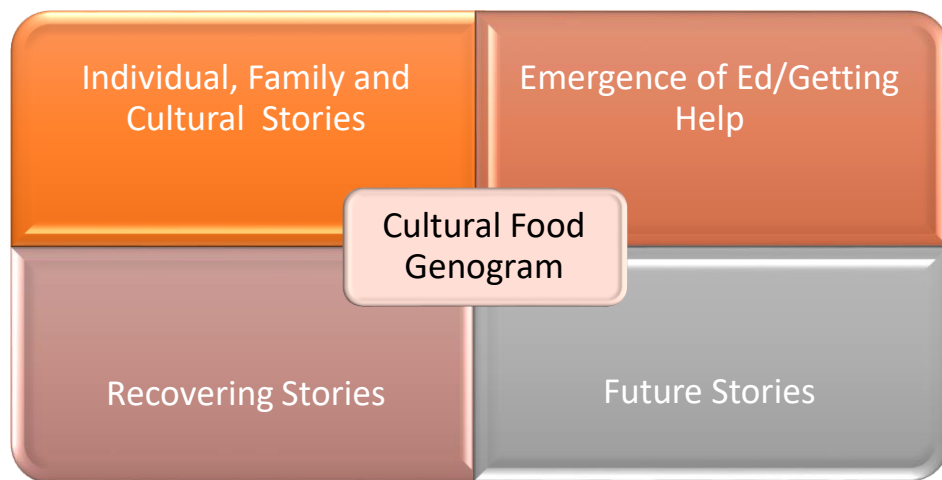
By cultural food, I mean food that connects us to our culture. These kinds of questions go to the heart of our narratives of our childhood and the stories we have heard about our parents' favourite foods. This may highlight an absence of this food due to lack of availability. Though with increased globalisation we can buy almost all food stuffs from around the world, storytellers say, and in my experience, it is not quite the same quality. Tara tells me of a specific dish her mother used to make that is available from the Untied States but does not have the same taste. I have decided here to show exactly what Tara said as I think it gets to the heart of this issue about food we grew up with. By not putting it here, I fear these words will be lost. Tara (Ta) says;

> ***Ta*** *Yeah oh well she would make this like rhubarb from scratch and it was just like a dessert and quite sweet you had kind of stringy bits and it was quite like a soup but a dessert but the smell of*

> *the sweetness and the texture of it there was that and there was a thing called Queen of Wheat, I don't think you have it here but its American you get it in a box you get instant ones now but its not the same and its got like a black man on the front with a chefs hat and she made this big huge pot and it was almost like a cereal like a wheat or oats and it was wheat based and it had like lumps in it and nobody else made it with the lumps I'd look forward to the lumps really' it was just like a creamy texture and had a particular taste like it took on the taste of the pot as she always made it in the same pot so I was always looking forward to that always you know and now I still have this crave for it yeah you have to go to King's Road to get it now*

This excerpt about special food carries with it emotions and I think captures longing, loss and grief as storytellers are reminded of events through their storytelling. I develop these questions as a tool to aid inquiry into food practices, habits and customs. The questions have the power to bring forth pride and shame issues within our cultural context using the cultural genogram, (Hardy et al 1995). The cultural genogram helps to develop cultural awareness and sensitivity in intercultural work. I use the same principles, asking about food where food can be both an idiom for expressing distress and can also provide comfort and a sense of pride. In this inquiry food stories can be quiet, absent and untold. The cultural food genogram acts as a visual aid in the interview with the storyteller and enabled dialogue to develop about food across the generations, about food that is no longer available, the meaning attributed to food and what it comes to represent in the family. The stories brought forth from the material below were constructed from these conversations. The sharing of the genogram also act as a transitional connection between us. It enables moments where eye contact is difficult; we could focus instead on the genogram and on the unfolding story. Later in the analysis I reflect how more generations are needed to fully comprehend the migratory, colonisation, racism and food traumas that are transmitted across generations. Moreover, the analysis also brings forth how Migration Maps[33] may be used in intercultural therapy.

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[33] A visual map that shows the migratory movements of ancestors across the globe

In this study recovering stories are embedded and obscured within illness narratives. In the planning stage, I explore the use of appreciative questions, questions that focus on possibilities not problems, (Cooperrider et al 1987, Oliver et al 2002, Partridge 2012a). This style of questioning is not about ignoring problems but is about coming at the problem differently. I persist with this style of questioning particularly when the storytellers seemed vague or unsure about their talents, as these stories are often marginalised. It is at these points that resistance to dominant cultural stories began to emerge. Data analysis and supervisory sessions encouraged me to persist with these shy stories when it became evident that I also minimise my own abilities and talents, (Partridge 2017).

The Qualitative Interview

The interview is a discursive activity where the storyteller and I are two active participants jointly constructing a dialogical narrative, (Reissman 2008). This constructionist approach attends to 'the how' of the interview, that is how meaning making is constructed during the interview and 'the what', that is the guide to the interview, and the 'what' of lived experience. This approach allows for more than the voices of the interviewer and the respondent but the voices we incorporate, those voices from our culture, heritage and family, the polyphonic voice. The storyteller is recognised as having interpretative capabilities that the interview process activates and stimulates to bringing forth a range of experiential materials relevant to the agenda of the study at hand, (Holstein and Gubrium1995). I presume narrative competence of the storytellers who are experts on their stories. I see the interview as 'an occasion for narrative production where the storyteller is an active participant who improvises, has expectations, feelings and opinions where, based on the structure of the interview, she draws from her stock of knowledges and connecting parts of her story in the retelling into a coherent whole, (Holstein et al 1995). The interviews are a one off occasion due to the limits of the doctorate, (Papathomas et al 2015).

Beginning the Analytic Process

The analytic process begins in the interview and continues until the study is written up. In figure 2 below I create a hermeneutic cycle that illustrates the back and forth nature of qualitative inquiry. There are moments in analysis where I leap ahead only to be reminded in data analysis sessions to slow down, not to make assumptions and stick close to the material. This slowing down, not missing out important steps or falling into the trap of seeing in the material what I was looking for, was vital to enable the stories to show themselves to me, not the other way around.

Figure 2 The Hermeneutic Cycle: The Analytical Practice

1. Voice centred method transcribe verbatim first,second, listen for the emotional-volitional tone, pauses, other non verbal markers

5 listenings

2. Attend to first person voices:read, make notes of primary themes: cultural differences and similarities in experiences of eds and my thought and feelings

3. Select stories for analysis, which involves listening for the stories that are calling out to be heard (phronesis)

4. What do I feel and think? develop more conceptual themes begin experimenting with Structural narrative analysis methods such as Gee or Labov

5. creative writing:a poem, a play, some prose to capture the feeling and sense of voice of narrator; what am I embodying?

6. Listen again, read again,attend to primary protaganist and listen for subjugated voices , minor characters and questions of the audience

7. Ask questions of the stories; move between stories to develop individual/ cultural stories

8. Develop collective stories that speak to minoritised womens' experiences of recovering from eds

9. Reflexively embrace personal growth and change: speaking out and talking back

Reflexivity Revisited

As a feminist poststructuralist researcher I have an ethical responsibility not to reinscribe the storytellers as victims or as powerless. Diagnoses and illness has already rendered a sense of powerlessness amongst the storytellers. I see my task being to show through analysis how resistance to cultural stereotypes and embodied practices are privileged, (Frank 2010, Bhavnani 1993). By applying an appreciative lens and having a desire to see good in everyone clearly shapes how I interpret. However I understand appreciative inquiry not only as focusing on positives but from a position of recovering, to review how the storytellers enable recovering, (Silverman 2006). Russell et al (2002) reminds me how our personal circumstances impact on interpreting the data. During a data analysis, Russell refers to a member of the research team who had ended her relationship with her partner and then appeared to see 'sadness' in the data more often that her co researchers. An example of this occurred when I presented material at a data analysis session. One student commented on the 'thin description' of the story told by one of the storytellers in my study and said this was due to trauma. I am aware of the attachment literature that suggests this yet I felt a protection for the storyteller being pathologised, I felt angry on the storyteller's behalf and I disagreed with the formulation. In my view, the storyteller reveals complexity in her story more associated with the oral storytelling tradition of collectivist cultures. By this I mean that the story was more poetic than prosodic, was collapsed in time so did not fulfil the traditional, 'this happened, then this then that', structure associated with Western storytelling and this point had been overlooked in the analysis session (Reissman 2008). In this interplay, I adopt a style where I aim to protect clients from negative formulations instead seeking more hopeful hypotheses. This style, referred to as being 'a kindly aunt', brings affordances and constraints in my clinical and research practices.

Another aspect of self-reflexivity is to consider whether I should speak from an omniscient narrator perspective as Richardson (1990) did in her study. The tension for Richardson was that if she wrote herself into the text, she was concerned she would distract the reader from her political and research goals, yet in writing herself

out of the text; she felt it positioned her as an authority to 'write about others'. She chose the latter but tempered this position by decentring her authority in the tone of the writing. This involves 'moral' writing; how we choose words that show respect and value for those we write about. I choose to write myself in, but I take care to decentre myself so that my story does not detract from the other stories. Below I story how the hermeneutic cycle came into being.

1. Voice Centred: Listen, Transcribe and Listen again

The first listening and typing word for word, is a visceral experience. I cringe at every clumsy question and notice leads that I did not follow. I feel self critical and I do not want to transcribe. I realise this experience is isomorphic with the stories. The storytellers were also unsure, and uncertain about how their contributions might help me. I have not read about this challenge and it is not something I could have predicted. I found myself doing everything but transcribe, a new literature search, buying a new book, more reading more writing but not transcribing. Despite this experience, I do not recommend a professional transcriber. It is during the multiple listenings, readings and writings that stories unfold. At least five listenings are recommended, (Frank 2012). I hear first the loud and dominant voices, then the quiet and subjugated voices; I attend to the emotional volitional tone, whilst what is said, that is the content, is analysed, the dialogical approach is more interested in how things are said, the phrases, themes, ideas, and concepts emerging from the written word and the paralinguistic markers such as tone, gestures, and inflection of voice, the rise and fall of the voice, the pauses, the soft tones and the laughter. As I listen I feel in my body a glimpse of how I felt in the room with the storyteller. Moreover I am beginning to tune into voices of minor characters in the stories. In other words I am attending to the performance of the talk,(Bakhtin 1993, Malson et al 2004, Skinner et al 2001, Reissman 2007).

2. Attend to First Person Voice, note Themes, notice my Thoughts and Feelings

Many stories jump out of the material. What is the storyteller telling me? What does

she wish me to hear? How am I hearing the responses? Do they resonate with my own family, how are they different? What is the importance of what is being said? Not everything can be analysed within the doctorate limits, so I attend to the stories that resonate with my research questions. I return to this section many, many times. I make notes in the margins of each transcript, jotting themes. At first the themes are actual words said, for example, Nicole,

'We were a close family, we did not argue'

Then the themes move to increased levels of abstraction. For example, I think about the storytellers who are dual heritage compared with storytellers where both parents are from minoritised backgrounds. This theme hung in the air for a while but I have not proceeded with it in this study due to the limits of the study.

I take several A1 pieces of paper, one for each storyteller and divide them into three columns. I vary the column headings depending on where I am in the hermeneutic cycle. I write in different coloured pens to denote the different type of emerging stories. An example of the column headings are: column 1, direct quotes, column 2, interpretation drawing on analytical interests such as 'systemic', 'sociocultural', 'acts of resistance', 'performance of affect' and 'embodiment'. The third column is a reflexive column, how am I understanding and connecting with the generating themes?

Table 3 The Analytical Process in Development

Direct quotes	*Interpretation*	*Reflexivity*
Re interventions	*Who can care for Tamara, who can help her, her mother had two other children with disabilities that needed her care, the professionals cannot help*	*How can I care for Tamara in this conversation- I let Tamara interview me*
In treatment		
"I used to hate my therapist, I used to scream 'I hate you' [..] I hated hospital, [..] they said 'there is nothing we can do for you"	*Tamara internalises she is too difficult to be helped*	

Re culture	Tamara is on her own, she lives in a hostel, apart from her mother, all extended and close family members are spread across the globe	I work to bring forth a more hopeful story of her heritage and she engages with this, eventually identifying her mother has taught her a lot about respecting others
'My mother travelled aged 16 from Somalia, her father was dead, there was a war, she was on her own'	How can Tamara develop her own sense of identity apart from a mental health Survivor?	

The table below is another example of the way I managed material visually.

Table 4 More Examples of Making Sense of the Individual Material

Time line Esme **Aged 0-10**	Identifying themes including political, cultural, systemic, affect, racism and acts of resistance	My thinking /interpretation
Lives alone with mother who has mental health issues		Mind and body loses its connection. Esme is not fed so she has to imagine food
Does not attend school	Affect: sadness, loss, trauma	
		Role reversal, she cares for mother
Esme says' I do not have a lot of memories because it is all bad memories [..] I have so many bad memories that my memory is just not, there is nothing really there, it is all the same'	Political: who notices this child? Who is caring for mother? Acts of resistance: Esme creates an imaginary world where she is running a bed and breakfast and she gets everything ready for her mum and she dreams of being with her father	Poverty, isolation and discrimination impact on this family

I use a variety of methods including dividing the interview into past (historical) recent past, present and future, whilst at other times taking one theme per page and using a mind map[34], insert quotes from each narrator that is evidence of the developing themes. Further readings, mappings, drawings take place each time searching for new insights. This might be re-membering sounds such as sighs or pauses, noticing laughter or silences. I start to notice patterns of sounds and utterances and notice the varied storytelling styles. In addition, I begin developing a mental narrative for myself of how the process impacted on me emotionally as well as how my story intersected and was different from their stories.

3. Select Stories for Analysis: Stories calling Out to be Written[35]

The storytellers narrate stories in which they describe taking personal responsibility for their eds. The storytellers tell cultural stories where they internalise the dominant narrative that eds are a mental illness and it is down to the individual to get better. As we engage in dialogue, I feel a metaphorical door open, shy stories timidly look at the opening, wondering if it is time to step into the light to become seen and heard. Harriet for example, seems unsure about the word 'culture' when I ask if she sees any connection between her recovering and her heritage. It is an unusual question in the first place. It is not long before each storyteller answers this question though it takes time. The stories begin to perform recovering; the stories themselves become the healer, the storytellers, perhaps for the first time imagines that they are recovering. Though most of the storytellers had caveats about how much recovering they might reasonably expect and some said they have moments where they slip back a little, the overall sense was of going on with their lives, little by little.

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[34] See appendix G for example of a mind map

[35] This is a process known as phronesis Frank (2012)

4. Structural Methods: Voice and Embodiment

With multiple listenings and readings multiple thoughts and feelings abound, requiring me to think at many levels. I hear stories that resonate with my own family experiences and clinical practice and I hear new stories that are very different from previously heard stories. I feel excited by this newness and I start to see how minoritised eds are formed through discourse, as a category for health care professionals ought to be taking notice of. I experiment with the structural methods of Gee (1991) and Labov (1979). These methods help to strengthen the scaffold from which new meanings can be brought forth. I am tempted to speed ahead and try exciting new ideas, I am cautioned to slow down and strengthen my argument through analysis. I attend to voice and embodiment because I prefer to maintain my epistemological position regarding language, which is different from the structural methods.

5. Write: Creative Methods and Embodiment

I begin to embody the process of reading and writing, of listening to my inner dialogue, I attend to polyphonic voices, there is a 'bubbling up' sensation as stories reach out to be written down. I learn of writing as a method of inquiry, (Richardson and St Pierre 2011,Simon 2011, Kebbe 2014). I experiment with plays[36], Haiku's, stories, and letter writing as a creative way to get into the material. The important point to these creative methods is to maintain rigour within the creativity to ensure the stories are grounded in the material whilst also being evocative, emotional and plausible, (Smith, McGannon and Williams 2015).

6. Listen for Subjugated Voices and Minor Characters

After many readings and listenings, I recognise the multiple voices spoken or

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[36] See appendix I for an example of a play

ventriloquated through the storyteller, both main characters and subjugated ones. This acts as a reminder that the stories are relational and dialogical, (Caddick et al 2015). During this part of the analysis I notice how fathers are constituted as a strong yet complicated absence/ presence in many of the stories. By paying attention to how the story is told, shines a light on what it is the storyteller wishes me to know, how the performance of her identity is acted, and what efforts she is making to occupy a position of resistance.

7. Ask Questions of the Individual/Cultural Stories

This process continues until a point where no new stories seem to emerge. Reissman (2003) answers the question about when one knows to stop analysing, by saying it is when the same themes keep coming up and no new ones are being brought forth. Continuing then, in a dialogical frame, I turn to the stories that are calling out to be written and to interrogate those stories with dialogical questions. I begin by asking questions derived from my protocol. I am interested in the stories constructed around growing up, food, relationships, heritage, emergence and recovering from ed and imagined futures.

8. Begin to Develop Collective Stories

This part of the cycle was not originally included. I thought I had exhausted the possibilities for the individual/cultural stories, no new stories were emerging, only more evidence to back up the stories produced. Something was missing that gradually become apparent as I continued to write. What started to happen is that the cultural stories that initially seemed to confirm what was in the literature began to take a different shape. The narratives embedded within the material began to take on a quality of resistance and I heard and felt a different kind of story. I return to the literature to find a name for these subjugated stories. I understand these different stories as Collective stories. These stories can be understood as a powerful antidote to individualised, personal stories that are often viewed as 'anecdotal'. The collective stories come with a red flag, stating loudly that these stories mean business. Ignore them at your peril. These are resistance stories.

9.Reflexivity and Personal Growth

After nine interviews, I have multiple stories available for analysis. As a researcher and clinician I am afforded the privilege of collecting a corpus of stories, some similar to these stories some different. I see many similarities across the storytellers and wonder about the connections. Richardson (1990) views cultural stories as normative stories. In this study, they are cultural stories with a twist, as they shape shift toward resistance/collective stories. Given my privileged status as the holder of many stories, and my working day to day knowledge of stories, I am in a position to offer tentative new perspectives to the storytellers. This step can only be written at the end of the study when I was able to step back and realise what transformations have taken place within me. I become aware of how I was changing my approach to my clinical work and it gradually flowed through all aspects of my life, personal and professional. I too am talking back.

Summary of this Process

The process described in this chapter appears sequential. However I move between 2 and 6 of the cycle iteratively because whilst the rigour of developing themes was central, I felt compelled to write poetry, plays and prose as I *embodied* the themes. I was constantly caught between whether the stories emerging are based on my expectations and assumptions or are they emerging from the material. If I choose to stick with the process moving from 2-3 I fear I would have lost some of the creativity of the process. It is about trusting your intuition and finding ways to go on that fits for you.

This ends my analytic practice chapter and now I move to Chapter 5, which further develops the process, described here and brings to life the dialogical analysis.

Chapter 5: The Individual/Cultural Analyses: Breathing Life into Untold and Unheard stories

This Chapter sets out the detail of analysis. I show how the hermeneutic cycle, page 77 is brought to life by first showing how I use of structural methods developed by Gee (1991) and Labov (1972). I then turn to creative writing methods for further analysis and finally I finally bring forth ten individual/cultural stories of minoritised women recovering from eds brought forth by dialogical narrative analysis.

I remind the reader of two of the five categories of story mentioned above on page 60 that I now focus on, (Richardson 1990).

- The Cultural: Narratives from one's particular culture, stock narratives (Chapter 5)
- The Collective: Voices marginalised by the cultural narratives (Chapter 6)

Early in the study, I became interested in the dialogical approach to both therapy and research. I have read many accounts of dialogical practices and note that I am not alone in at times wondering what the approach is. That is because it is both a simple and complex set of ideas, practices and ways of being, ways of being human that it is referred to as a 'way of life', (Rober 2005, Thomas and Longden 2013).

As I reflect on the analytical practice of Chapter 4 the analysis begins with recognition of the adversities and struggle with a number of traumatic life events and situations, so I begin here honouring and making visible the stories as further scaffolding to the analyses on the coming pages. Below in table 5 the adversities illustrate the challenges faced by the families/storytellers whilst also acknowledging how each storyteller has worked to transcend positioning as a patient, sick person or victim.

Table 5 Adversities Experienced by the Storytellers

Death of a grand-parent whilst birth parent was still in childhood	Experience of abuse, neglect or domestic violence in family	Migration of parent/ grandparent to Europe or North America	Mental health issues experienced by parent/s	Experiences of racism in first or second generation	Parental Divorce/ separation	Problem relation-ship with food in early childhood
Preetam and Nicole	Tara, Esme, Sarah, Tamara, Emily	Esme, Preetam, Emily, Sarah, Nicole, Harriet, Lilly, Tamara, Tara	Esme, Sarah, Tamara	Esme, Preetam, Emily, Sarah, Nicole, Harriet, Lilly, Tamara, Tara	Esme, Sarah, Tara, Tamara, Harriet	Esme, Preetam, Emily, Sarah, Nicole, Harriet, Lilly, Tamara, Tara

Two storytellers experienced 6 of 7 adversities.

Three storytellers experienced 5 of 7 adversities

One storyteller experienced 4 of 7 adversities.

One storyteller experienced 3 of 7 adversities

One storyteller experienced 2 of 7 adversities

And by contrast

All the storytellers express the importance of a collective identity. By this I mean strongly voiced opinions about the importance of family relatedness and connection despite challenges and problematic events and experiences of family life

Working Through and Bringing Forth the Analyses

I recap my narrative research position. There are two main narrative research traditions based on different epistemologies; one views the status of the narrative as 'naturalistic', that is there is a world out there awaiting discovery and that the stories are an accurate representation of the world. The second position, the position of this study, drawn from the poststructuralist tradition, is to explore how women construct their reality drawing on the cultural resources available to them, (Squire et al 2014).

Willig (2010) suggests several possibilities for undertaking a narrative analysis. These include focussing on the content of the story, the tone, the themes, or the social/psychological function of the narratives. In keeping with the dialogical approach to narrative, I concentrate on voice, emotional tone and embodiment. Whilst themes are generated in the process, it is the emotional tone of voice that is performed within the overarching themes that are the focus rather than the themes themselves. It is in the interpreting and writing of these categories that I produce individual/cultural and collective stories as analytical findings.

To ensure the stories are vivid and generative, I select those that *differentiate* from my clinical work with white /European families. I am reminded of Littlewood (1995) who said that we should not presume eds amongst culturally different populations are an appropriation of the developed countries thinness ideal; rather he argues it is more likely to be about self renunciation, that is where the individual gives up their self interest for the interests of others, in this case parents. It is in this space that theorising about minoritised women and eds can begin to take shape.

Stories of family life emerged as soon as we discuss the cultural food genogram. In a later conversation with my supervisor we talked of the idea of migration maps. These maps highlight the extent of migration that even very young people are taking as populations are on the move. This has been occurring throughout time and impacts on the storytellers and my own family. I do not know how many moves my father's ancestors made. I am mindful now it is probably more than I have

realised. Developing a migration map in intercultural therapy alongside the cultural food genogram is suggested later in the findings and concluding chapters, Chapter 7 and 8.

The Hermeneutic Cycle Brought to Life

I took the small steps from the hermeneutic cycle of page 77 above and grouped them into three main analytical categories as illustrated below in figure 3.

Figure 3 Bringing forth the Individual/Cultural and Collective stories

C: Both/and: Dialogical Narrative Analysis: The Individual/Cultural and Collective stories (steps 8-9)

A: Both/and: Structural methods, voice and embodiment (steps 1-4 of the hermeneutic cycle)

B: Both/and: Creative methods and embodiment(steps 5-7)
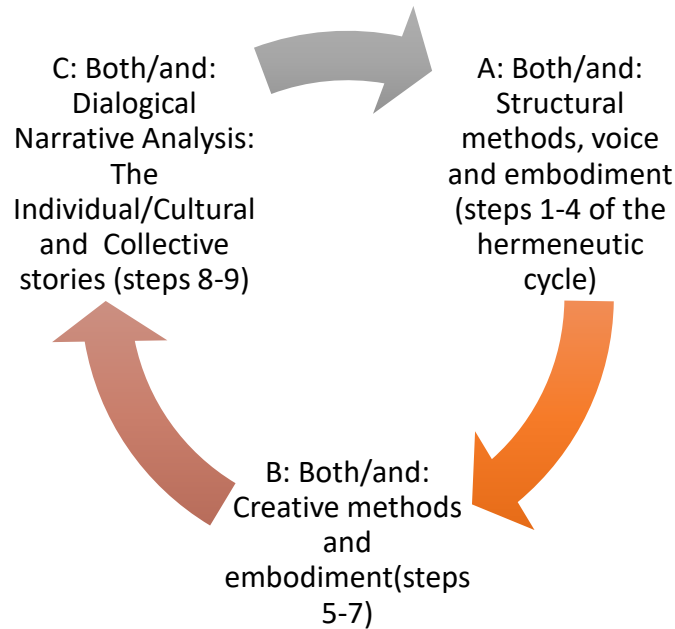
Developing the Narrative Analyses

I share here the process of analysis as outlined above in figure 3, beginning with Structural methods, then Creative writing methods and finally the Dialogical method. I continue to privilege a Bakhtinian/dialogical approach to language to all aspects of the analysis. I then move to Chapter 6 where the Collective stories are brought to life.

A: Both/and: Structural methods, Voice and Embodiment

Analysis begins in the interview context as I listen, observe, feel and embody the emotional intensity, the silences and pauses, the rise and fall of the voices and the multiple non verbal signs in the room, for example how Tara wraps her scarf around her in a gesture I saw as comfort and self care during moments of painful storytelling. The process continues after each interview, on my journey home as I reflect on the experience and make notes. It continues when I transcribe. After transcribing I annotate the transcripts, by creating spider diagrams, notes, drawings, charts and further listening. Voice and embodiment are not typically associated with structural methods, though in order to get into the dialogical aspects of the material as a new researcher, I practice these traditional analytical methods of Gee (1991) and Labov (1972). Gee's analysis can be used as a way of managing large and unwieldy amounts of text with a focus on how a narrative is spoken in units. Attention is given to how the words sound and how we use certain tones and pitches in our sentences to signal to the listener that we have reached the end of a sentence, (Reissman 2008, Emerson et al 2009). I then practice a Labovian analysis, (1972), that attends to the personal narrative, a monologue that is in answer to a specific question where the context is seen as less relevant, (Andrews et al 2008). Both of these methods view narrative as a transparent reflection of the person's experiences, (Squire et al 2014). These methods become the scaffold working towards the dialogical narrative analyses.

Gee's Ethnopoetic Method

Gee's ethnopoetic method attends to the rhythm, accentuation and pauses in participant's speech, (Reissman 2008). The method privileges the storyteller's meaning making and enables the stories to be seen within broader cultural contexts. The method shows how personal stories both illuminate and resist dominant discourses. Gee's method appeals to me because he makes an important distinction between the oral storytelling cultures. He found that where prose is analysed amongst collectivist societies, it takes a poetic form in contrast to the prosodic style of narrative amongst those from developed/minority nations. This

theorising connects well with this study because the storytellers predominantly originate from cultures that privilege oral storytelling traditions.

There are two components to a Gee poetic analysis; one is the micro building block that includes 'pitch glide'. This is the spoken emphasis that signals to the listener the focus of the sentence and is shown in capital letters. Second, there are the macro building blocks revealing stanzas; that is lines that sound as if they go together. The strophes are the bigger parts made of two stanzas, (Emerson et al 2009). Gee looks at rhythm and use of metaphor in narrative accounts and explores the poetic form within those accounts, (Murray et al 2012).

I select a section of Sarah's story that speaks to me of the story's desire to be heard. It is an historical story told in an impassioned tone, tinged with sadness and humour as she ventriloquates her parents' voices. I make several careful listenings of the recordings, to hear the intonation as well as reading the words on the page. I concentrate first on how the lines go together. A change of the common theme binding the lines together signals the end of one stanza, (Gee 1991, Reissman 2008).

There are a number of stories in Sarah's narrative. I become caught up in the story of her father's struggle with work. It speaks to me of the history of migration of Jamaican families, travelling to the United Kingdom with or without their children to help develop the infrastructure after World War two. Moreover, it reminds me of how my father came to the United Kingdom, though not on board the Empire Windrush, he was expected to go to the United Kingdom to forge a better life for himself. This personal connection highlights how some stories leap from the page whilst others sit back quietly. This connecting process between my story and the storytellers story is where our narrative habitus' has common ground and explains why I highlight and bring forth these particular marginalised narratives over and above other possible storylines. As I read and listen, I ask interpretative questions opened up by the stanza. Sarah is aware of constraints imposed by the cultural story and recognises her father's dilemmas. Sarah's mother, who because of her gender, is not required to perform in the same way, finds capacity to resist the

imposition of the cultural narrative and implores her husband to do the same, (Richardson 1990). Within the section of transcript[37] I listen closely a number of times, noting the pitch glide, that is how the words are spoken, the tone of the words, the pauses, the rise and fall of the voice, as the storyteller, Sarah, works to communicate to the listener. In the analysis below, Sarah's story of her parents early life together is a strong cultural narrative of suffering and the desire to do the right thing for the family in a political, economic backdrop that does not privilege minoritised persons sense of belonging in the United Kingdom. The full force of the effects of racism, deprivation and colonialism comes to bear on the narrative, (Reissman 2008). The analysis opens up for interpretation ideas about race and culture and about gender.

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[37] See Appendix K for Excerpt of Sarah's transcript

Table 6 Sarah: Gee's Poetic Stanza

> ***Stanza one: A man's job is to work***
>
> *so after that MY DAD*
>
> *he had A LOT OF JOBS*
>
> *TRYING to get BACK ON HIS FEET*
>
> *but then he went a period*
>
> *WITHOUT HAVING A JOB*
>
> *for about 18 MONTHS*
>
> *no matter what he TRIED*
>
> *he used to CLEAN TRAINS*
>
> *HE DID EVERYTHING*
>
> ***Stanza two: Cultural role reversal; women and work***
>
> *because my dad GREW UP from a JAMAICAN household*
>
> *where a MAN is SUPPOSED to work*
>
> *that is the CULTURAL*
>
> *its CULTURAL identity*
>
> *MY MUM then*
>
> *she was GONE BACK to college*
>
> *and DONE some courses*
>
> *she WENT BACK to uni*
>
> *she had ENOUGH QUALIFICATIONS*
>
> *I don't think my dad could HANDLE the fact of HER working*
>
> *and BRINGING IN THE MONEY*
>
> *while HE DIDN'T HAVE A JOB*
>
> ***Strophe one: Co construction of genderised rules regarding work***
>
> ***Stanza 3 relationship stress and breakup***
>
> *MY MUM said to him*

when things are BAD

you DON'T HAVE TO break up

WE CAN work through

but he COULDN'T get HIS HEAD ROUND

NOT BEING the traditional STEREOTYPICAL MALE ROLE

and THAT'S what BROKE THEM UP

Stanza 4 The loyalty bind

THEY had PROBLEMS at church

my mum WENT to the church

we are very CLOSELY TIED to the church

my MUM AKSED[38] for marriage counselling

they were going through ROUGH PATCH

they DIDN'T GIVE it

I am an ADVENTIST

you HAVE TO have marriage counselling BEFORE they allow us to GET MARRIED

they SIT DOWN with you,

they TALK TO YOU about WHAT TO EXPECT in marriage

to give you some TIPS and GUIDANCE

they would HAVE HAD THAT before hand when she was getting married

WHEN SHE was married and she AKSED them for more BUT THEY DIDNT

My mum said they had the perception of our family that we were the perfect family

they DIDN'T LIKE my mum at church

SHE ENDED UP LEAVING

Strophe two: The intersection of culture and religion where neither afford protection for this family

---

[38] This is how Sarah said 'asked'. It is familiar to me as my father and relatives say it

The words, "She ended up leaving" is followed by a big pause and the pitch glide drops signalling the end of the episode, (Gee 1991).

Initially I produce three stanzas but the literature suggests that stanzas work as related pairs, where two stanzas become a strophe. It was a surprise to go back to the material and find a related stanza directly after Stanza three that I had not noticed and therefore had not analysed. Stanza one and two are related by gender roles. The strophe highlights the difficulties of the cultural construction of rigid gender roles. Stanza three and four are linked by the intersection of cultural norms and the role of religion for the family and how both are found wanting. I like the sound of Sarah's father. He is portrayed as a hero, strong and determined, but he is also portrayed as a victim of a traditional patriarchal and racialised culture that places this burden on men.

This analysis is a cautionary tale reminding us of how society treats us if we do not have a job. It is not a story of resistance as her father and mother are victims of both racism in the job market and of a capitalist meritocratic society. They are unable as parents to stand up against this cultural narrative and separation follows. By contrast, Sarah's mother can be seen to resist the cultural narrative of 'a man must work' by offering to work, arguing that they should not have to separate because of this external pressure. Moreover, her mother resists the positioning by the church that implies she is responsible for the family difficulties; she leaves the church feeling unsupported when she most needed help. Sarah positions herself as audience to her parents and sees the constraints of that time in her parent's lives, she is sympathetic to her father's plight and she also sees her mother's courage. In this retelling, Sarah is positioned to learn from this story as she goes forward. The analysis opens up ideas of personal struggles being political struggles, (Emerson et al 2009).

I move to the second traditional structural method of Labov (1972).

Labov's Structural Method

After the Gee analysis, I experimented with a Labovian analysis to build on and

extend the foundation of the analysis. Moving from where the Gee analysis opens up questions of how white privilege can prevail in the job market and where racism serves as a marker of inequality because of the colour of our skin, I was curious to gain further insights into the material.

Labov's method was one of the first in Narrative Analysis, a systematic way of compartmentalising a narrative. Labov privileges 'event' over 'experience' dealing with whole stories, ridding transcriptions of talk that is considered to be extraneous, for example present tense, eventless dialogue is not analysed, (Patterson 2009), what Richardson (1990) calls 'everyday talk'. The structure is expected to be clear in terms of what events are being talked about, chronologically ordered and typically to follow a style of, 'this happened, then this happened, then that happened', (Murray et al 2012, Squire et al 2014). I was initially unsure of this method; I read a critique that Labov's work was mainly with men and boys and that he failed to address the 'subtle interactional intricacy of female personal narrative,' (Patterson 2009). I then learned that he studied the storytelling sophistication of African American youth, so I recognised and appreciated his attention to diversity, (Andrews et al 2008).

I select Tamara's narrative for analysis. It is not a typical event narrative, nor is it temporally coherent so it appears unsuitable for a Labovian analysis. However as I looked more closely at specific segments of the material rather than try to apply the approach to the whole transcript, I became curious about wanting to make meaning of her talk, (Murray et al 2012). I select a section of dialogue[39] where I ask Tamara whether she thinks her cultural heritage has brought any advantages to her as she works towards recovering. From this analysis, I find that there is not only an increased coherence in Tamara's story, but more importantly I hear a new story emerging, minute-by-minute. It is apparent that Tamara has not voiced this story in this way before because her emotional tone is hesitant and uncertain, yet there is a doubled coherence in her dialogue as she manages both the confines of

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[39] See Appendix L for excerpt of Tamara's transcript

the ed and its moral control over her and begins to sense there is more to life than the ed.

Table 7 Tamara's Labovian Analysis

Abstract – *what is the story about?*

Tamara responds to my question about whether her culture has had any part to play in her recovering form anorexia: She begins by saying 'no' and I ask again, in a slightly different way because my experience tells me that this may be a moment of going beyond normative narratives

This time she tells a detailed story, a story constructed in the moment as she reflects in action as my question resonates for her

Orientation *(who is the story about, when did it happen, setting in which events of the story will be told)*

The story is about Tamara as an in-patient with other women with eds. The hospital is not named nor does she tell me when this event occurred. I do not ask her for this detail of when and where, I want her to remain uninterrupted in her dialogue to see where it takes her.

Tamara 's narrative is beyond time, collapsed time, it maybe a vignette drawing on several admissions and different experiences.

Complicating action *(Spine of the narrative, relates to events typically follows a then and then structure – events need to be related and in chronological order)*

Tamara talks animatedly about the other patients and specifically how they speak to their mothers when they come to visit the ward. She simultaneously tells a story that she is thinking about children starving in Africa, 'because she is from Africa' She has observed that eating disorders make you a bit 'in your own world', not quite self-absorbed but nevertheless it has an impact on relationships and behaviour. She sees how other young women talk to their mothers. She observes them being rude to their mothers and how this embarrasses her. She reflects and contrasts her position with theirs. How it is that these other women want their mothers to think 'it is normal not to eat' whilst Tamara recognises that this would not be accepted by her mother, due to her mother's culture. She expresses difference between herself and the other patients in how they talk and what they are able to say to their mothers. She reflects that she has two arms and two legs that work, and food and thinks this is a good enough reason to get better in contrast to what people in Africa do not have. She asks the other patients if they are allowed to talk to their mothers like that, then she remembers a time when she was at home, whilst at secondary school, she used to go to friends houses, black and white girls. She observed there that the white girls were rude to their mothers, swearing and being rude. She reflects that this is something she would never do, calling it a 'cultural thing' and referring to 'two completely different things' meaning in her black friends homes there is a general sense of respect, similar to her home. In contrast going into her white friends homes she observed something different with girls swearing and being rude to their parents.

She jumps again in time to being in hospital as being a similar experience

Evaluation *'the soul of the narrative' (Reissman 2008)*

> *In the telling, Tamara reflexively evaluates her story. She is grasping an idea which does not come out fully formed, that eds have something to do with being self absorbed and in your own world but she appears to be distancing herself from this position. So if you were 'self-absorbed or in your own world' somehow this gives you permission to be rude to your mother and she is clear this is not how she behaves. This leads to the idea she has been raised differently and she also draws on her heritage and her race to help explain why she is different in terms of her worry about starving children. She wonders if it is because she is black that she thinks differently but it is something she has been unable to express before now.*
>
> *She does not step out of the telling in order to tell her audience both the story and how she wants to be understood. So we learn that there is a difference in terms of race (black, white) and culture about how teens treat their mothers, both when they have an ed and when they do not.*
>
> *At the end she talks as if she is in the time when she spoke to her friend and the final sentence is a rhetorical question to herself and is in the present timeframe; the; "oh why is she used to it, should she be used to it? is as much a question to herself, to me and to the wider audience*
>
> ***Result*** *– what finally happened? How does the story end?*
>
> *What is interesting is that Labov focuses on the past tense whereas Tamara moves easily between past and present. There is evidence that women and men tell different stories and that non Indo- European traditions may put place and character ahead of importance of time, which seems to be evident with Tamara. (Patterson 2008).*

The benefits of both Labov and Gee is that they recognise social difference in terms of use of language, for example how different social groups use the spoken word in a variety of ways such as slang and patois. Gee analyses words that appear nonsensical for example the words spoken by a woman with schizophrenia. The limitations of the structural methods are to do with their view on language, so within these methods language is seen as a transparent medium through which stories are told in contrast to a social constructionist view where language is constructed through dialogue, (Squire et al 2014).

B. Both/and: Creative Methods and Embodiment

This section explores the use of creative writing methods as an analytical technique, page 89 above, figure 3. I weave and quilt the emerging themes from the structural methods to further develop thicker descriptions of the stories,(Sparkes and Smith, 2012, Grant 2015,Caddick et al 2015, Papathomas.et al 2015, Richardson 1990). Embodiment and relational aspects of storytelling are centralised in this method, (Caddick et al 2015). This style of analysis is no less

robust or credible though it is novel and as a new method it has been less scrutinised as a qualitative methodology. Smith et al (2015) suggests that in order to write a good creative non-fiction the researcher needs to consider a number of factors. For example, the story should 'show rather than tell'; there should be a moral and theoretical point to the story; it should emotionally engage the reader by being evocative and visceral and the researcher importantly *'thinks with her body'*. This guidance also suggests that it is a useful step to undertake prior to the Dialogical narrative analysis. Richardson et al (2011) speaks of 'coming out', finding traditional methods of analysis boring. Many of her minoritised students gravitate towards creative writing as a method. She argues that creative writing represents a challenge to traditional social science writing conventions, to include poetry and drama for example. I experiment with creative writing after speaking with Dr Papathomas who had written on this method. He offered brief feedback on style and literary conventions, (Papathomas et al 2015). It *felt* a good fit for me because unlike the structural methods above, this method affords a creative freedom, ensuring that the writing is evocative and emotionally engaging whilst also paying attention to its coherence, staying close to the material and bringing forth new questions. Examples include a short play where Lilly explains to school friends the impact of hospitalisation. Here is a brief taster of the play:

Table 8 Excerpt of Creative Non -Fiction Play[40]

The characters: Lilly 18 British/Japanese, Rita 17 British/Muslim, Susan 17 Irish/English
Setting: college canteen
Susan What's up with you? Not eating these….-
[Susan begins to take the chips from Lilly's plate]
[Rita watches and smiles as she crams the food into her mouth.]
Rita Bet you weren't allowed to do that in the hospital did you?

[40] See appendix I for the full play

> **Lilly** *Don't talk about that. Thank God I'm not there anymore!*
>
> *[Susan makes a blessing with her right hand and mumbles a recitation]*
>
> *[Lilly looks at her friend]*
>
> **Lilly** *Yeah, Rita don't talk about hospital it makes me ill. People are so fucked up in there. I hated it. Thanks Dad!*
>
> *[Rita shakes her head]*
>
> **Rita** *you hate your dad too??*

Other examples of creative non- fiction writing (Smith 2013) include:

- Esme train journey story[41]
- Fathers in a support group story
- A time line from a first person narrative
- A second person narrative about being parents of a sick child
- A father writing to his daughter about their relationship

Some of these stories are incomplete but the process aids my developing analyses. I enjoyed delivering a workshop at a research conference using these methods. I asked participants to read a section of transcript and to write a poem or prose from the transcript. I received helpful feedback about the potential for this writing approach. Initially participants of the workshop were unsure of how it might lead to analysis but with a few practices, they produced a variety of poems, letters and prose that were then shared with the workshop group. The effect of the continual reading and listening to the narratives had a visceral impact on me. I felt an urgent need to capture this sensation. Lilly's dialogue brought forth warmth and a sense of someone so full of energy and determination that it is difficult at the same time register, as she puts it,

> **L** *I have been ill for a quarter of my life*

I find this sentence both profound and sad. Lilly is of Japanese heritage. My husband suggested I write a Haiku. To write a Haiku there are a set number of

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[41] See appendix N for Esme's train journey story

syllables per line, five, seven, and five. I learn that Haiku's use sensory language and this seemed fitting for this task because in writing the Haiku I find I begin to connect in a visceral and emotional way. I did not edit the Haiku's. They are the first lines I produce and I feel capture Lilly in the moment.

Table 9 Lilly's Haiku's

Food food no food food

Rice full belly jam sandwich

Rage brightness life fun

Let me go, I want

more than this, love, hate, you ,me

Free, sing, dance, tattoo

East west fat thin, no

Stop, start learning to be me

Katsu curry, rice

Dad mum together

Where do I belong here, there?

Time passes to go

Thin thin fat thin no

Not one not another, me

Clever girl with dreams

Look at me yes you

> *Listen to me please listen*
>
> *What do I want for?*
>
>
> *No sun only dark*
>
> *Hollow belly, don't tell me*
>
> *Don't control me please*
>
>
> *I did not know you*
>
> *Family there, here, nowhere*
>
> *Who are you to me?*
>
>
> *Uni, I am off*
>
> *Fluent Japanese that's me*
>
> *Friends, create, life is great!*

The Haiku's stand as exemplars, in the way Narrative Analysis draws on exemplars of stories to demonstrate paradigmatic ideas. The Haiku's perform a dialogical embodied sense of Lilly. I hear a young minoritised Japanese woman's bid for freedom, to spread her wings. She expresses feeling controlled by her parents especially by her father, to do well. She is bright, talented and creative yet feels this is not recognised. Her ambitions do not connect with her parent's ambitions for her. The Haiku brings forth in a powerful way, Lilly's dilemmas and how she begins to resist the cultural story she has grown up with. This approach offers a quick and powerful *emotiona*l insight into this young woman's world. As I read the transcript I remember Lilly sitting in the room in CAMHS, with her piercings and yet to be described tattoos, her school uniform, her glossy black hair, her smallness in contrast with me, her neat, precise speech, her short sentences and terse tellings (Boje 2001), her laughter, her wonder at why I might be interested in talking with her about her experiences. To capture all of this in words

that are meaningful for the audience who do not know Lilly affords a direct connection to this young woman's experiences, her sadness and her brightness in a dramatic, punchy way, (Charmaz 2008, Potter and Hepburn 2005). Ultimately it needs to grab the reader; there is no point in worthy research if the reader is bored, (Caddick et al 2015, Smith et al 2015).

C. Both/And: Dialogical Narrative Analysis: The Individual/Cultural and Collective Stories

I move now to the heart of the analyses, the dialogical, relational approach. Through the storytelling process, each storyteller breathes life into a number of important stories that are no longer in the margins. See page 89 above, Figure 3. The stories talk back to us as clinicians and researchers; we are caught up in them. Frank (2012) calls this 'interpellation', that is, how the stories teach us who we are, and how to respond. These stories hail us to perform certain actions, for example in our practice clinically. They hail me as part of the research endeavour to shine the spotlight on them. In doing this I hope change is possible to ensure that minoritised women receive excellent care, (Kirmayer 2012, Kline 2014). In this section I use Preetam's[42] narrative as an exemplar of the stories told. I use line numbers on all quotes from Preetam.

The dialogical approach recognises that our stories embody social and cultural templates that we use in our talk. The stories are not only individual stories; they are historical documents, citing social and cultural mores of the 21st century. Reissman (2009) calls this the political work of stories. Dialogue is viewed as anticipatory, unfinalised, embodied and coordinated, like a dance, (Bakhtin 1984,Rober 2005). When the stories come together as in this study, the stories take in new voices and new ways of talking. The stories talk to each other for the first time; they can dialogue with each other from one to many voices. (Frank

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[42] See Appendix J for Preetam's complete transcript

2010).

I am interested in what Frank (2012) calls 'mutual recognition'. It reminds me of Timimi's extended family metaphor, where in the moment of realisation, we remember our humanness, we are no longer doctor or patient, therapist or client, researcher and the researched but we are a family of humans together in a particular moment in time, (Anderson 2012). This is when the researcher and participant come to see each other as human, with lives outside of this relationship, coming together for a mutual moment in time. I learn from the storyteller and she will learn from me. An example of mutual recognition is when Tamara asks[43] about my family. Moreover, the intersubjectivity between Tamara and myself reveals how embodiment plays a part in all relationships. Tamara and I hugged as she walked me to the bus stop so that I did not get lost on my way home. It was an easy, comforting and warm gesture. I did not think, '*I have crossed a boundary,*' a sentiment so frowned upon in mainstream therapy culture. In a similar moment, a minoritised doctoral student spontaneously hugged me when we met after not having met for some time. She remarked how easy it was to do this with me in a way she felt she could not do with white students. It has taken some while for me to feel comfortable with my embodied difference, because throughout my training it was not something to be encouraged or spoken about. This embodied spontaneity ought to be celebrated and not dismissed as boundary crossing. The genie is out of the bottle as far as embodied practices are concerned and I believe it will afford relief to many practioners who have had to sit on their hands, not show emotions and certainly not touch others, (Afuape 2017).

Dialogical Narrative Analysis: The Individual/Cultural Stories

In this section I bring forth 10 individual/cultural stories constructed from the analytic practice. The stories here are produced by the constant comparison across the individual narratives in the method described in the hermeneutic cycle,

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[43] See appendix M for Tamara's transcript excerpt

Story 1: Food as Disturbing Metaphor: The storytellers' Longstanding, Devastating and Ambivalent Relationship with Food and Eating

All the storytellers perform stories of a longstanding struggle with food and in some cases the struggle is experienced and described in babyhood. This material was brought forth by asking questions using the idiom of food to explore relationships. I ask about food they enjoyed, whether there was access to, and preparation of, cultural food, who prepared food and the food that is no longer cooked or available. The questions were generated using the cultural food genogram. The cultural stories brought forth speak loudly of difference between my clinical cases and the stories presented here. The food/body image prevailing discourse in my clinical work is not played out in the emerging storylines presented here. This resonates with Littlewood (1995) who argues that eds amongst minoritised women are not 'appropriating' white womens' concerns.

Tamara (T) tells me that as small child she was taken to paediatric and mental health specialists for failing to thrive at the age of two. She tells me there are so many factors leading to her ed, that '*we would be here until tomorrow*' if we were to go over it all. She tells me her mother struggled with ed issues.

Esme (E) reflects how her mother who has alcohol and mental health problems, raising Esme as a single parent. Esme had no contact with her Jamaican father until she was seven. At the time of Esme's birth, her father had his own family with young children.

> *K so what do you remember about food in your, when you were a little girl, what you ate, what your mum liked to cook?*
>
> *E I remember like, that when I was about 10, I was like I had to do everything for myself, so I would say before that she would, (4) I don't think it was food, I think it was just like crisps and cereal and stuff because she was drinking so she would never be able to make me anything*

I ask a question that I have never asked a clinical family

> *K do you remember, were you ever hungry when you were living with your mum?*
>
> *E ehm (7) I had little appetite when I was with her*

She goes onto say,

> *E It was very hard, like I don't have a lot of memory because it is all bad memories, I just, you always think of the good memories, that's what makes you remember. I have so many bad memories that my memory is just not, there is nothing really there because it's all the same*

In my clinical work, I rarely hear stories of food availability and only in very few cases do I hear stories of such problematic relationships with food from earliest memory.

I hear from Tara (Ta) how being able to eat her favourite food was contingent on getting on with her cousin. Tara also expressed problems with her memory about food

> *K so what do you remember of the years growing up with your mum and dad, your early memories of food and what you ate?*
>
> *Ta Well I was trying to think, do you talk about the distressing bits first or the nice bits? Well there was domestic violence and I think, yeah, my dad was violent towards me quite a lot, so yeah, not a lot of, kind of, difficult times, its really hard to remember nice times*

By evoking childhood, traumatic stories of domestic violence are brought forth. Once again this is a story of not remembering. I ask Preetam (P) what her favourite food was when she was growing up

> *L177 K nothing springs to mind? Did you have Western food or Indian food?*
>
> *L178 P a bit of both, no I cant really remember much about food*
>
> *L179 I was thinking what you were saying about the importance of family and*
>
> *L180 P mmm*
>
> *L181 K and culturally I was imagining, my mind was imagining part of that would be meeting*

> *other*
>
> *L182 relatives and having group gatherings and often that is around food*
>
> *L183 P yeh*
>
> *L184 so I am wondering what those events were like, weddings or other celebrations around food what*
>
> *L185 would you have been drawn to or interested in*
>
> *L186 P I don't know, yeh there would have been a lot of food but it would probably have been mostly*
>
> *L187 P Indian food, I don't know, I don't think I really thought about it that much and when I did start*
>
> *L188 P thinking about it that's when I started avoiding things so*

Tara tells me;

> *Ta Oh I do remember my dad force feeding me uhm fried egg plant, I won't eat egg plant to this day*

Emily (Em) explains that her mother was depressed, that she does not remember what made her ill but that she began throwing up

> *Em ehm, I, I think I lied a lot and was quite like deceptive ehm, I don't know, I remember, probably in some of my, like worst times I like pretend to eat a lot and hide food in tissues and that sort of stuff and, ehm, I'm sure that they to some extent that knew that after dinner I would go and throw up and like exercise in my room and stuff like that, ehm, they couldn't do much about it , sometime they were nicer and tried to sit with me whilst I cried and things like that but quite often they yelled at me*
>
> *K: to eat?*
>
> *Em: yeah, ehm, yeah (4) I think that I was equally as difficult so like I don't blame them for it*

Harriet's (H) story has some overlaps with my clinical caseload, she remembers not eating in order to change her body shape.

> *H: I am gonna lose some weight and it goes on from there really*

Sarah comments that her mother had depression and that she has always had problems with eating and not being thin enough.

Lilly experienced low mood and her ed was picked up in CAMHS. Lilly conveyed a complex relationship with food, which was ventriloquated as her mother's voice as '*food being life'*. Lilly asked as a small child for jam sandwiches and crisps instead of katsu curry.

Although Tara has some good memories of tasty food, mealtimes were not easy. In this example, Tara clearly enjoys food yet there is an affective component as to how could she get to eat her favourite breakfast without having to rely on her cousin's mood on the day?

> *Ta We all lived together, every Saturday was a big fry up, kind of fried spam really crunchy and crispy or pancakes and bacon, I lived for Saturday morning you know and it was almost a thought that I needed to be nice to her so I could get that, it felt contingent in some ways*

In summary, the storytellers reveal a longstanding, ambivalent and traumatic relationship to food, and weight disturbances alongside parental mental ill health and other family disturbances.

Story 2: Caught Unawares: The Ed Captures the Storyteller

The second individual/cultural story reveals the insidiousness of ed, creeping into the womens' lives. How eds capture the storytellers and the journey to illness, is not straightforward or clear. The storytellers are unsure how and why the ed thrived, yet they know there was a long build up over many years, to a point where their eating was no longer something within their control.

> *Em I don't remember what made me ill, I began throwing up, one of my teachers noticed. The school nurse got involved. I had a sense of getting more unwell but it took a bit of time to get help*

Nicole (N) says

> *N I don't know really, I was not feeling good about myself*

Preetam says;

> *L189 K what age was it when you became conscious that you were starting to avoid food?*
>
> *L190 P 11 or 12*
>
> *L191 K uhuh, so before that food was just fuel*
>
> *L192 P yeh I didn't think about it, I didn't dislike it, I just didn't really think about it. I must have thought*
>
> *L193 P about it a bit, because I went to school at 5 and said I was a vegetarian, I was eating meat up until then*
>
> *L194 until then, and my parents were like 'oh well she says she is a vegetarian ' so yeh, that's all I remember*

> *Em my parents were arguing all the time over dinner, it was really uncomfortable*

This experience for Emily accords with Littlewood (2004) who says that eds for minoritised women reveal that

> "*Self starvation maybe an accessible way of expressing distress in any context where food refusal denotes illness and where nurturance is articulated through an idiom of shared food prepared by women.*" *(P599, 2004)*

Littlewood (2004) argues further that this 'ascetic self starvation' is not driven by a fear of fatness, a symptom that forms the core of classification for 'anorexia nervosa'. Many collectivist cultures practice fasting and purging that is not equivalent in meaning to vomiting and fat phobia leading to severe restriction of food.

Story 3: Professional Positioning: Out of mind, out of sight[44]

This story is well documented in the literature and is a dominant theme of the storytellers' experiences, (Chowbey et al 2012, Wales et al 2017). As clinicians we receive training from within the dominant and ethnocentric discourse on eds. Consequently we have no training on minoritised eds. It was meeting Hana, a young Muslim woman with 'anorexia' that brought forth the idea of eds amongst diverse women. Up until that point and including working on an in-patient unit, I was unaware of eds amongst other cultures. Googling for eds amongst minoritised women shows photographs, You Tube clips and research articles from the Unites States but little in the United Kingdom. It was not until this year, The Guardian/YouTube (2017) that a clip became available from a Guardian journalist that is now on You Tube and one I now use in training.

I ask Preetam whether her body shape played a part in not getting treatment

> *L481 K anyway, slight build anyway, did any of that feature?*
>
> *L482 P I think that is what took longer for me to, yeh, because the first time I was diagnosed with an*
>
> *L483 P eating disorder, so I would have met the criteria for anorexia but by the time I had reached*
>
> *L484 P services, ehm, when I was 15, I think I was in CAMHS, the first time I had a proper psychiatric*
>
> *L485 P assessment, by that point I was bingeing and purging like ten times a day*
>
> *L486 K gosh*
>
> *L487 P I'd gained lots of weight so the first diagnosis I got was bulimia, ehm and then, when that kind of*
>
> *L488 P shifted and I was restricting again I was already known to services for having an*

---

[44] Burnham (2012) reversing the usual idiom of 'out of sight out of mind' meaning minoritised persons they are not in the minds of mainstream policy makers despite being 'in sight' and visible.

> *eating disorder*
>
> ***L489 P*** *even though I didn't really agree with it but I think if I had first come to services at like 14, 15 or to*
>
> ***L490 P*** *my GP they would have found it difficult to diagnose me because I had always ben naturally slim as well and my mum would have gone I was skinny at her age they would just have thought it was*
>
> ***L491 P*** *genetic ehm,*

I ask Nicole and Esme how their ed was picked up

> ***K*** *when did you decide or did someone decide that you needed to get some help?*
>
> ***N*** *I just had sort of sudden weight gain and that was when my mum found out, well not found out but thought I was losing a lot of weight and took me to the doctors [..] Now when I look back on it, when I see pictures, I am like 'oh it did get quite bad' but I think any more it would have got, I think my mum did notice at the right time, to be fair, she took me to the , when she initially took me to the doctors I was only a little bit underweight , the doctor wasn't too concerned, like you just need to eat more to make up for what you are losing then it was only a month two months in between and when I went back it had dropped a lot more[..] and my periods had stopped and I got a diagnosis of anorexia*

> ***E*** *I was told there was nothing wrong with me by the doctor, I was admitted a week later at coma level, my heart was very bad*

Sarah (S) explains how she tries to get help but she could not see herself represented on line. She took this to mean she did not have an ed and she carried on with her extreme restriction followed by binge periods. She interpreted this as meaning she was to blame for her difficulties. Eventually she could no longer cope and realised she had a serious problem. Her description below illustrates that even once you start looking for help, it is not easy and there are many hurdles to cross.

> ***S*** *I need to fix this, problem, if something is wrong then it needs to be put right, [..] it was very difficult that I had to fight so much to get referred, the first thing was like you've got an eating disorder and people are like 'you don't look like you've got an eating disorder', I'm like 'I do, and I need help' so that was difficult*

Sarah's experience is evidenced in research that identifies that minoritised women may outwardly not look as if the have an ed, yet are inwardly struggling, (Bordo 2009). Binge eating disorder, that is binge eating but no compensatory purging, is a new category in the latest diagnostic manual. Binge eating disorder is found to be more common in minoritised communities such as Latino, Hispanic and African American, so it is important we are also aware in the Untied Kingdom of some of the differential presentations from different minoritised groups, (Franko 2007).

> *S continues*, so then I went back again, I went on the website, this was a couple of months after I first went on [..] Talking about different eating disorders and when it came to Binge eating disorder, I looked at it and said 'that's me' (tapping the table to emphasise) and I felt a bit relieved [..] I remember telling my mum and sister 'I have an eating disorder', and saying 'that's me, every single point and it was something I had done and they were like 'its not you, its not you, you don't eat in secret, you don't this, and they had to come to terms that, I was telling them 'well yeah, I do' and that was really difficult and then after that I was, 'well if I have a problem, I need to get help, I need to get help' I was like, its like everything else, it needs to be treated [..] so as soon as I read that thing I made a doctor's appointment.

She goes on to describe the process of getting help. During this period in the conversation, Sarah was very animated, she constantly tapped the table, performing such determination, it was easy to believe if someone has less confidence than Sarah, that this difficult process of getting help may have been even harder, if not impossible. Sarah continues for five uninterrupted minutes and the dialogue is as powerful as it is disturbing. Sarah is a dynamic confident minoritised woman. Despite her confident physical presence, her determination and family support, she struggled to get the help she needed. Sarah's emotional volitional tone is analysed because taken together with her words; she reveals strength and resistance to the cultural narrative that minoritised women do not get eds. Sarah's experience of binge eating was found to be one of the most troubling and distressing symptoms amongst African American students according to one study of college students in the United States. It is not possible to say if it would be the same in the United Kingdom as there are no studies of this type. But given how little is known amongst clinicians about binge eating disorder coupled with clinicians lack of awareness of variable ed presentations by minoritised women, it is possible to conclude that this condition is not only hard to identify amongst

minoritised women. (Franko et al 2007)

Story 4: Family Positioning: 'Out of Mind, Out of Sight'

There is wide recognition that health services and mental health promotion must consider culture in order to be ethically sound and clinically effective, but that racial bias continues to impact on access and treatment of minoritised persons in the United Kingdom, (Kirmayer 2012, Donald et al 1992, Kline 2014). These factors impact on minoritised families awareness and understanding of services. Because of the bias, minoritised families are uncertain, suspicious, fearful and anxious about how services might be able to help them and they raise concerns regarding confidentiality and fear of stigma impacts on accessing help. The storytellers describe their family as being very unsure of what to expect in treatment, to being hesitant, angry, puzzled doubtful and many more feelings besides. The lack of representation in the media fuels the idea that minoritised women do not experience eds. Therefore it is of no surprise that minoritised parents also have a lack of knowledge of eds, (Chowbey et al 2012). Here Emily, Nicole and Harriet comment.

> *Em, Eating disorders are definitely less understood, dad said he hadn't come across anything like this before.*

> *N no, she (mother) did not know anything about it, she read up about it on the internet, yeah it was sort of alien to her*

> *H her sort of thing was there is nothing wrong in your life that means you need to do this, so why are you doing it she (mother) did not understand*

Sarah's mother and sister had heard of a/b but not 'binge eating disorder' and therefore presumed she did not have an ed.

Here Preetam recognises how parents know and yet not know. Preetam explains how her mother spoke with Preetam's maternal aunts yet Preetam's own siblings

were kept in the dark.

> *L364 P even though she knew uhm, you know, my brother came to family therapy at*
>
> *L365 (psychiatric hospital) last summer and like although he knew, he'd been to visit me in hospital, in*
>
> *L366 two years ago, two years ago I was in psychiatric hospital, he came to visit me there L367 and like he's not thick he knew what kind of hospital it was but like nobody properly L368 spoke to him and then we had a chat after one of the family therapy sessions and he L369 was like 'yeh I knew that was going on' and I said 'yeh I know you did, I don't think you L370 are stupid' its just that no one talks about any of it properly*
>
> *L371 K and is that, in your experience, a feature of families where there is eating disorders in L372 general, or would you say its in relation to a different cultural approach, or a bit of both?*
>
> *L373 P its probably a bit of both, like, you know, I have got friends who are like when thy L374 were first diagnosed their parents would like, read up on all the information they could, L375 you know, and follow all the instructions to a t that they were given and then there were L376 families like my parents who turned a blind eye for a long as possible hoping it would go L377 away , so yeh, I don't, yeh a bit of both , for my parents, pretending nothing was*
>
> *L378 happening, ehm, and I think also, because I was getting such conflicting messages its L379 not all their fault some of the blame was on me because they would hear one thing from L380 like a doctor and I'd be like 'no no everything's fine' so it would be exaggerated so my L381 parents were, I guess, well who do we believe? Well we would rather believe our*
>
> *L382 daughter because she also seems a lot better we don't want to think are like 'we have L383 to lock up our knives I think, so I can understand why they did some of that as well*

Story 5: Hospitalisation as (more) Trauma

Malson et al (2011) refers to admissions being a ' distinctly unpleasant experience' and the experience of Lilly, Esme, Tamara and Preetam's experience mirrors this. In patient treatment does not differentiate on cultural grounds. Therefore minoritised women can expect the same treatment as everyone else on the ward.

The stories of this study differ from my clinical work in both *the duration* of the in patient treatment, *the moving* to several different treatment centres and the fear and dread of being held down and forcibly medicated. All represent a terrifying ordeal for those storytellers who experienced admission. Tamara tells me,

> *T [..] This is the last resort hospital, this is where you going to go, this is literally where any hospital hasn't worked for anyone, this is where you go."*

and the sense of disempowerment that follows.

Lilly's ed is picked up whist she is in CAMHS. She was treated for four years including an eight-month in patient stay. Although Lilly is aware she was at risk of dying if she did not go into hospital for treatment, she found the treatment experience terrifying.

> *L when I was an in patient I remember looking around at everyone [..], there were people with depression trying to put scissors in their arms, [..]Personality disorder and [..] bipolar, schizophrenia [..] it was like a bit disturbing to be around, [..] Some people who were actually genuinely really crazy and there was this girl called (xxx), she would turn into a baby sometimes and wouldn't talk to anyone, she would shout at you 'what you looking at?' like 'nothing' then she would like, piss [..] I remember sort of sitting there, like, with all of these people, [..]Something really bad has happened to them and they cant do anything about it, all I have to do is pick up a fork and I can get out of here, but like these people cant, [..], so I remember thinking this, I am just taking up a valuable bed space.*

> *E they were literally like a pack of animals on me*

> *T I feel I need to tell you this, because my hospital, I can never talk to anyone about this because it is not normal talk*

Preetam's narrative of hospitalisation is more nuanced. She does not openly acknowledge traumatic experiences in the way Lilly, Tamara and Esme did, her talk minimised both the frequency of her hospitalisations dating back to her being 16 years old and the impact on her life to this point. Her experiences talk to current findings in the literature that specialist settings are likely to be more helpful than

non-specialist ones and Preetam seems to find sanctuary in her experience.

> *L530 P ehm, I was in hospital twice when I was younger, just a short admission to general*
> *L531 hospital because of overdoses ehm, and then, I was doing quite, I was doing all right for*
> *L532 a few years and then when I came to London I did well for like a year or so and then my*
> *L533 mood started dropping, ehm, and then my eating kind of went out of the window as well*
> *L534 and then, and then I was referred , up until that point I had just been in the general*
> *L535 mental health services then I was referred to the (Specialist) eating disorder service, it*
> *L536 was the first time it was specifically targeted and focussed , they decided I did have a*
> *L537 problem with my eating, it wasn't just because of my mood or whatever else my mood*
> *L538 just kept dropping and then I ended up having to go to medical hospital for a week to*
> *L539 get like physically stabilised*
>
> *L540 K gosh*
>
> *L 541P and then very very reluctantly agreed to be admitted so they could get like the right*
> *L542 P medication and stuff*
>
> *L543 K was this as an adult*
>
> *L544 P yeh as an adult an adult ward for a few months and then, so that was just purely to*
> *L545 P treat my mood really which it did, it helped I got sleep and rest and everything and*
> *then*
>
> *L546 P I started the day care programme at (specialist) eating disorder service which was*
> *for 9 months or something so*
>
> *L547P that was good, so the in patient sorted my mood out and then I got to be a day*
> *patient L548 P to really work on my eating which is something I had never done before,*
> *ever so that L549 P was good, really helpful and I went back to work and they just gave*
> *me like outpatient L550 P support*

Story 6: A Cultural Double Bind: Body Image versus Embodiment

There is evidence that as minoritised women become more acculturated to a globalised mainstream media that emphasises the thin ideal, we increasingly become exposed to this dominant pernicious message, (Littlewood 2004).

> *H I am gonna lose some weight and it went on from there really, […] I remember going on*
> *blogs and [..] all the kind of pictures of very thin women, yeah, I guess they were always*
> *white […] I remember talking to (father) [….] how in Jamaica like it is so celebrated to*

> *have, you know, curves and […] you see Jamaican women trying to squeeze themselves into these outfits [….]but here, culturally its really not acceptable, you don't flaunt your body if you haven't got an ideal body, whereas the ideal body (in the Caribbean) is just so different*

Here Harriet is making a connection as she speaks, she is making meaning of some of the differences she has observed and in her tone of voice it is as if she is joining up some previously disconnected ideas. Harriet is calling up knowledge, retrieving information whilst simultaneously responding in the present and is knowledge in the making, reflecting in action, (Holstein et al 1995,Schon 2016). The 'ideal body' in the United Kingdom is very different from the ideal body in Jamaica, her conversation with her father is brought forth and she places it alongside her own experience. She goes on to talk about her Indian ancestors who are described as 'being quite round'.

Sarah also has a moment of recognition like this. Though difficult for Sarah to accept, when her therapist tells her, 'your body is not meant to be thin', she experiences this as a terrible shock yet an important realisation that she is different, **and it is okay to be so**.

> *S but to them (your family) you are normal, in fact you could probably put a bit more weight on and its difficult because culturally I feel there isn't an understanding [..] He adored me the way I was, he was like 'I don't know, you are perfect, you don't need to lose weight' and I was like 'no, I need to lose weight, I am really fat' [..] because I know that's not a cultural thing, so its difficult for me to talk to friends about it, [..]'Culturally you're fine, you've got curves' and this and that and I'm like 'no' and they don't get it*

> *E I just didn't like my body and tried to hide and copy others*

> *Ta I dated an African [..] and that was a whole other thing around food because he was really into his food and he loved African food and em of course he had different ideas about weight and shape and liked big women so for me it was very confusing at that point, you know I was still going to the gym even though I was in a foreign country, I was still kind of struggling around food, I wasn't purging like I was, I still had the body image*

> *thing going on.*

Tara goes on to say that she lost and gained weight and began to realise it 'was not normal'.

Preetam by contrast does not describe body image problems. She is clear her mood affected her ability to eat and can be thought of as unwanted embodied feelings.

> **L517 K** *if someone had asked you about your shape and size, would you, how would you have answered?*
>
> **L518 P** *it was something I became aware of as I got older, the illness had gone on for a lot longer, I definitely*
>
> **L519 P** *know I didn't restrict my eating because of how I felt about my shape and body*
>
> **L520 K** *mmm*
>
> **L521 P** *it as just that I had no appetite because I was really low in mood*

The stories here represent a mixed picture on the issue of body image, seen as central diagnostic issue for a diagnosis of anorexia, yet not always described by minoritised sufferers.

Story 7: Transmitting the Legacy of Silence: Not Telling Parents

Several of the storytellers do not tell their families about the ed. This accords with my clinical experience of working with minoritised women, who are often anxious about a family approach. I am working with a young Muslim woman; I will call her Meena, who is from Pakistan. She does not want her father involved. Her mother attends some sessions. Meena disclosed she is lesbian and is unable to tell her parents. In sessions her mother describes her as a respectful Muslim girl and Meena is determined not to let her mother down. Standard evidence based treatment would invite her father to the sessions but this clearly has far reaching implications for Meena.

Both Emily and Preetam first spoke with the school nurse and there was an issue of confidentiality at stake. As things became worse, the school nurse planned on telling the parents. This led to them both distancing themselves from the school nurse and though both young women did get help eventually, there is a risk of being untreated in this scenario.

Preetam was very aware of this yet found the school nurse very helpful and got her through a difficult time. In thinking about enhancing services to meet the needs of minoritised women, the role of the school nurse maybe a hidden but important one.

> *Ta I did not tell my mum, she was working two jobs, looking after my sister and living in her mother's home […] I still haven't told her [..] I had lots of help once I left home to go to university*
>
> *Em I think I lied a lot and was quite like deceptive ehm, I don't know, I remember, probably in some of my, like worst times I like pretend to eat a lot and hide food in tissues and that sort of stuff and, ehm, I'm sure that they to some extent they knew that after dinner I would go and throw up and like exercise in my room and stuff like that, ehm*

> *L509 P I was eating breakfast and I was always eating dinner with the family but I ate nothing during the*
>
> *L510 P day and then later I stopped eating breakfast but I was always eating dinner it might*
>
> *L511 P have been*
>
> *L512 P small er portions but I was eating one meal a day so it was very difficult for anyone L513 P to know that I*
>
> *L514 P wasn't eating during the day, so yeh, say if my mum had taken me to the GP I'd have*
>
> *L515 P said, yeh, I*
>
> *L516 P am eating during the day and because my school hadn't picked up anything they weren't aware*

> *L517 P that I was or wasn't eating*

> *N well during that period, it wasn't noticed but there were times I did consider going to my parents and saying 'I think I have, like, something' but I didn't and it sort of just managed to go away by itself, I just sort of tried to stop bingeing and tried to eat better, ehm, and it was sort of ok and then it was when I started to work and then, I didn't, yeah and I just had sort of sudden weight gain*

Accessing timely interventions is paramount for a good prognosis yet there is evidence of both poor identification of eds amongst minoritised women and uncertainty about treatment.

Story 8: Race as a Fact of Everyday Life: How is Intercultural Practice Enabled?

The storytellers construct racism explicitly and implicitly. For some storytellers the dialogue of race is embedded in stories of 'trying to fit in and belong'. Lilly immediately comes to mind because although she argued race was not a feature of her life and clearly she has privilege in terms of class that is protective, nevertheless she laughingly tells me how in order not to be the butt of racist jokes she makes them first. She graphically and emotionally conveys how as a small child her packed lunch cast her as different, as 'other'. She poignantly speaks of asking her mother to provide a packed lunch of a jam sandwich and a packet of crisps. Thus it is important that when storytellers do not cite race as problematic that as researchers we do not fall into the trap of supposing that this is not a factor in every day life, (Gunaratnam 2003, Totsuka 2014).

The storytellers speak of varied experiences of intercultural therapy, mainly that culture/race is not addressed and where it is raised, there are concerns that it can be stereotypical. Clinicians and storytellers have varying levels of understanding of the issue of culture/race and eds.

 Emily says;

> *Em I don't remember them making sense of culture, no [...] when I was 17 in CAMHS*

> *the therapist said "that day you were out with your friends and you had a milkshake, that sounds great, maybe you should do that again", my mum didn't like that, didn't think it was appropriate*

This is an example of ethnocentric practice where the therapist is drawing on social motifs of European culture, in this case, the idea that socialising after school with friends is a positive sign of recovering whereas her mother saw it as interfering with their cultural practices where children do not socialise in the same way and are likely to be expected to socialise with family and community friends.

> *Ta rehab had no cultural focus [..] I was the only black patient [..] I had a lot of black counsellors but I would not tell them of the food issues unless I was sure they had experience of ed's*

Preetam reflects on her parent's uncertainty about sharing stories of their own mental health issues.

> *L389 K I mean, in terms of thinking culturally, how might mental health conditions be*
>
> *L390 thought about*
>
> *L391 P it seems it is just one of the things that isn't spoken about, uhm, yeh, I'd remember having*
>
> *L392 P CAMHS assessments and they would ask like a family history and they would be like L393 'no, nobody*
>
> *L394 P has problems, everyone is fine ' when actually, like, I know a few of my aunts and L395 P several of*
>
> *L396 P my cousins have had, you know, depression and anxiety and stuff, and my mum was*
>
> *L397 P she was depressed when she was a teenager, uhm, and also like she must have had eating L398 issues,*
>
> *L391 P she was just like, really slim and anaemic at one point and needed a blood*
>
> *L392 P transfusion and*
>
> *L393 P you don't just get that anaemic through like you know, eating properly, so yeh, it*

I remind Tamara of something she said earlier

K One of the things you said before I turned the tape on was that you did not want to sound racist"

T yeah, white girls [..]I mean, it sounds really weird because if is like all the staff act different towards you in hospital,[..] like it was really weird, like some black staff wouldn't like me[..] like how they talk to the white girls and how they talk to me, from some references that were made, they didn't take me seriously because I wasn't white [..] but then other black staff they would really love me like I was their daughter because I was black so it was weird like and ehm cos growing up I had a lot of problems with racism

As Tamara works the dialogue, she is brought face to face with her earlier experiences of racism. The dialogic conversation opens a space for 'race talk' to begin. Tamara begins to make sense of her context, her circumstances and her difference compared to her peers. These resonances enable her to embody a felt sense of being a minoritised woman.

Nicole doe not remember culture being referred to and as she sees herself as English, she did not think to bring it up. I am interested that Nicole places the responsibility on herself to raise issues of culture rather than it being a professional responsibility.

Harriet found family therapy helpful in creating a space for dialogue. It enabled the bringing together of the extended family where shared understandings developed. Culture in its broadest sense was explored in terms of local family culture of how Harriet undertook a position regarding class and how she had to adapt to different positions depending on whom she was with at the time.

Lilly and Nicole do not see culture as relevant so it is not a surprise to them that clinicians do not mention it. Whereas for other storytellers such as Sarah, Emily, Preetam and Tara, who identify strongly with their heritage, the lack of acknowledgement by clinicians was problematic and further added to a sense of

isolation. Not only were they the only women of colour in the service, their racial/cultural narrative was not attended to clinically.

Story 9: Absence of Blame

This was a surprising finding. It took a while for this theme to emerge because it is the absence of something. After working on all of the narratives, I noticed blame was not in evidence so it is an absence of a common theme that is in my clinical work. It is evidenced in the material though I would call it a shy story because it seemed to hide from the surface. This is a resistance story. I compare this story with my clinical practice where many of the young women are in a problematic relationships with one or other parent, where blame is either levelled at the young person or the young person blames her parents who are viewed as lacking in understanding. This set of beliefs levels the burden of recovering with the individual.

By contrast, the storytellers who had told their parents of the ed or the parents had found out, all took time to explain how much their parents tried to help, despite things being difficult at home.

> *H I put pressure on myself to be a certain way, I aimed quite high […..]I remember her (mother) crying a lot, we just fought constantly and I wasn't very nice […] so yeah, it had a massive effect on our relationship*

Here Harriet places a lot of responsibility on herself, for upsetting her mother, she does not say anything about how her mother might have behaved differently

> *N well, ehm, initially they were quite upset or didn't really, a bit worried, obviously didn't really know ehm, but they have been really supportive, ehm, yeah, they were, overall they were helpful*

Preetam makes an interesting point when she notes that because there is such an emphasis on *not* blaming parents in the therapy, that she began to blame herself. She recognises why her parents may have been protective rather than controlling

> *L792 P yeh and I guess I hadn't given that really much thought, just thinking they*

By contrast Lilly voices her anger at her father for being to blame for her difficulties. This story I feel is in its early stages of analysis but I place it here because it is a small but powerfully loud story in need of further analysis.

Story 10: Recovering as an Act of Resistance

This story extends the resistance story of 'no blame'. There is pessimism in the literature about recovering and this feeds into a culturally held view, including for sufferers, that this is such a complex illness with a poor prognosis and as such, influence sufferers perceptions on their recovery, (Hardin 2003). Recovery, for Malson's participants is constructed as 'unimaginable', (Malson et al 2011). By contrast, and paradoxically, minoritised women are not as caught up in these discourses. I found the storytellers eager and excited about their futures and work and study prospects. These are examples of resistance to an established cultural story where there is a lot of pessimism and doubt about recovery.

Despite social disadvantage Esme and Tamara are eloquent in describing their hopes and dreams

> *K So what are you most looking forward to as you continue to develop your talents?"*
>
> *E I want to go into the beauty industry [..] I thought, I'd do beauty cos you can do all different things in beauty, you don't have to do just hair and beauty is a lot more higher in the industry than hair [..] you can get a lot more money for it [..] I want to, I want to own my own business [..] but I think maybe before that I want to travel the world [..]My dad thinks I would be good at it, but I'm like no I am like let me do my two years of beauty and if I want to do that, then at least I have got my beauty as well*

Esme discusses her ideas with her family and is tentative yet excited about her prospects.

I ask Tamara if she plans on going to college.

> *T I am just, because I was in hospital for so long [..] I am just taking X and Y course [..] because I wanna be a paramedic one day, [..] I have not had too many good experiences*

> *with them! [..] in the past, but I have met some really nice ones but it is just , you know that they are saving people [..], I knew this was the right job for me because I love helping people , like I always said I want to dedicate my life to helping others, [..] I am good in emergency situations [..] so when I started to realise that I was recovering , I was so happy [..]I have always like, wanted to do something with my life, helping people because I think when **you** go through stuff and you don't get help for it then you start thinking you would never like anyone to feel like you do*

She is some way off realising her dreams, yet she reveals a longstanding desire to help others and this has not been derailed by her immense suffering in many in patient settings. She remains upbeat, enthusiastic and hopeful about her future.

Harriet reveals her ambitions

> *K so as you develop your talents in your literary works, what are your hopes and dreams and aspirations?*
>
> *H [4] I don't know, I would like to make it being an agent that would be pretty ideal, ehm, yeh, I think being more involved, at the moment I am quite passive in, I get to read all the submissions coming through, yeh, it would be nice to actually have an influence on a book and see, yeh, take part in that and see something progress from*

Preetam tells me how her upbringing enabled her to stand up to her low mood and ed.

> *L716 P I think that kind of perseverance and that hard work has, from my parents anyway, cos I*
>
> *L717 P know that, like all my family have put in a lot of hard work and effort to get to where they have got now, like the house and all of that, like the experiences that we've got, like my parents have had to work long and hard for what we've got, that is something that I value and appreciate, ehm and I think as a result they want to make things easier for us, they don't quite understand why I want to live on my own in London, why I need to spend half my salary on rent when I could be living at home and saving up all that money, so that's a bit , like that was a bit, a cause of friction for a while cos they just couldn't understand why I didn't want to be at home and why I am making myself stressed over money and I'm like 'I am not making myself stressed over money and I can get by. I can understand they do not want me to go through eh experiences that they had to go through, ehm but actually that's, I don't know, that's given me some independence and a lot of skills as well, ehm, yeh, ehm yeh, they're important*

Dialoguing and analysing the material to co produce 10 stories reveal a number of important findings that differ from the dominant discourse surrounding eds in developed nations.

Table 10 Summary of 10 Individual/Cultural Stories

*Story 1: **Food as Disturbing Metaphor**: Bringing forth the storytellers' longstanding, devastating and ambivalent relationship with food and eating*
*Story 2**: Caught Unawares**: The ed captures the storyteller*
*Story 3:**Professional Positioning: Out of Mind, Out of Sight**[45]: Barriers to recognising and treating eds*
*Story 4**: Family Positioning: Out of Mind, Out of Sight** Barriers to family understanding*
*Story 5: **Hospitalisation as (more) Trauma***
*Story 6: **A cultural Double Bind:** Body image versus embodiment:*
*Story 7: **Transmitting the Legacy of silence**: Not telling parents*
*Story 8: **Race as a Fact of Everyday Life**: How intercultural practice is brought forth*
*Story 9: **Absence of Blame***
*Story 10: **Recovering as an Act of Resistance***

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[45] Burnham (2012)

Table 11 The Storytellers and their Embodied Cultural Stories

	Tamara	Esme	Lilly	Preetam	Emily	Harriet	Nicole	Tara	Sarah
Story 1:Food as disturbing metaphor	*	*	*	*	*	*		*	*
Story 2: Caught unawares	*	*	*	*	*	*	*	*	*
Story 3: Professional positioning	*	*	*	*	*	*		*	*
Story 4:Family positioning	*	*		*	*			*	
Story 5: Hospitalisation as (more) trauma	*	*	*	*	*	*		*	
Story 6: A cultural double bind	*	*	*	*	*	*	*	*	*
Story 7: Transmitting the legacy of silence	*	*	*	*	*	*	*	*	
Story 8: Race as a fact of everyday life	*	*		*	*	*	*	*	*
Story 9: Absence of blame	*			*	*	*	*	*	*
Story 10: Recovering as an act of resistance	*	*	*	*	*	*	*	*	*

What strikes me powerfully as I see the figure above is how the stories have taken

on a life of their own. As I look at the stories I notice how they change down the list from Story 1 to Story 10. The order evolved iteratively. They move from being constructed as deficit cultural stories, for example Stories 1-7 to stories that take on the identity of collective stories discussed below in Chapter 6. Such is the shift from cultural to collective stories that I made a memo to myself asking *' Is Story 10 too similar to Collective Story 4?'* That is 'Recovering as an act of resistance' (Story 10) and 'Talking Back as Resistance' (Collective Story 4). In fact, Story 10 shows the capacity to move from a cultural to a collective story.

In summary, I approach the interpretation of material in several ways. I begin with the structural methods of Labov and Gee. These methods afford an opportunity to get close to the material, and help to sift through dense material using a structured format, (Reissman 2008, Emerson et al 2009). I then experiment with the new paradigm of 'writing as a method of inquiry'. Kebbe (2014) writes of struggling with a systemic doctorate to find the right kind of qualitative methodology and she settles for essay writing. It is her description of the process of feeling frustrated, confused, lacking in a way of connecting her systemic practice with the philosophy of research that spoke to me of seeking alternative methods. I move finally to show how a dialogical approach to analysis is brought forth, focussing on voice and the emotional tone as well as the text of the storyteller to produce a series of individual/cultural stories. As a reflexive footnote, once I completed the stories in this chapter, I am aware there remain embedded and incomplete stories that I have not analysed. I recognise my active role in shaping the stories here that are co produced through the conduit of my subjectivity, (D'Arrigo-Patrick et al 2016).

I move now to Chapter 6, the Collective Stories, a chapter that could not exist until Chapter 5 came into being.

Chapter 6: Dialogical Collective Stories: Who can Speak for Whom?

Where Chapter 5 develops, analyses and shares individual/cultural stories, this Chapter engages with broader the sociopolitical meaning of stories. I share collective stories as exemplars of how analysis brings forth a shift from marginalised narratives to centre stage ones, knowledges of the experiences of minoritised women and eds. The collective stories are brought into being via the individual/cultural narratives of Chapter 5. Those stories showed their potential for becoming broader political stories. Collective stories are more than a sum of the parts; they represent a 'liberating of subjugated knowledges and life stories', (Kogan and Gale 1997).

Critical Race theorists speak of 'counter stories', described as,

> *'A tool to contradict racist characterisations of everyday life'.*

The counter story is also a collective story. The collective story is a way of countering race's neutral discourse, I am thinking of the example of Sarah's teacher singling her out due to her black skin and using her as a biological experiment in class, (Merriweather et al 2006).

How the Collective stories are brought into being

After the individual/cultural narratives were brought forth, I thought analysis was complete yet I felt restless, with a sense of unfinished business. Several of the individual/cultural stories felt like stories I had heard before; they fitted with dominant discourses of minoritised eds. I returned to the hermeneutic cycle, page 77. I began to notice a collectivity of themes that I called 'cultural chaos'. I was not sure at that time what sense I made of these emerging ideas. I had an embodied sense of the material that was connected to biographical disruptions, losses, racism and the migratory experiences. I wondered if these events acted as forces against recovering. I saw how hard it was for storytellers to be dialogical, being

caught up in monologues of ill heath and racism. The women did not know of other minoritised women with eds; they did not see themselves represented in the media; In treatment their cultural identity was largely ignored. I felt caught up in these stories and could not see beyond the deficit narratives. When I asked about recovering stories I began to hear, feel and respond to broader political stories; that despite the journey each storyteller had experienced, there was a well of untapped resources for each storyteller and a collective resource was being opened up and dialogued with. This is doubled listening, (White 2003). The stories hint at shyer stories. I pushed the stories further to see their radical potential. I wondered how it was that resistance stories were wedged between the individual/cultural stories. By this I mean the storytellers were matter of fact about becoming unwell, what Hardy (2008a) calls 'the psychologizing of self. The storytellers accepted their illness and it was their responsibility to get better.

As I collaborated in the development of stories told, I became witness and curator of stories. No longer was it nine collaborators but a myriad of voices occupying major and minor roles in the storytelling. As the voices come together, there are more possibilities for dialogue within, between stories and the wider audience. By this I mean the stories talk back to one another, the reader can talk back to my findings and minoritised women recovering from eds can talk back to being positioned as 'other', marginalised in the health care system. (Frank 2002,Frank 2012, Pearce et al 1998). The storytellers do not know each other, yet there are similarities in their stories, as if 'a script has been passed around', (Frank 2012). I understand this as being about how we use our narrative habitus as a guide; that is what we know to be our way of being in our family and communities. Over time they become a second sense, we are intuitively drawn to some stories over others and how some stories, not part of our habitus, repel us or we express distaste for them, (Bourdieu 1979). As we grow into the narrative habitus laid down by our culture, the taken for granted set of rules and expectations are there but can become derailed due to illness. For the storyteller families, these experiences with their daughters are not the first biographical disruption in their family story and in the process of recovering, there is potential for old wounds to be opened, of

previous illnesses, of suffering and of loss.

I analysed the collective material by continuing to ask dialogical questions of the stories that go beyond and resist cultural individualised narratives, (Richardson et al 2011). The purpose then is to weave what looks like individual marginalised personal experiences into a tapestry that shows the 'dialogic possibility of how the storytellers are connected', (Frank 2012). Four collective stories made their presence known, some more forcefully than others, as I prised them from nestling between the individual/cultural stories to stand up for themselves. The weaving together of stories, a bricolage where I pull together resonant themes running like a river through the narratives and finally they settle at the confluence of the river for collection, (Pearce Associates1999).

Collective Story 1: Migration

I ask what are the common factors across the stories that can tell us something of hidden talents and strengths. The migration collective story is divided into two interconnected yet distinct stories. They are two ends of a semantic polarity, (Ugazio 2011). At one end, the story performs a troubled story; the second story is a mirror image of the first story, a counter story.

In the interviews I asked about migration. I think of my father's migration story and I am curious about how the storytellers understand their heritage and history. My first question asked;

> K: 'Can you tell me something about how your parents came to be in this country?'

I asked this question because I know that living in a country that your family was not born into brings additional stresses for families and young people as they learn to adapt to a different culture. I realised as I continued to inquire into the story's history that more abstract stories unfold, stories I did not look for or anticipate. What can I learn from the bigger stories, what are they telling me, that will help inform practice? Colonisation, though not explicitly mentioned by storytellers, is an

'absent presence' in the stories, (Hardy 2008a). I searched the dialogues for migration stories to bring forth the 'not yet said' hidden in the dialogues. These stories appear to be embedded deeply in the collective consciousness in need of a reawakening.

Migration Story 1a: The 'Cultural Chaos Knapsack

I call the first of two migration stories, the *Cultural Chaos Knapsack*. Like the 'white privilege knapsack', a metaphor used to explain how it is that white people are born with unearned privilege because of the colour of their skin, (McIntosh 1998), the cultural chaos knapsack is a collection of unknown, untold, unheard stories, fragments, splinters of the not yet said. These stories may lack temporal structure, may be thin descriptions, competing narratives of events, stored away, not spoken of, as life takes on new meaning in the land that becomes home. The important aspect of the knapsack is that stories may have been told but unheard, so return to the knapsack, in time becoming untold over generations. Each individual is said into these stories much as white men are born into unearned privilege by the availability of the content of his knapsack. The cultural chaos knapsack is a shadow of the white privilege knapsack, it brings forth no privilege; rather it has the capacity to transmit intergenerational unheard, unspoken stories of trauma and instead is unearned disadvantage, (Thomas 2016, Coyle 2014, Daniels et al 2007). This knapsack appeared in my minds eye as a metaphor carrying traumatic histories on our backs without knowing the full contents, nor why it feels burdensome. I say 'chaos', because stories remain untold, unknown or unheard for many reasons. Frank (2012) refers to three core narratives, chaos, restitution and quest. In the chaos narrative, the protagonist has many difficulties shaped by illness and other experiences. One thing leads to another and life begins to unravel. The cultural chaos knapsack becomes a metaphorical or liminal space where stories of trauma, loss, racism, and migration are both transmitted, inherited and the knapsack contents are transmitted into the next generation without the wearer being aware of it, (Lee 2012). This resonates with Thomas' (2016) notion of the transmission of trauma through generations. I imagine the traumas being transmitted and stored in the knapsack. Whilst this idea was forming, I retreated

from it, worried it carried negative connotations. What formed in my mind was the how discourses and structures were implicated in the knapsack of minoritised eds.

Drawing on poststructuralist thinkers who argue that modern society is a site for the production of eds, I continued to formulate my ideas, (Epston et al 2009). I theorised that the cultural chaos knapsack connected with Bourdieu's notions of habitus. Yet it did not quite fit because habitus refers to what is second nature to us, our tastes and preferences that are so familiar we are unaware of them. I began then to think about 'ante narrative' habitus rather than narrative habitus. By this I mean the contents of the knapsack could be thought of as 'pre stories', stored in a liminal space, not yet dialogued due to them being beyond consciousness, not even second nature like the narrative habitus, something 'before', stories unknown and untold, (Boje 2001, Lee 2012). The narrative habitus thus includes the ante narrative habitus of the migration stories. These are the quiet, shy, barely told, barely known, barely recognised as traumatic, silenced stories. There are many biographical details missing yet somehow they are embodied and transmitted from the knapsack seeping into women's bodies. When I asked about migration, I sensed pride, sadness and loss. Each storyteller spoke of her family and migration stories, about the losses in this process, about the courage of parents. It is not only the content of these stories that spoke to me, but it is the emotional volitional tone of the telling. What strikes me is that despite some stories lacking detail each storyteller quickly moved to stories of loss particularly the early deaths of several grandparents. The parent/s of the storyteller have had to cope with early loss of their parent as well as to cope with migration often at the same time. I find this hard to contemplate and imagine. It is only by close analysis and attention to detail that a few words can open up into a major collective story. I understand this uncertainty from the storytellers about whether I am going to be interested in what they have to say, as a sign that others have not shown interest so the storyteller is unsure and positioned awkwardly.

I asked Nicole how she identifies herself culturally. Nicole is dual heritage. This question affords an opportunity for a dialogical space to be created where exploration of stories that are often marginalised and unspoken are brought forth.

> *N* *uhm I'd say English first but its weird, cos you do have to say half this and half that and I think culturally I feel more, um, because I guess I've been there more often, more sort of connected to Northern Ireland (her father's heritage), uhm, I wouldn't say I am Mauritian but I'm half Mauritian because of like, my mum, I have got that in me, but I wouldn't say I am culturally Mauritian*.

As she speaks out loud Nicole seems to embody being half Mauritian. The hesitation shows her uncertainty and perhaps how the question is a new one for her. I wonder how she is able to connect to her Mauritian heritage when her mother has little to say about her growing up there. Nicole's mother is of Mauritian Creole descent, originally being taken from the French colonies as slaves.

Tara's mother's family name is a slave name, her ancestors were slaves and though her father was born in (African country), his surname originated in the United Kingdom. Tara's mother was subject to segregation as she grew up. Preetam's family of Indian descent arrived from Kenya, not India, 'twice migrants' brought as indentured labour to build Kenya –Uganda railways, (Anitha and Pearson 2014). As I listen over and over to the migration stories I think again of migration maps mentioned above in chapter 4. Where have persons been? Why did they move? What choices did they have?

As this story comes into being, I am struck by its capacity to blame those that keep secrets, who filed their stories in the cultural chaos knapsack as if they are personally responsible for the stories they inhabit. I begin to see that the stories are ones the storytellers and their ancestors are caught up in, stories that they grow up with as part of their narrative habitus, but stories that have the effect of controlling those caught up in them. They become reinscribed by my retelling and this is a risk of the analysis. So I go further with this analysis and formulate a second migration story as an extension of the first, a story that offers the storytellers the possibility of transcending their cultural stories to be able to shape a 'free from' the ties that bind.

The second migration story is called 'Cultivated Amnesia '.

Migration Story 1b: Cultivated Amnesia[46]

I listened to a radio four programme[47] about Guyana, the birthplace of my father. I heard a conversation a Guyanese man had with his work colleagues. He said that his working and living in the United Kingdom was political, saying to his colleagues',

> *" I take a little back that you stole from me".*

Colleagues ask what he means;

He says;

> *" The sugar in your tea, rice, gold, diamonds and bauxite."*

His story tells us of colonisation and loss. He resists victimhood by asserting his political will, his resistance to being positioned as a migrant. This storyteller is 'holding his own' in the telling of his story. Our parents, grandparents and great grandparents do not always tell stories of their ancestors. These are *purposeful* untold stories, (Pearce et al 1998). I hear the stories as 'cultivated' in the sense of 'to prepare, to tend, to manage', as distinct from its antonym, 'to abandon, to ignore, to neglect', in other words this is a purposeful decision to not tell. I did not know about indentured labour during my father's lifetime. My ancestors experienced forced migration from India to Guyana and a different, economic migration, from Guyana to the United Kingdom and the United States. I do not know my ancestors migration map in detail, it was not told, but each time persons move they must embrace difference in culture, food, religion, customs, habitus and language. Listening to the radio show, I feel and embody the land where my father was born. Indentured labour meant that poor people were tricked into leaving an impoverished life in India with the promise of money and food and a passage back

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[46] This term was referred to in the radio programme to depict purpose in not telling

[47] Radio 4 documentary: Sugar, sari's and green bananas: sugar in my blood 18th September 2015

home in a few years time. Few if any returned to India. We get a glimpse of history, of colonialism, of suffering and of resistance. My father cultivated and carefully stored stories in his knapsack as a way of having them stand up to the chaos stories that were also in the knapsack. He did not tell me many stories. It is not because, as I had previously thought, that he did not have any to tell. The one story my father told time and time again was that as children we must ensure we get a good education in order to compete with our white peers.

The stories in this study, are now **U**nleashed, having been filed away in the cultural chaos knapsack. I add another **U** to the LUUUTT model. The stories are unleashed because the storytellers are asked directly about the migration stories in their family. The context and the manner in which the questions is asked, in the interview setting, my voice, my visible social difference, my desire to hear of their experiences I hope afforded these conversations to begin. As I work with collective stories I see how cultural chaos stories have the capacity to move either into cultivated amnesia stories where the story is *purposely* kept back for reasons of protection, or how they move from cultural chaos, that is move from an untold/unheard/unknown story to a heard/told/known story. In co constructing stories the dialogical potential is unleashed as the now-told stories bump into previously untold/unheard/unknown ones.

An example of a cultural chaos story becoming a cultivated amnesia story was when Lilly told me at the beginning of our conversation that her mother was an only child. As the dialogue unfolds, Lilly appears startled when she remembers her mother had a sister. However Lilly chose not to say anything more about this. In this way she displays a purposeful cultivated amnesia. At a future moment it may become a told story.

Nicole's story below is another example of how a cultural chaos story goes further than Lilly's story and becomes a told and heard story perhaps for the first time.

I ask why Nicole thinks her mother is overprotective.

> *N ehm, I think that (4) I don't know, I think that she just worries quite a lot, she's a worrier, I guess she didn't really have parents to look out for her, so, [..]*
>
> *K does your mum talk about what that was like, you know, her parents dying and living with her aunty and moving to England?*
>
> *N ehm she does but I think she was quite young as well, but she does talk about it sometimes, not sort of too much, I know that she is really appreciative of her aunty*

Nicole's story is tentative, hesitant; her narrative constructs her mother as a worrier. She begins to make connections in our dialogue as she realises why her mother performs worry. Not only did her mother experience migration at a very young age, she was further traumatised by the death of her mother and shortly after that, the death of her father. These trauma stories nestle in the cultural chaos knapsack. As we continue to talk, newer stories are unleashed where I hear of Nicole's maternal great aunt bringing her mother to the United Kingdom. There is potential for the story to stay in the cultivated amnesia space yet as we continue, Nicole embodies brightness and her voice is full of pride as she tells me of her great aunt's courage and support of her mother. The story is moving into the sun as it is told.

As I we explore migration, I notice that those who migrated had no control over the events and experiences. The storytellers are aware of some of their family losses yet appear to be spared the detail of monumental sacrifice, of hurt and of loss experienced by the generations preceding them. Instead the stories nestle in the cultivated amnesia space for future attention, safe keeping and processing.

Another aspect of a purposeful keeping of stories is about what to tell to the next generation. Was it by choice that the full extent of the horrors were not told, or being positioned by the host culture to integrate, to look forward not back, to make life bearable, that the stories became dispersed, diluted and eventually not told? This clearly has resonances for Holocaust stories. It has resonance for my father not telling us of the racism he experienced all his life. In this way he *cultivated* this amnesia to protect us. I find this to be a practice of ethics that our forbears endured. It reminds me of a vignette where a mother from Chechnya did not tell

her son about the violent death of his father saying, this is a;

> *'Thing we do in Chechnya '*

As further dialogue emerges, we hear of a purposeful silence; a protective strategy, a culturally different way of approaching silence. As developed nations therapists we encourage persons to talk where lack of talk is viewed as problematic. It is about protecting her son from unspeakable pain, (Rober et al 2013).

The storytellers, their parents and grandparents and our ancestors are the legacy of colonialism, their migration both forced and economic, form part of a global movement of people, a diaspora, often moving more than once or twice across generations, seeking sanctuary for themselves and their families. There are so many moves due to slavery that families do not know where their ancestors came from and it is impossible to truly know of where they may have come from. The doubled migration story enables 'cultural chaos' stories; those are the unknown, disembodied stories to move to 'cultivated amnesia' stories that are untold but embedded, ready for telling when called upon to do so. Then they become unleashed, dialogical and embodied, altogether a more resilient position. The diagram below illustrates this movement.

Figure 4 The Impact of the Storytelling Process

| Cultural Chaos Knapsack Unheard/Unknown/Untold Stories | → | Cultivated Amnesia (partly)Told Stories Safely Stored for now | → | Out of the Margins Told /Unleashed Stories |
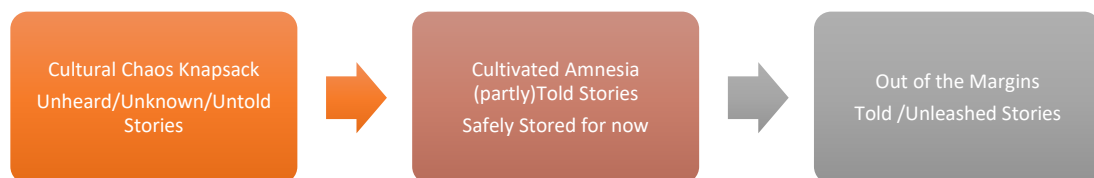
I put the told individual migration stories together acknowledging some stories

remain in cultural chaos and cultivated amnesia yet noticing how stories have escaped in our dialogue and are out of the margins now for further reflection. I consider these as collective stories exemplifying the extraordinary yet hidden narratives of suffering and courage across the stories. In order that we do not to continue to have a racial stain on our conscience, we need to demonstrate our attempts at correcting the wrongs of the colonial past and this means relational risk taking and putting the 'Grr' back in the SG's, (Hardy 2008a, Partridge et al 2017).

Colonialism has impacted on all the storytellers in this study. Though the migratory routes to the United Kingdom are multiple, varied and fragmented, it is the experiences through the generations that are similar in terms of racism, discrimination multiple losses including separations, loss of language, of cultural traditions, of foodstuffs associated with 'home' and actual losses of parents/grandparents, (Gunaratnam 2003, Smolak et al 2001, Burke 2005b).

Collective Story 2: Doubled Coherence: A Foot in Both Camps

This story came into being because I was troubled by the individual/cultural Story 6 that revealed a cultural double bind between ideas of embodiment and body image. Smolak et al (2001) refer to the challenges of living in two cultures where a person is expected to adapt to the dominant culture's values and belief systems. It is inconclusive whether a more acculturated[48] versus a less acculturated[49] woman is at risk if developing eds, (Capodilupo et al 2013). I noticed that my storytellers were telling me something different. They were talking about an ability to co exist as minoritised women in England whilst embodying a collectivist cultural heritage. This thinking challenges the stereotypical idea that minoritised women are either positioned as 'traditional' and at risk of a clash with mainstream cultural ideas, or they are acculturated, merged with the host identity. Neither are helpful constructions. A more helpful discourse is to consider the advantages brought forth

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[48] Adoption of majority culture's values

[49] Adherence to traditional culture of origin values

by coherence across cultures rather than an either/or position. The issue of whether they were more or less acculturated, did not appear significant. All of the storytellers enjoy living in Britain, more than one storyteller saw themselves as British rather than hyphenated with Black British, or British Asian. Seven of the nine storytellers were born in the United Kingdom. They are living lives where their narrative habitus includes family cultural stories they have grown up in *and* the developed nation habitus influences of their peers, school and social lives around them in the twenty first century Britain. This means they draw on contemporary developed nation cultural templates to make sense of their experiences whilst also drawing on family cultural templates. These, like migration stories, become marginalised narratives that are brought forth in dialogue, exemplified by moments of pause and quiet reflection. It is in these moments the storytellers are reflecting in action (Schon 2016) as they search for alternative narratives. By asking questions that the storyteller may not have been previously asked, enables new knowledges to be brought forth as history is connected in the present and new ideas form, (Holstein et al 1995).

Tamara exemplifies this point when I ask "so what do you make of that, what do you think about that?" (Being the only black patient on the in patient ward)

T I never really paid that much attention to it, does that make sense?[ ] like (3) I wondered but, not really, I don't know[…] no they never really treated me any different or anything [.]. Yeah white girls […] I mean, it sound really weird but it is like all the staff act different toward you in hospital, like in (specialist hospital), like it was really weird, like some of the black staff wouldn't like me […] like how they talk to other girls and how they talk to me, from some of the references that were made, they didn't take me seriously because I wasn't white, [..]I had a lot of racism growing up [..], its really weird, there are these two black girls that worked there, they did not like me at all […] yeah they didn't take me seriously, in their head they probably thought only white girls are anorexic.

Tamara sees her habitus within the home is different from the habitus of her friends outside the home, (Burck 2005b). In this transcript, Tamara is not providing answers; she is thinking out loud about identity, the complexity of being a black woman, experiencing racism and having anorexia; a set of experiences that are not typically thought of as an anorexic experience. On the one hand the storytellers

were unaware of structural historical abuses yet they were still able to hold a different cultural construction of personhood, the sociocentric self, associated with Eastern cultures. It is possible that this doubled coherence has enabled the storytellers in this study to manage their recovering differently from white service users, (Bourne 1991).

Preetam shows a deep commitment to her family including wider kinship ties, whilst also connecting to being British, (Krause 1993). I ask her about religion and cultural heritage;

> *P L69 "I am proud to say that I am `Sikh and Indian heritage., ehm but first and foremost I am British L76 […] PI think definitely, I cant ignore the Indian bit , I don't want to lose it,*
>
> *L77 I cant speak my mother tongue but I am aware of it and I can understand it, ehm, yeh that is something I do not want to lose, that I am quite proud of ehm, and yeh, I guess how my parents came here and the hard work that they put in when they first came to England, or you know, like my grandparents did, I think you know, by just saying I am British or English, kind of loses sight of that*

Preetam encapsulates what it means to belong to two cultures maintaining a doubled coherence, not a doubled confusion.

Emily shows an interesting way of resisting an either/or position by speaking with pride about her culture of origin whilst also choosing to live away from her parents, not to practice Islam, and finds 'dipping in and out of family life' helps maintain her connections. I ask about whether she still observes Ramadan.

> *Em I don't tend to fast, it just ended, you know, a week ago, uhm, I fasted for like two days uhm [.] I was back in London seeing some (Muslim) friends [..] I spent a day you know, crashed over at their house and they did (fast), ehm, I think I probably would've if I was at home because its, more, easier if everybody is doing it whereas here, I am kind of running on my own schedule, going to work and things [..]one of my best friends is , ehm, Muslim as well and she is quite like me and , I don't know, like for example using alcohol and that kind of stuff, she fasted for Ramadan, so yeh*

Collective Story 3: Hidden yet Powerful voices: Fathers

I ask questions of the stories, in particular one that Frank (2012) asks.

'Who are the marginal characters in the stories?'

The storytellers ventriloquate their fathers. These stories are highly charged, told in emotional tones that reveal complex and challenging relationships. First I thought the challenging relationships occurred in all stories. After more analysis I realised there were several nuanced stories emerging that were not easy to categorise. Fathers had not been involved with childcare for some of the women; for others, fathers occupied a traditional male role within the family and appear distant, whilst for others there were mixed feelings expressed about fathers and in one case the storyteller's father was found to be a great role model. I wonder if the narratives of mothers had not been so detailed, whether the father narratives might not have been so noticeably marginalised. I construct fathers as '*hidden yet powerful'* because the rhetoric of fathers was powerful even if fathers did not play a central role in their upbringing. Fathers generally are marginalised clinically and in research. In the literature fathers are seen from a deficit perspective. Fathers are viewed as abusive, absent or disengaged with little appreciation of a father's role in supporting his child with ed, (Elliot 2010). The onset of the ed may account for some aspects the fathers' behaviours. The feeling of rejection by fathers is 'not uncommon' when their daughter is suffering from an ed, (Papathomas et al 2015). Fathers are constructed as having problematic relationships with their daughters. In this study fathers are constituted as complex, diverse, ambivalent, abusive, supportive, loving and challenging long before ed gets grip. The nuanced story of minoritised fathers is one where fathers are positioned precariously as problematic and as important figures in the storyteller's lives.

Tara experienced abuse by her father when she was a small child. As an adult, she tried to find her father but found out he had died some years earlier. Yet she tells me a story of her father's ancestry with pride. Perhaps if she met him as an adult, they may have had different conversations.

> **K** *what do you know of his family?*
>
> **Ta** *Well he didn't really say much and then I came here and I sort of heard well he got ill and so I was thinking well I need to kind of connect again with his side it was very hard cos we had*

> *a Civil War there in the '90's and so it was hard to get through*
>
> *__K__ was he in (African country) by then?*
>
> *__Ta__ No he never really went back only to visit and they actually didn't know where he was for ages so I think friends of his ended up contacting them about his illness and I was trying to be in contact with everybody [..]I mean I kind of never really had a proper conversation, but with my cousin about yeah I sort of always planned to but he didn't talk about them at all. He kind of just did a brief history of the family like in terms of like the slavery and the fact that his ancestors were in (Alaska) and then when slavery was abolished in (African country), it was like the first democratic enclave, it was only just (Capital city), the rest of the country wasn't free, it was kind of like an experiment.*

Tara is piecing together her history based on fragments told to her as a child. She hears her father is ill and wants to meet him.

In this dialogue we have together, I hear and feel Tara working to develop a different, preferred narrative of her father. As she speaks of slavery she begins to see her father- as- victim to the legacy of slavery with a backdrop of generations of multiple hardships, (Thomas 2016).

I ask Emily what she remembers about what her family/community thought about the ed. She surprises me with her reply because she mentions her father first.

> *__Em__ my dad has, well I have an aunt and uncle in Chicago and I remember him, hearing him on the phone saying like Emily is not very well and that kind of stuff, I don't think they really understood it to be honest, ehm, yeh, mmm, I think probably up until now my dad probably doesn't understand it*

Though Emily says her father does not understand her illness, she notices his need to talk to his family to seek support. This is not an example of a father who is disinterested or distant. Many parents 'do not understand eds' yet this is an example of how what we read in the literature where fathers are unfairly represented, and a different story of fathers emerged in this study.

Lilly's father bought her a table tennis table for her seventh birthday. Lilly says she did not ask for it. Her view was her dad wanted it so he bought it for her. As the story unfolds, I hear of the previous summer spent playing table tennis with her

father and I wonder if the table was bought as a way to reconnect with Lilly as their relationship was becoming more and more strained.

Collective Story 4: Talking Back as Resistance: Affording Opportunities to Move Forward

Ken Hardy (2015) in a moving blog called *'The view from Black America, Listening to untold stories'* eloquently shares with the reader the many and various times in his life when he has been victimized and suffered at the hands of racism including in the educational institutions where he studied and in his workplace. He eventually snaps when he tells his boss,

> *'Who do you think you are? Do you think you can talk that way to me because you are white? I know you do not want me to acknowledge race but to me this is about race'.*

He subsequently was asked to resign. It can take many years to talk back; Ken was probably in his forties then. I now talk back and I am still learning. I am not sure I could say what Ken said but I have felt it.

A final question I have of the stories is;

> *How are the storytellers holding their own in the retelling of their stories?*

 This question comes from liberationary, resistance movements and social justice ideas, (D'Arrigo-Patrick et al 2016). When persons are sick, traumatized or disadvantaged because of social difference, the temptation is to see such persons as victims. This collective story shows that the storytellers are not victims. Drawing from Hardy's (2015) blog, he cites that when he is working with minoritised persons, he is struck by the psychologizing of self that occurs, the client constructs social problems as individual failings in themselves. He notes that his white training also prepared him to seek psychological solutions. His experience in working with impoverished minoritised communities helps him to see how psychology does not fix the social environment. The fact we are trained to be GEMM therapists, adds to this lack of activism amongst minoritised therapist and researchers, (Hardy 2008b).

As I reflect on this writing process, I realize now that my interest has been to 'shift attention' from illness narratives to recovering narratives to see if I could access material untold where storytellers stand up to diagnosis or where the storytellers resist being seen as victims, where even through difficult periods in their lives they have stood up against being pathologised. Each storyteller has a story of success to tell. The success stories shown in the table below show how the storytellers transcend stock stories of mental ill health.

Table 12 The Storytellers[50] Success Stories

Preetam is applying for a doctorate
Esme is doing hair and beauty at college
Lilly hopes to begin a degree at Bristol university
Nicole is at university
Sarah works as a volunteer manager for a charity
Emily works in sustainability
Tamara wants to train to be a paramedic
Harriet works for a literary agent
Tara is a psychotherapist

Lilly's story of how she talked back to the in -patient system that was harmful, traumatic and punitive to her. She showed her ability to stand up to the powerful force that compelled her to eat, or the powerful force of anorexia, which compelled Lilly not to eat, are exemplars of resistance.

> *L oh, ehm, it was just literally everyone telling me to and no one letting me not, just cos I remember I was out of (in patient) and then 2 weeks after I was put back (under her breath, 'are you fucking serious?) in and because after that they, put you on a strict thing if you don't*

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50 The names are all pseudonyms to protect identity

> *gain a certain amount of weight in one week, then they send you back [..]And then [..] they take away everything and say like you can only do this 'if', cos I remember I had a ticket to go to Reading Festival, [..]They said 'you have to be this weight before you are allowed to go' and I was like 'mate, I paid so much for this ticket '[..]Now I have to gain this weight so I can go to Reading, Ok fine, so I do all that, when you are a certain low weight, you cant think properly, until you break through a certain barrier, you are always gonna have a like stronger voice of ehm, anorexia than you do of your normal voice, when you are still thinking about food all the time, so then ehm, yeh, and when I got to college, [..], I was kind of like 'ok , I could be a bit more lenient with stuff now ' like I was vigorously counting calories , it was like , 'I've got more , like to live for , than food ' like food is not the most important thing ever*

It is not just what Lilly says, but her voice, her energy and her way of saying 'f… you' to the system tells me of her resistance. Here she talks back to staff and to anorexia. If you could see Lilly with her elegant piercings and tattoos you would know what I mean.

Table 13 Summary of the Collective Stories

> *Collective Story 1:* **Migration**
>
> *Collective Story 2:* **Doubled Coherence**
>
> *Collective Story 3:* **Hidden yet Powerful Voices**
>
> *Collective Story 4:* **Talking Back as Resistance**

If we become the stories we tell ourselves, what do the storytellers become? The 'illness' stories are lengthy compared with themes of ' future hopes and dreams' and 'recovering'. It is perhaps right that these stories were so detailed. For many persons who become unwell often find there is no outlet to talk of how the illness has impacted on their life and those around them. This is what Frank (2002) calls the opportunity to 'talk back' in order to see how one person's experiences of illness might connect with another's. It is also possible that this has more to do with the dominant narratives that exist in our culture. Identity becomes conflated into 'being sick' making it much more difficult to view oneself as recovering, with hopes for the future, (Malson et al 2011,Reissman 2003)

In summary, I show here how through the dialogical analytic process that stories

start to take on a life of their own. When I first co produced ten individual/cultural narratives of Chapter 5, I thought the analysis was complete. Frank (2012) reminds me that stories cannot be finalised, that analysis is always incomplete because the storytellers are in the moment, telling other stories and so the cycle continues. This process highlights how analysis occurs by the continued attention to the stories and how writing is a craft rather than as a procedure. I refer back to the five commitments of dialogical narrative analysis on page 62. It has been my continued commitment to the dialogical processes that lead to the collective stories. It was my embodied sense of unfinished business, noticing at the end of the previous chapter, Chapter 5 that lead me to continue the analysis. Some of the individual/cultural stories did not enable increased possibilities for the stories and that the stories did not all hold 'hold their own'; they still felt disempowered stories rather than empowering ones. With the completion of the collective stories it feels more possible to conclude analysis for now, knowing that as clinicians we can begin to think of the meaning of the stories for our practice. Further reflection has me wondering how the individual/cultural and collective stories might be interlinked. It has been the process of mapping the individual/cultural stories that has enabled the bringing forth of the collective stories.

I move now to Chapter 7 the discussion chapter where I summarise my findings and look at the strengths and weaknesses of all aspects of the inquiry.

Chapter 7: Discussion

In this Chapter I begin by sharing my findings. I then critique the quality of the inquiry; revisit the strengths and limitations of the methodology. I then reflect on the research questions and the implications for systemic practice, training and supervision. Finally I make recommendations for future research.

From my social constructionist viewpoint I remind myself of the contested and partial nature of ideas of culture so I refrain from making assumptions regarding homogeneity within cultural groups or heterogeneity between diverse communities and white European groups. I therefore recognise that the findings cannot be used to compare minoritised experiences with European experiences.

Summary of Findings

This study is a systemic dialogical narrative study. Whilst a summary of findings is considered 'undialogical' (Frank 2012), I have an ethical responsibility to make the results available and transparent. This is also a requirement from those who granted my ethical approval to undertake the study as well as the ethics departments of the trusts that collaborated on the study. Finalising these results does not mean the storytellers are finalised, they will continue to tell new stories and tell old stories in different ways.

The first finding is illustrated in chapter 4,figure 2, page 77, where I developed a hermeneutic cycle showing how I prepared the material for analysis. This cycle grounded me in the analytical process and offers transparency to the reader who may wish to conduct a similar approach to dialogical narrative analysis. The cycle enabled the scaffolding of the analysis. As a novice researcher, it provided me with the opportunity to undertake other types of narrative analysis first, provided the scaffold for the dialogical analysis. I then moved to Chapter 5 where I began the analytical process.

A second finding, that further helped to capture the process of analysis, is the smaller cycle, first shown above on page 89, is reproduced below, to create three

broad interpretative categories to capture the interpretative process. By following the hermeneutic cycle's process, I was able to bring forth the substantive findings that appear above in Chapter 6.

C: Both/and: Dialogical Narrative Analysis: The Individual/Cultural and Collective stories (steps 8-9)

A: Both/and: Structural methods, voice and embodiment (steps1-4 of the hermeneutic cycle)

B: Both/and: Creative methods and embodiment (steps 5-7)
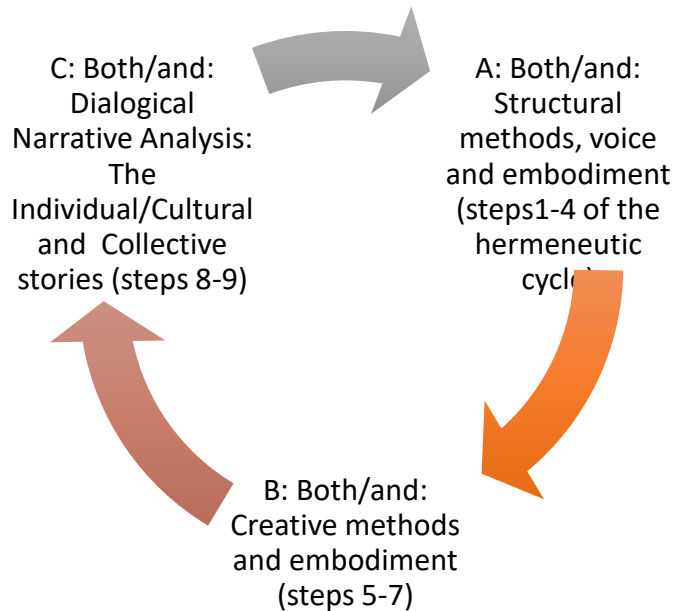
The three-both/and categories are;

- Structural Methods, Voice and Embodiment;
- Creative Methods and Embodiment
- Dialogical Narrative Analysis: Individual/Cultural and Collective Stories

All three categories worked recursively to produce the individual/cultural and collective narratives. The first interpretative category '*Structural Methods, Voice and Embodiment'* took shape in the interview context. I listened, observed, felt and embodied the emotional intensity, the silences, the pauses, the tone of voice and noticed non verbal language for example when Tara wraps her scarf around her in a gesture I saw as comfort and care during moments of painful storytelling. The analysis continued with transcribing. I annotated the transcripts, creating spider diagrams, notes, drawings and charts. I did a Gee's ethnopoetic analysis and Labovian analysis, as above on pages 90-98. These cycles enabled an opportunity to get into the structure of the stories, helping me to deal with extended narratives and enabling a close examination of narrative units, (Reissman 2008). The detailed

focus on small pieces of material brought forth many interpretations that formed the individual/cultural narratives. Within the structural paradigm I included dialogical constructs of voice and embodiment to emphasise the emotional tone and the felt reality as well as the written word. The limitations of the structural approach were epistemological; it is the discursive aspects of talk that interest me rather than viewing the stories as representing a window into the mind of the storytellers.

The second interpretative category 'Creative Methods and Embodiment' involved experimenting with creative writing techniques. I produced Haiku's, several stories and plays, see above, pages 99-102 (Papathomas et al 2015). This afforded a visceral sense of the material, a sense of voice and helped to bring the material to life. Creative writing began where the structural method ended, taking with it voice and embodiment as continued threads, (Elliot, Fischer and Rennie1999).

The third interpretive category, 'The Dialogical Narrative Analysis' brought forth the production of individual/cultural narratives, from pages 104-128. From a dialogical perspective, the storytellers 'hold their own' in their storytelling. The stories are a performance of day to day experiences of the storytellers struggle to access help for ed. It is also a performance of family stories of migration, racism, identity, loss and trauma. These stories are ventriloquated that is spoken through the storytellers' polyphonic voices; I heard voices of family members, their friends and professional voices, all brought to bear in the storytelling. The stories are dialogical and relational even though I met only with individual storytellers; I entered a relationship with the wider system, (Caddick et al 2015). As the analyst, I witnessed multiple stories and had the privilege of bringing a corpus of stories together to form collective stories, (Frank 2012).

The stories performed challenges of racism, migration, and loss, for example, Nicole's mother Patsy's story of migration and the death of Patsy's mother, or how Sarah's father came to England as an economic migrant to face experiences of racism and the stress of being out of work. The individual/cultural stories became told stories of the difficulties faced by minoritised women with eds in terms of identification and treatment. Once in treatment, standard treatment was used with

little cultural awareness. I remind the reader of the ten individual/cultural stories.

Story 1: **Food as Disturbing Metaphor**

Story 2: **Caught Unawares**

Story 3: **Professional Positioning**

Story 4: **Family Positioning**

Story 5: **Hospitalisation as (more) Trauma**

Story 6: **A Cultural Double Bind**

Story 7: **Transmitting the Legacy of Silence**

Story 8: **Race as a Fact of Everyday Life**

Story 9: **Absence of Blame**

Story 10: **Recovering as an Act of Resistance**

Story 2; '*Caught Unawares'*; Story 3; '*Professional Positioning'*; story 4; '*Family Positioning*" and Story 8; '*Race as a Fact of Everyday Life'*, are *known* stories that are further elaborated in this study, (Wales et al 2017, Chowbey et al 2012). These stories are known because researchers have inquired into how our ed clinics are almost exclusively made up of white women with eds, (Waller et al 2009). This is despite disproportionate numbers of minoritised women living in inner cities who remain in the margins whilst specialist services exist in those localities.

The literature challenges myths for example, that eds are a middle class white female illness; or that minoritised women are protected from eds because they are *not* high achieving white females; or ideas about non white families preferring to keep things to themselves; or that African Caribbean culture prefer bigger woman or the pride of Asian families if their children are slim. Although these stories are in the research literature I hope to reinforce them in clinical literature as a reminder to services, clinicians and stakeholders that we cannot continue to ignore that minoritised women are experiencing the distress of eds whilst not accessing

specialist care.

By contrast, Story 1; '*Food as Disturbing Metaphor'*, Story 5; '*Hospitalisation as (more) Trauma'*, Story 6; '*A Cultural Double Bind'*, Story 7; '*Transmitting the Legacy of Silence'*, Story 8; '*Race as a Fact of Everyday Life'*, Story 9; '*Absence of Blame'* and Story 10; '*Recovering as an Act of Resistance'*, are new to the literature. I have put Story 8, *Race as a Fact of Everyday Life'* in the 'known' and the 'unknown' stories. This is because race is an 'absent presence' as described by Hardy (2008a) above. Whilst race signifies daily in the lives of minoritised persons, and so it is a felt and embodied 'presence', white professionals are fearful of speaking of race. Moreover, GEMM therapists are also discouraged from mentioning race, (Hardy 2008b).

Why is it that these stories not known? What can we learn from the new stories about, for example Story 5, the hospital experience for minoritised women? This connects to the 'already told' stories above because if minoritised women are not accessing care in a timely way, hospitalisation becomes more likely as a crisis unfolds. Story 1 shows how the storytellers in this study experienced food and eating problems in many cases dating back to infancy. Story 6; '*A Cultural double bind'*, reveals the challenges faced by women of colour. The dominant societal discourse is one where body image based on white European women is constituted as a powerful expectation that *all* women should conform to. Minoritised women are positioned within the bind such that this body image is not representative of their cultural body shape. This story is a subtle one. The storytellers who did report body image concerns, paradoxically upon realising that the powerful images did not include them, appeared to transcend this by learning to embody their shape difference. Sarah came to terms with her body shape as being a cultural body shape, and is different from white women. This realisation helps her to move towards acceptance. Story 7; '*Transmitting the Legacy of Silence'*, revealed a pattern where the storytellers wanted to protect their parents from worry. This replicated a cultural historical pattern of purposely not sharing certain stories, as described in the collective stories of '*Cultivated amnesia', above* page 129 above. Story 9; '*Absence of Blame'*, is new to me. I cannot say whether

'blaming' or 'not blaming' parents has any part to play in recovering but the story left me reflecting on collective ideas of identity where duty to family relationships are privileged over individual autonomy. Story 10; '*Recovering as an Act of Resistance'*, demonstrates resistance to individual pathology stories and maps onto collective Story 4; *Talking Back as Resistance,*. It is at this point that I am beginning to embody connections between the individual/cultural and the collective stories.

Not all stories are analysed as part of the doctorate. Other stories left underdeveloped for future research include stories of class, sibling stories and dual heritage stories. As I reflect now, a more detailed story about race and racism may have helped further to draw attention to the inequality of service provision and suffering experienced by minoritised women as they try navigating their way in the health service.

I now discuss findings from the Collective stories.

Collective Story 1: **Migration**

Collective Story 2: **Doubled Coherence**

Collective Story 3: **Hidden yet Powerful Voices**

Collective Story 4: **Talking Back as Resistance**

The individual/cultural stories sowed the seeds for the collective stories providing a scaffold for their visibility. Littlewood's (2004) important idea that minoritised eds are not an appropriation of white 'Western' eds resonates here.

As I developed the analyses I saw connections between the individual /cultural stories and how they map onto collective stories. These connections are shown in figures 6, 7,8 7 and 9 below. Individual/cultural Story 1; '*Food as disturbing metaphor'* Story 3; '*Professional positioning'*; Story 4; '*Family positioning'* and Story 9; '*Absence of blame*' bring forth the collective migration story, see figure 5 below.

Figure 5 Story 1,3, 4 and 9 map onto Collective story 1: Migration
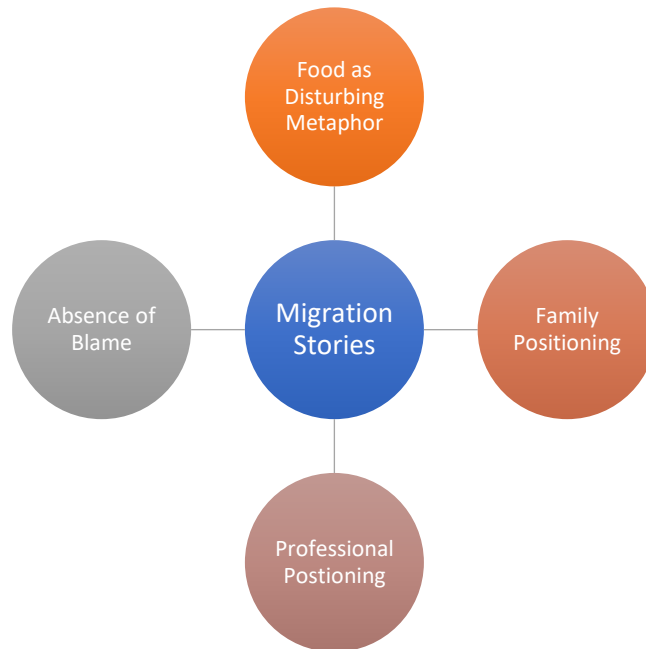
Food as Disturbing Metaphor

Absence of Blame

Migration Stories

Family Positioning

Professional Postioning

Story 5; '*Hospitalisation as (more) trauma*', Story 7; '*Transmitting the legacy of silence*', story 8; '*Race as a fact of everyday life,*' and Story 9; '*Absence of blame*', sow the seed of the collective story; 'Doubled coherence', see figure 6 below.

Figure 6 Stories 6,8 and 9 map onto Collective story 2: A Doubled Coherence
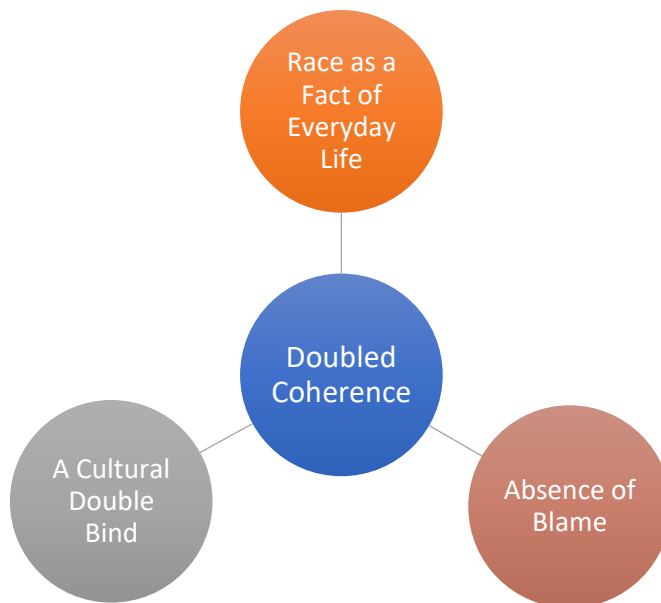
Race as a Fact of Everyday Life

Doubled Coherence

A Cultural Double Bind

Absence of Blame

Story 5; '*Hospitalisation as (more) Trauma*, Story 7; '*'Transmitting the Legacy of Silence'*, Story 8; '*Race as a Fact of Everyday Life'*, and Story 9; '*Absence of Blame'*, contribute to the collective story 'Hidden yet Powerful Voices', see figure 7 below.

Figure 7 Stories 5, 7, 8 and 9 maps onto Collective Story 3: Hidden yet Powerful Voices

Story 8; '*Race as a Fact of Everyday Life'*, Story 9; '*Absence of Blame'*, and Story 10; '*Recovering as an Act of Resistance'*, bring forth the collective story, 'Talking back as Resistance', see figure 8 below.

Figure 8 Stories 8, 9 and 10 map onto Collective story 4: Talking Back as Resistance
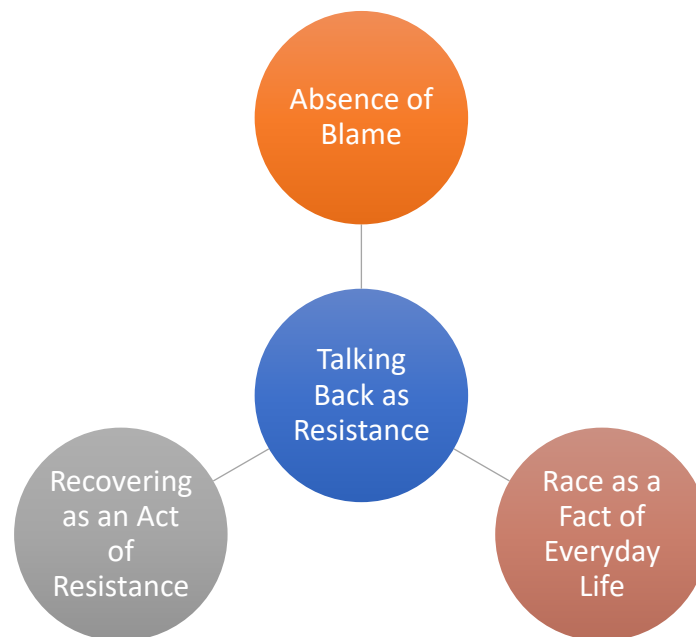
The maps are not fixed and final. The reader may map them differently. I may do so if I looked again at the mapping exercise. The point is that the hermeneutic process of analysis is brought forth through writing and dialogue and can continue infinitely save for the need to finalise the writing for this study. I move now to discuss the collective stories, a combination of older, told stories and new untold and unheard stories.

Collective Story 1: Migration

These stories alert practitioners to think about the legacy of slavery, racism, migration and acculturation and importantly how these stories may not be immediately available to be told. Practitioners need to acknowledge that eds exist

amongst minoritised women. With increased awareness and sensitivity we are then better placed to notice signs of emerging eds that shifts from individual/cultural Story 3; '*Professional positioning as out of mind, out of sight'*. The usual idiom is, 'out of sight out of mind'. Burnham (2012) coined this reframe that I think is more powerful than the original. To be out of mind yet being visible is a very powerful metaphor for this study of marginalisation. This increased awareness leads to thinking about accessibility of services. Moreover this compels services and commissioners to think about the barriers to accessing help and to work on rectifying this. A key aspect of the migration story is for clinicians to recognise that parents will not always tell children of their traumas as a protective factor as discussed in the cultivated amnesia section, page 132 above. How and when parents decide to speak of trauma to their children requires careful consideration in the therapeutic space. What is different and new, I argue is that as therapists, we can begin to be more transparent about the impact of colonialism and slavery into our hypothesising.

I suggested a five or six generational cultural/food genogram. This may be onerous compared with three generations we undertake, but the untold stories may not be in the three generations and so we risk underestimating the legacy of colonialism and slavery, affording only thin descriptions of transmission of trauma, (Coyle 2014). The migration map can help to explore how, where and when persons/communities migrated. I would have liked to explore further Preetam's Sikh heritage, for example the legacy for her family of losing rights to visit their holy shrine once the partition of 1947 happened and their subsequent migration to Kenya then to the United Kingdom. Using the cultural food genogram and the migration map may aid the storytelling to unfold so that the multiple enforced journeys our ancestors have taken will help to bring forth cultural chaos, cultivated amnesia and recovering stories. I see this as our responsibility to enable the telling of these stories whilst being attuned to the idea that the family/young woman may not be open to tell. We need to be mindful of issues of shame and stigma, how minoritised service users may have had negative experiences of services and feel mistrustful. Moreover, some families may not be used to sharing personal stories

with strangers, (Ma 2005).

Collective Story 2: Doubled Coherence

This story brings forth how it is possible to be connected with our culture of origin and a developed nations culture. As clinicians we can then avoid an either/or split where minoritised women are either acculturated, that is assimilated into the host culture, or that they are 'traditional' and therefore more aligned with culture of origin values. For intercultural practice, both/and position of curiosity is needed. This story privileges doubled coherence and doubled description over double bind. We hear ed stories from a deficit perspective. We need to attune to embedded narratives of capabilities, a privileging of marginalised untold stories.

Collective Story 3: Hidden yet Powerful Voices

This is a familiar story in mental health generally. This story is a mixture of old and new stories. The legacy of slavery and colonialism has positioned minoritised men as controlling, abusive, absent or unreliable. Instead it is the discursive psychologising of men that has positioned them so. There is little awareness of the discursive social construction that puts men in these cultural stories. In this study fathers are experienced in a number of ways including rescuers, needy, difficult and abusive. The collective nature of this story has drawn attention to the dominant discourse of men in general and minoritised men in particular. A common racist narrative is that African Caribbean men are positioned as 'absent fathers', or 'controlling'. Men from South Asia are positioned as 'tyrannical, controlling and overbearing'. For example, Littlewood (1995) spoke of anorexia as a way of resisting the control by Chinese fathers. The point is that there is a discursive reality that not only positions women to be concerned with body image but positions minoritised men/fathers to be seen as 'the breadwinner', 'responsible for the family', 'financially in control' and not as warm, empathic caring fathers. In our intercultural work with fathers we are invited to resist the deficit narratives and to explore how fathers can be active in their daughter's recovering.

Collective Story 4: Talking Back as Resistance

This story brings forth the possibility of how minoritised women with eds transcend and resist the dominant pathologised narratives that surround them. Clinicians are invited to be open to the possibility that experiencing eds does not imply only victimhood, personal failure or vulnerability; rather that as clinicians we might consider wider political discourses that permit racism, discrimination and inequality of access to services to flourish in 21st century Britain. It is through intercultural practice and appreciative questions that invite possibilities for hope and change alongside the social justice and liberationary paradigm to co exist. *Collective story 4* is hopeful, brought forth by the power of the individual/cultural stories that each storyteller in their own way is beginning to resist and critique. All of the stories are now in the public domain and have the capacity to talk to commissioners and clinicians and to ask that the stories be taken seriously.

In summary, I co produced ten individual/cultural stories that in turn enabled four collective stories to be brought forth. I move now to critique the study.

Critiquing the Quality of this Qualitative Inquiry

I draw on Elliot, Fischer and Rennie (1999) and Tracy's (2010) guidelines for judging criteria of excellence in qualitative studies. I synthesise their guidance to give an account in terms of the following.

- Ethics, confidentiality, reflexivity, credibility and transparency
- Relevance to the literature
- The theoretical, methodological and analytical rigour
- Resonance with the reader

Ethics, Confidentiality, Reflexivity, Credibility and Transparency

I begin with my ethical responsibilities to the storytellers. As I mentioned above, a social constructionist position on ethics is interested in content and process embracing ideas of collaboration and co production, (Swim et al 2001). I consulted with service users, but I did not involve the storytellers in the setting up of the

study, this is something I would consider for future research. In further considering ethics, I kept in mind the delicacy of this process, researching 'human subjects', to do no harm and to afford a high degree of respect to those taking part in the study. The notion of 'to do no harm' does not mean however, refraining from asking difficult questions for fear of 'getting it wrong', in fact the clumsy question might be the most useful one and is a concept I offer to the clinical team in our Diversity Dialogue group, (Partridge et al 2017). Instead, it is the lack of thinking or reflexivity that affords the biggest risk to do harm. It is relational connectedness, from process ethics, my use of self, self disclosure and transparency that are foregrounded to counter harm.

I paid attention to the environment to ensure the women felt comfortable, warm, were offered refreshments, time to have breaks and I expressed great appreciation for their help. A challenge in this context is the question of 'informed consent'. Squire et al (2014) asks if persons understand this concept fully. I reflect now whether I gave enough time for this conversation. I remember storytellers seeming to rush over this part, saying '*yes I did receive and read the Participation Information Sheet,*' or '*No I do not have any questions*' and the consent form was promptly signed. If I were to undertake further research I would spend more time with this really important aspect. The issue of confidentiality equally requires attention. How guaranteed is it? If my study collaborator is to read the study and she recognises a story description of one of her clients, have I made enough effort to protect storytellers from identification? It is important that I do everything to disguise the identity of the storytellers. I changed or left out data such as geographical location or hospital in order to protect confidentiality. I plan to email all storytellers to ask if they would like a copy of the study and/or a shortened version of the findings. If they wish to read it, I cannot guarantee they will like what they read, agree with the stories or if they had any regrets in participating. If I were starting out again, I would pay greater attention to this aspect. I would be interested in more collaboration before, during and after with storytellers drawing on the participatory paradigm.

This study makes no claim as to its representativeness. If another researcher

replicates this study with a different group of minoritised women, there would be similarities and differences brought into being through the unique process co constructed in the research endeavour, or if the same group of storytellers met a different researcher, again different stories and voices would be privileged.

I have thought about how I will present my findings and have to contend with audiences/readers/storytellers having differing views on the credibility and plausibility of the study. Because I know how I approached the study, how I worked hard to stick closely to the material, how passionately I felt about the material and the analyses, how I worked to accept feedback and to look for my blind spots, means that I have been as authentic as I can possibly be. I feel a sense of pride as I bring forth important marginalised stories of eds in our minoritised communities. The issue of transparency is something I attend to in therapy and in this study and has been evidenced for example, my conversation with Tamara and when I have spoken of my heritage, my family life and my clinical role, (Roberts 2005).

Relevance to the Literature: What will the Study Contribute?

This study adds to a small but growing number of qualitative studies on minoritised women and eds, (Wales et al 2017, Chowbey et al 2012). During this study, I observe more interest at conferences and amongst colleagues on culture/race and ed. Moreover, I raise the issue of diversity at all GP and other training that I deliver as well as raising it with commissioners and within our service. The study additionally contributes to a body of qualitative studies undertaken within the systemic field and foregrounds diversity and race conversations that we ought to be having in our teams. This study highlights the importance of recognising the legacy of colonisation, slavery and access to food, including histories of famine and starvation informs and how this might be implicated in the ed story.

The Theoretical, Methodological and Analytical Rigour of the Study

Feedback from storytellers is something I wish I had obtained. Alongside individual interviews, mentioned elsewhere in the study, I would have liked the opportunity to

interview family members. The point of rigour is to ensure any claims I make are grounded in the material obtained. My fieldwork notes could have been more detailed, rather than the short notes I kept after each interview. This is a personal style, as I am known for my brevity in note taking. Nevertheless, I made notes to my self throughout and I am still finding them tucked away in my filing cabinet, as well as a folder on my computer called 'my thinking' where I jotted ideas. It is not so much the production of these aide memoires but the process of thinking. I am aware as I look back that I have embodied and embedded much of the thinking as I have gone along to the point where I no longer need the notes. I attend to rigour by attending data analysis sessions, research conferences conversations with colleagues and friends. The concept of member checking comes from modernist research and is not a feature of poststructuralist research. The findings are co constructed and include my subjectivity.

Resonance with the reader: How does it grab the reader intellectually, emotionally, viscerally?

I am very close to the material and it is difficult to step back and imagine how it will grab the reader emotionally viscerally and intellectually. As I try to imagine this I hope the reader will have a visual image of the nine storytellers in their minds. With these images in mind I hope the experience of sensing these women and their stories will also bring forth emotional and visceral awareness and feelings. I think the storytellers share important stories so I hope that collectively or individually they are in a position to tell their own stories to the field of psychotherapy and beyond. I am also aware that the reader will form their own views and opinions of the merits of the study based too on their subjectivity and it is something I do not wish to control for or manage. Rather like dialogue it is the in the difference that learning takes place so the idea that the reader will form a different view from mine is to be welcomed.

Alternative Methodologies Revisited

This study is influenced by social constructionist theory and makes certain claims about the meaning of language, the status of memory and knowledge acquisition.

In other words, language is differential not referential, (Belsey 2002). Approaching the study from different methodological standpoints would yield different findings. For example from the phenomenological[51] approach, a project would be less interested in the construction of language use and more interested in interpreting the participants' thoughts, feelings and perceptions of the world, as if things are what they appear to be, in contrast to a constructionist approach who questions all assumptions, (Barker et al 2016). An ethnographic study or cooperative inquiry would have been good choices. However there remains the issue of finding participants, as they are not visible in services. The coordinated management of meaning, CMM is a methodology that lends itself well to this study, not only for its social constructionist sensibilities but also because of its stance on multiple levels of context politically, socially and individually. Discourse analysis came a close second in my methodological choices for its political, feminist positioning. Although I chose a dialogical narrative approach, I have theorised from multiple methodological positions to bring forth this study. For example, I view the storytellers as co researchers in the way an ethnographic or cooperative inquiry study would; I attend to the power of dominant discourses and the problem of power and knowledge as exemplified by discourse analysis. This style of bricolage, that is using a brick as a hammer, is a personal as well as professional style and is in keeping with my ideas on doubled research and doubled listening.

Strengths and Limitations of the Study

The limitations relate to questions of rigour discussed above. It was challenging to recruit participants and because of this, it organised me to only offer one to one interviews. If I were to repeat this study, I would like to interview the participants on more than one occasion, not least to clarify any points but also to explore findings with them as they emerged. Additionally, I would like to interview other family members as I think this would add to the richness of the storytelling and/or draw on other narrative methods such as use of diaries or use of blogs. I would like to make

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[51] The systematic study of people's perceptions and experiences (Barker et al 2016)

contact with local minoritised groups to hear more about the community experiences of access to /barrier to services. I did approach one group prior to the study but I did not get a reply. With more time, I would like to have followed this up, as this would provide an opportunity to share my findings and to learn from other minoritised persons whether the stories appear credible. In the interviews I reflect now that I could have extended my dialogical approach by including less of a question and answer style and more conversational style. I notice this developed with subsequent interviews as I became more relaxed with the knowledge I was not seeking a truth that would provide all the answers.

I focused on recovering rather than illness narratives. The narratives of recovering are mainly absent in clinical discourse. For these stories I turn to personal memoir, (Hornbacher 2010). In clinical settings recovery is constructed within the biological paradigm; the return of the menstrual cycle, a healthy weight range and improved physical signs of blood pressure and temperature. I chose to look to the future, explore how recovering is constructed for minoritised women. I read Malson et al (2011) who were interested in how dominant narratives impact on a woman's ability to imagine recovering. Her team explored recovering by hearing of in patient treatment experiences. In a similar way, I enabled constructions of recovering to be brought forth by both exploring migration, food, the emerging ed and treatment and future oriented appreciative questions to push for new stories of recovering. I reflect now that if I had focused on migration and emerging ed stories, it is likely that more painful stories of extreme suffering would be co produced. I reflect whether my focus on recovering was not only to do with looking for alternative hopeful stories but also because I might have found the historical stories too painful and fearful about the depths of emotion that might be expressed. Though I set out to embrace double listening, it is at this moment I reflect of the single listening that took place. This also fits with how I describe myself as a 'kindly aunt' above. I do subscribe to Timimi's idea that you know when you are doing good work with a family when you come to feel like a member of the extended family, (Maitra 2011). I word incredibly hard to get alongside the families with whom I work, anxious about conflict at times and I recognise there are limitations to this

position as it is not always possible or desirable to take this position, for example in situations that require that I move out of the domain of aesthetics to the domain of production and act on actions or situations that are of concern, (Lang, Little and Cronen 1990).

I interviewed nine women for this study. There is no definitive guide in qualitative research to say how many participants is the right amount. This can range from one interview to two hundred and everything in between. What counts is not the number, but the kind of claims I am making. More does not mean better. For a narrative analysis, which involves many hours of transcription and interpretation, designed to explore detail and complexity, I think nine participants afforded a good opportunity to explore this level of complexity, (Baker and Edwards 2012). However I think one or two more participants would have added to the richness of the dialogue.

I created the hermeneutic cycle, figure 2 page 77, to map out the process of my reflection and action as I analysed the material. The cycle could have been constructed in many ways; it is personal to my subjectivity as well as being an attempt at creating a template for other researchers that may be more or less useful.

Finally I discuss the limitations of narrative research. One critique is the argument of instead of gathering stories with a view to bring forth new knowledges, that instead we should become involved in direct activism that can lead to social change rather than hope our research endeavours might lead to change. Moreover the ubiquity of narrative can itself be a critique and we read and hear of narratives daily. To overcome the limitations Squire et al (2014) argues for self reflexivity as a researcher so that other methodologies are considered and fascinating or not, is it good enough to warrant a research study?

Clinical Implications of the Study

I reflect first on my research questions

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Questions 1 How do minoritised women construct narratives of recovering from eds?

Question 2 How can the process of research amplify and elaborate the experiences of those co- producing the research?

Question 3 How does the talking back and resisting victimhood enable the taking back of knowledges' and performance of not yet heard stories?

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Question 1: How do Minoritised Women Construct Narratives of Recovering from Eds?

As I reflect on question 1, I am reminded how the narratives were brought into being in our conversations together; how initially I felt uncertain about the material. This was because the stories appeared 'normative', in other words, the stories reflected, rather than challenged dominant narratives about suffering with eds, (Wren 2012). I realized how we all draw on normative narratives as part of our narrative habitus; they are taken for granted habits, practices and values, second nature, (Frank 2012). The point of the first question with its focus on recovering was my attempt through appreciative inquiry, to move beyond mainstream discourses. The storytellers had moved beyond ed in contrast to Malson et al (2011) whose participants considered recovery to be unimaginable. This is because of the dominance of British/American cultural values regarding body shape and size, on the pressure to eat 'healthily', the rhetoric of exercise, the constant preoccupation with food and food restriction, that either places women within the dominant cultural story and the risks associated with being an insider, or if women embrace alternative stories they risk being placed as outsiders. Paradoxically in this study the storytellers are caught up in the rhetoric of female body concerns and position themselves outside of this rhetoric in order to move on. The storytellers of this study were not preoccupied with a sense of being on the outside or belonging once they had become well.

Question 2: How can the Process of Research Amplify and Elaborate the Experiences of those Co Producing the Research?

This question is based on my subjective view; it is not possible to know of the impact of the research on the storytellers. My hypothesis about this question is that the study has the potential to bring forth new ideas into the public domain based on the co production of stories. When I developed the hermeneutic cycle, page 77, it provided me with a practical way of organizing my material and my thinking about the material. This cycle represented a finding that helped to shape the analytic process and may help future researchers to organize their approach to dialogical narrative analysis and in so doing, contribute to how study participants are foregrounded throughout the study, not just the material produced. The findings highlighted how the storytellers entered into new dialogue about not yet heard or untold/ unknown stories. The 'cultural chaos knapsack' revealed to the storytellers as well as to me the hurt that languished there. Emboldened with the knowledges of these previously untold or unknown stories created a context where further dialogue could take place or that they could remain, temporarily, in the 'cultivated amnesia' space for further private reflection. Through this reflexive process the storytellers were able to move beyond normative cultural narratives to co produce collective resistance narratives.

Question 3: How does the Talking Back and Resisting Victimhood enable the Taking Back of Knowledges and Performance of Not Yet Heard Stories?

The third question connects with the first two questions. I hope that as the findings are taken forward into teams that these questions are heard. For example by developing culturally informed practice, clinicians will be able to keep in mind how presentations of eds can be different cross culturally. My findings recommended that clinicians are thoughtful of at least five generations so that they are aware of the complexity of intergenerational transmission of trauma, racism, colonialism, slavery and migration. This can be undertaken through the use of the cultural food

genogram and the migration map, see below page 182. It may be impracticable to co produce a 5 or 6 generational genogram with a young person or family, the point is to have an awareness of the contextual historical processes brought to bear on storytelling. If the not yet heard stories become told and heard stories, this can act as a catalyst to stand up to dominant narratives that places minoritised women both outside the awareness of practitioners and in turn reduce barriers to seeking help. Because question 3 highlights how there are not yet heard stories within the narratives, it has been possible to look for those stories and as such the study shines a light on how minoritised ed stories are subjugated, marginalized, unheard, untold and unknown, in a context of a politicized health service where minoritised persons in all aspects of health care experience disparity between their experiences and those of non minoritised persons, (Becker et al 2010a, Malek 2011,Campion et al 2015). This question also create a context for stories to become heard and known by the storyteller and she may choose not to share it more widely, this is within her gift.

I argue therefore that the three research questions are addressed by the study. Moreover, the methodological approach lends itself to appreciating and valuing the storytellers as co producers of findings. Additional research would help to further explore if research has the capacity to move people from positions of victim to positions of talking back and resisting marginalisation and denial of services.

Implications for Systemic Practice, Training and Supervision

As more systemic psychotherapists undertake research projects, the flow between research and practice becomes more integrated and is brought from the margins of academia integrating it more fully with practice that this combined approach will increase resources for clinicians and therefore the people we treat, (Holmes 2016). I have discussed how systemic therapists can embrace research as an experience of daily practice (St George et al 2015). In the ed field, research is fundamental to clinical work though it is the quantitative paradigm that prevails. Many of these studies typically have small participant numbers, highlighting the difficulty in recruiting to studies, especially randomised controlled trials. The implications are

challenging, as there are few minoritised women available for study participation. The black and minority ethnic population in England and Wales is 14%, a sizeable minority with figures as high as 30-50% in some cities, (Office for National Statistics 2011). We need epidemiological data about the incidence and prevalence of minoritised women experiencing eds. This requires creative ways of gathering data including publicity through local radio, posters and leaflets to make links with diverse populations through mosques, temples and local community groups. Additionally there is a need to undertake further qualitative studies addressing minoritised women's experiences of access to services and the services themselves, in order that as systemic practitioners we can collaborate on bringing minoritised eds out of the margins into mainstream thinking and clinical practice.

In systemic training there are opportunities for conversations about diversity and papers to assist us with this such as the Cultural genogram (Falicov 1995, Halevy 1998), Race and family therapy (McDowell 2004, Laszloffy et al 2000, Hardy 2008a) the SG tools (Burnham et al 2008, Divac and Heaphy 2005,Totsuka 2014), the Family life cycle (McGoldrick, Garcia and Carter 2011) Culture and systemic practice (Krause 2012, Malik et al 2005, Singh and Dutta 2010). In my experience unless there is a minoritised practitioner in post, the issues are rarely considered. Moreover as minoritised clinicians are trained in Europe/America we learn how to become a GEMM therapist, trained not to rock the boat, not to mention race, work harder than colleagues, stay invisible, accept homogeneity and colour blindness, amongst other accepted practices for minoritised clinicians, (Hardy 2008b). I can see how I have been a GEMM therapist for years; it is through this inquiry that I am able to stand up to this narrative. I hope clinicians will find the study's practical findings in the form of Culturally Informed Guides, below in Chapter 8 useful in their clinical practice. When the practitioner engages in intercultural thinking and behaviour, drawing on the cultural food genogram and the migration map that they are in a position to engage with the family and the stories in a culturally informed and sensitive manner. Alongside centralising diversity in clinical practice and service delivery, it is core business in systemic clinical and supervision training.

The employment of minoritised trainers and supervisors is essential but as discussed above, the findings of Kline (2014) make chilling reading where there is evidence of **fewer** minoritised persons employed in the health service than seven years ago and in particular the access to the 'snowy white peaks' of the board rooms, the executive and non executive remain elusive for minoritised persons. Include minoritised persons on interview panels can help to militate against this. As minoritised practitioners we are used to teaching ourselves of diversity and centralising race because we are unlikely to have a minoritised supervisor, (Totsuka 2014).

At present I am the only minoritised person in a team of approximately twenty persons. We need to think about our interventions or offer alternative interventions to minoritised persons. We should not presume our usual treatments would be effective, (Krause 1998). Peterson et al (2016) remind us that successful treatment involves 'three legs', that is evidence-based practice, clinical expertise and families values and preferences. The third leg needs strengthening in the field of eds and diversity.

Systemic therapy and the qualitative research paradigm afford a good fit as more and more systemic researchers undertake a variety of projects. Our advanced interviewing skills, attesting to ethical issues of researcher representing 'the other', viewing participants as co researchers rather than subjects is all part of the task of qualitative research, (Gabb et al 2013,Burck 2005a). Within the systemic paradigm there is a move towards greater ownership of research ideas where methodology can be thought of less as a set of instructions to follow and more in keeping with our postmodern sensibilities. Methodology might more usefully be viewed as relationally interconnected with all aspects of reflexivity that oils the wheels of the study enabling an integrated thread throughout, (Simon 2016).

Implications for Future Research

The key findings from this study remind us as clinicians of the need to centralise intercultural thinking in our practice and how race is a central organising principle

of daily life. Because service users often hide race from discourse, it does not mean there is not a longstanding history with its roots in slavery and colonisation. It is our responsibility to name race and racism so as not to fall into the culturalist trap of exoticising cultural difference. As communities become more diverse, our ethical responsibilities increase to ensure we are able to talk across intercultural spaces remembering that the encounter with others is a meeting of cultures. (Krause 2002, Nolte 2007, Karamat-Ali 2007, Rober et al 2013). Further research may explore if and how racism, colonialism, slavery, intergenerational and migratory trauma are linked to eds and other mental health issues.

The ed field needs both quantitative and qualitative research as there remain many unanswered questions. There is the risk that as a consequence minoritised eds become subsumed into a dominant construction of eds. We need to factor in the many contradictions in the data and to recognise the global changes that are impacting on persons as they move around the world. They include the effects of industrialisation, increased individualisation, the erosion of collectivist cultures, family break up, higher longevity and reduced fertility, changes to food, cultural and religious practices, the erosion of traditional healing practices due to the impact of colonisation and psychiatric practices globally. We need to consider how these factors impact on emotional well being and sense of identity, (Fernando 2012, Littlewood 1995, Lee 1996). Huey et al (2010) comment that there are several manuals in the mental health field available to clinicians that do not provide any guidance for the treatment of minoritised persons. Keel and Haedt (2008) suggest future research needs to attend to the increasing number of minoritised women experiencing eating difficulties and they need to be included in studies. The majority of epidemiological studies in the United Kingdom focus on white participants whereas in the United States incidence and prevalence studies are possible with a range of minoritised groups including Latino, African American, Asian American populations, (Smolak et al 2001).

In my clinical role I have sought to improve cultural awareness and sensitivity amongst clinicians both within the team and as part of my training remit in the community to commissioners, schools, GP's and other tier 1 and tier 2

practitioners. I have introduced Diversity Dialogue group, an experiential group for all staff to explore the SG's and clinical practice. This group is established in my previous CAMHS team and it has been running successfully for five years. I notice how we have attracted a number of clinicians of diverse backgrounds to the team; I hope making transparent these kind of dilemmas has enabled opportunities for employment in a previously all white team. The Diversity Dialogue group is now beginning in my new team as well as the idea of this kind of experiential group rolling out Trust wide. I have been influential in ensuring that the publicity for the new ed service actively addresses diversity in all its leaflets, websites and information. Moreover I have dialogued with B-EAT, the national ed charity to improve their publicity on diversity and have sat on the questions table at the national NHS England ed training addressing diversity in eds.

To further consolidate and expand this study's findings it will be important to make links with minoritised communities and survey how specialist ed services can meet diverse need. By adopting a liberation psychology approach it may mean practitioners going into communities, moving away form traditional notions of clinic-based treatments. The issue of barriers to help seeking need further exploration, (Wales et al 2017). We need to ensure our tools for measuring are culturally valid and appropriate (Smolak et al 2001). We need to be thoughtful about the use of the diagnostic criteria bearing in mind that the diagnostic manuals are founded on white 'western' populations (Pike and Dunne 2015). There is a need to research current models of treatment to find out if adding in culturally informed and culturally sensitive practices can augment current treatments or is there an argument for alternative methods of treatment, (Smolak et al 2001, Franko et al 2007). Huey et al (2010) argue both for cultural adaptations of manuals whilst also arguing that clinicians should not presume homogeneity of response and that attention also be given to within group differences such as experiences of migration and acculturation. We cannot presume that all families wish to discuss their personal family issues with a professional in a clinic, (Ma 2008).

I studied a heterogeneous group. It would be useful to study one specific cultural group, for example, South Asian females born in the United Kingdom to gain

insight into the specific cultural features such as views on body image, collectivist experiences, local family meanings of food refusal, what might be the environmental stressors contributing to the ed and so on, (Franko et al 2007, Cummins et al 2007).

A mixed methods approach designed to both explore narratives and the use of a questionnaire may be beneficial. For example a questionnaire designed to assess cultural and family beliefs, as the Asian American Value Scale-Multidimensional (AAVSM) which can measure attitudes to collectivism, conformity to family norms, emotional self control, family recognition through achievement, and humility. The authors wonder if the questionnaire can highlight how eds might be an expression of managing two cultures, (Tsong et al 2015).

From this study findings, I privilege dialogue, research and training that explores how it is that minoritised women are experiencing eds as we cannot presume there is the same trajectory into the illness as white women. The legacy of colonialism, migration, racism and slavery impact on past generations where stories have remained untold or unheard for generations coupled with the purposeful keeping of stories to protect others. The storytellers are subject to the same interventions as white persons, with little if any attention to their social difference. Where it is raised, the storytellers report it to be stereotypical and simplistic that impact on the storyteller's desire to remain in treatment. The storytellers have resisted and stood up to deficit positioning, moving from cultivated amnesia to storytelling, beginning to resist the cultural stories by becoming successful, vibrant, phenomenal women.

I now move to the conclusion in Chapter 8 where my findings outlined in this chapter are consolidated into a series of culturally informed practice and training guides as well as the unfinalised words of the storytellers.

Chapter 8: Culturally Informed Guides and the Storytellers' Unfinalised Words

As I come to the conclusion it strikes me that I am learning until inserting the final comma, full stop, and then beyond as ideas continue to emerge, change and develop. There is 'an imperfect relationship between the analysis of data and the lived experience', (Gunaratnam 2003). My wish it that the written word is faithful to the co constructed oral dialogue that shaped this study. What the analysis cannot do is bring forth the embodied felt reality, the humanness of the encounter; as the written words in their entirety can only be an approximation of the lived experience.

I offer here a series of culturally informed practice/training guides that encapsulate my findings.These guides are ready for use whilst also being ready to be amended, added to, debated, agreed with or disagreed with. They are designed with the clinician in mind, to help with the development of culturally informed practices in ed work. Colleagues have expressed an interest in piloting the guides in their practice settings. The next step on my research journey will be to evaluate their utility in clinical settings.

As I draw conclusions from the inquiry, it strikes me how the guides are a shift from a postmodern to a modernist epistemology in the sense that throughout the study I have wrestled with the tensions of meaning making of eds from multiple perspectives whilst my clinical colleagues are more likely to hold a greater degree of certainty about what eds are, that is a mental disorder. My task therefore is to offer the guides as an opportunity to begin conversations about sociocultural language that can be put alongside biomedical language so that newer stories of eds and recovering can be constructed.

Throughout the study, I engaged with theorizing of minoritised eds as a cultural construction. I raised awareness of the existence of eds amongst different populations, both globally and in the United Kingdom whilst also thinking about 'diagnosis' in parenthesis, mindful of its social construction. The narratives co-constructed with the storytellers revealed a/b as a moral, controlling voice, (Epston

et al 2009). It is through the production of newer, counter stories that the storytellers relax their self critical gaze. Each storytelling moment is a unique performance of unfolding dialogue, of polyphonic voices multiply constituted, as the storyteller and I dialogically relate with one another. This is what Frank (2012) refers to as the storyteller 'holds her own' in the act of storytelling.

In collaboration with the storyteller, I introduced double descriptions into dialogue, bringing forth other possibilities that may add to understanding of how it is that eds have entered their lives. This connects to research question 2; this affordance of double description invited the storyteller into a reflective space where she may consider alternative descriptions of sickness. As the storyteller interacts with her own storytelling, as the stories move from untold to told stories, she begins to talk back and to resist dominant narratives that has so far positioned her in a sick role with little agency power or authority.

As I said in the introduction, it is important that as clinician/researchers we are in the driver's seat, that we continue to ask questions of our practice. Gergen (in Simon et al 2014), says

> *'It is possible and desirable to engage in research practice as part of the daily engagement with others in the work setting' (p.vii)*

I see the production of the guides through this lens. My position now is to afford better integration between research and practice. St George et al (2015) offer a useful model drawing comparisons between the aims of research and the aims of clinical practice. Simon (2016) goes further, arguing in her training role that trainees are committed to viewing systemic practice as research, referring to it as 'transformative inquiry'. This is similar to McNamee's (2014) 'relational inquiry'. Others refer to 'research as practice', (Partridge 2012a) or 'research as intervention' (McNamee 1988). It feels transformative to read that Simon's students notice that commissioners are asking for case examples alongside empirical evidence. This represents a shift towards a greater integration and away from the dominant discourse of quantification, (Simon 2016).

In the spirit of systemic research where I have benefitted from guides for practice, for example, Hardy's et al (2000) list of questions asking how one defines oneself racially; or Hardy et al (1995) cultural genogram questions; or Halevy's (1998) 'Genogram with Attitude' enabling exploration of how we learn about prejudice as we grow up; or the many and varied exercises by Burnham (2008, 2010) or the useful tool box of diversity exercises by Singh et al (2010), or Karamat-Ali (2007) who privileges diversity talk in the South West of England. I see my guides in this light.

Throughout the study I did not differentiate between the different heritages of the storytellers. For the purposes of these guides, I think it is helpful to show clinicians where there are differences between different cultural groups to aid their clinical practice. Not only do clinicians need to be aware that not all cultural groups are homogenous, they need also to be careful of interpreting standard outcome measures and questionnaires as if they are equally applicable to white and minoritised persons. For example, the Bulimia Investigatory Test, Edinburgh (BITE), a tool used for deciding if a person has bulimia nervosa, was used in Jaipur, India. High scores were found suggestive of a bulimic presentation yet the participants were not were concerned with body fatness, (Henderson and Freeman 1987, Littlewood 2004). The Eating Attitude Test (EAT) revealed high scores amongst British Asian women but they did not have a fear of fatness associated with high scores, (Garner et al 1979). This is further contrasted with men and women in Lahore, Pakistan where there is said to be a strong dieting culture where the EAT results were found to be comparable to persons in the United Kingdom.

I remind the reader that there is no common pathway across or between different cultural groups so we cannot convincingly say that eds are brought into being for minoritised women because of any specific factor, (Littlewood 2004). Instead the findings of this study invite questions about the role of culture in ed development, in particular, the impact of migration, racism, colonialism and slavery that structurally impede the process of storytelling and open dialogue is silenced, stories stored in the cultural chaos knapsack or as a cultivated amnesia until it is safe enough to be brought forth.

Culturally Informed Guides

- Culturally Informed Guide 1: Key messages to assist an intercultural eating disorders assessment
- Culturally Informed Guide 2: Raising clinical awareness of important differences in ed presentation to assist with early identification
- Culturally Informed Guide 3: Assessment guide
- Culturally Informed Guide 4: Treatment guide
- Culturally Informed Guide 5: The Cultural Food Genogram[52] and Migration Map

The first guide provides key theoretical messages. Guide 1 and 2 could be used in primary care settings including general practitioners, schools, school nurses and other community settings. All guides can be used in training or clinical practice. There is an important caveat regarding the use of the guides. Diversity/ed research is patchy, often comes from the United States so all the guides are tentative possibilities rather than the truth. I think of the guides as an opportunity for dialogue in teams to ensure that any racial stereotypes about eds and diversity do not obscure recognition of eds amongst diverse women, (Abbas et al 2010).

To bring the guides to life, I have provided a vignette from my clinical practice, the case of Hana, the young Muslim woman mentioned in the introduction:

Hana aged 16 has just finished her GCSE's and is about to start at 6th form college. Her older sister, Mia, 18 has finished college and is applying for university. Hana and her family were born in the Middle East and came to the United Kingdom fleeing war. Mother, Laite, is a qualified teacher but is not qualified to practice in the United Kingdom. Father, Peter is also a qualified teacher but is unable to work due to being injured in a rocket attack in the Middle East some years ago, after which the family fled, initially to Scotland then to England. The family live in a small 2 bed flat provided by the local council. The family live on Income Support and receive Housing Benefit. Laite is also a carer for her husband but is hoping to do a course to update her teaching qualification. Peter is learning English at evening classes.

Hana found the move from Scotland to England just before her GCSE's very difficult, she has not settled into the local area, has not made friends and worries about finances and her father's poor health. She began to restrict her intake of food shortly after arriving in England about three

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[52] Two fellow doctoral students, Kevin and Philip helped to coin this term

> *months ago and currently has lost about 6kg, she is a weight for height of 78% representing 'amber' in terms of risk for physical complications.*

Using the Culturally Informed Guides below, clinicians can develop hypotheses drawing on ideas about migration, trauma, racism and prejudice that might impact on this family.

Table 14 Culturally Informed Guide 1: Key Messages

Culturally Informed Guide 1: Key Messages (Guide 1 of 5)

- *Eating Disorders affect all genders, ages, races, ethnicities, body shapes, sexual orientation (including transgender) and socioeconomic status (NICE 2017)*
- *Eating Disorders occur in diverse ethnic and cultural groups in the United Kingdom and globally (Franko 2007)*
- *Understanding the context of Racism, colonisation, migration*, war, famine, trauma and acculturation is crucial for engagement and may be implicated in the emergence of an eating disorder (Littlewood 2004)*
- *Stigma, shame and a lack of understanding of eating disorders within cultural groups and families, somatisation of distress confidentiality issues, may act as barriers to seeking help (Chowbey, Salway and Mubarak 2012)*
- *Sufferers report a tension between the expectation to be grateful for food and their food refusal (Chowbey et al 2012)*
- *Consider religious festivals, celebrations and the implications of fasting for the sufferer as there may be pressure to conform to traditions if the family is unaware of/or does not understand the meaning of the eating issues (Wales, Brewin, Raghavan, Arcelus 2017)*
- *Minoritised women are more likely to remain in primary care rather than being referred to specialist care (Currin, Schmidt and Waller 2007)*
- *The point above may be related to atypical presentations and it may be harder to ask for help, e.g. non fat phobia (Becker, Thomas and Pike 2009)*
- *Weight loss or weight gain may be viewed as healthy in South Asian communities so there may be a lack of awareness of the seriousness of an emerging eating disorder (Tareen, Hodes and Rangel 2005).*

*Families/individuals may be reluctant to share migration stories or may have limited knowledge of the migratory experiences of their ancestors

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Table 15 Culturally Informed Guide 2: Identifying Eating Disorders amongst Minoritised Women

Culturally Informed Guide 2: Identifying Eating Disorders amongst Minoritised* Women (Guide 2 of 5)

- *There are a variability of presentations, for example Asian and Chinese females may be of smaller stature, usual height and weight charts** may not apply (Lower pre morbid %weight for height/BMI)*

- *One survey identified higher than expected prevalence of bulimia nervosa amongst Asian school girls in North England (Abbas et al 2010)*

- *Asian/South Asian females may continue to menstruate yet be seriously underweight (personal communication)*

- *Asian/South Asian females may report distress, low mood but **not** report body image concerns, or desire for weight loss (Littlewood 2004)*

- *Vomiting found to be best predictor of distress*** amongst Asian population (Franko, Becker, Thomas, Herzog 2007)*

- *Bulimia Nervosa may be more prevalent amongst non whites than whites (Waller et al 2009)*

- *Reasons given for food refusal may be somatic, e.g. gastric complaints and bloating and loss of appetite (Tareen, Hodes, Rangel 2005)*

- *Age of onset of anorexia may be different (younger)(Franko et al 2007)*

- *Bulimia Nervosa: may not binge/vomit with duration and frequency to reach diagnostic threshold (Franko 2007)*

- *The length and course of the illness may be different (Franko 2007)*

  *Some of the research findings here are from the United States and are not necessarily transferable but are here to help with developing cultural awareness. **Do not presume homogeneity across cultures** for example, be cautious when interpreting screening and outcome measures where high scores indicate pathology where there is none*

  ** Minoritised refers to the **process** of becoming a minority*
  ** There are plans to modify current charts
  ***i.e. Does symptom lead to impaired functioning that leads to help seeking?

Table 16 Culturally Informed Guide 3: Assessment Guide: Assessment of Eating Disorders amongst Minoritised Women

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Culturally Informed Guide 3: Assessment Guide: Assessment of Eating Disorders amongst Minoritised Women (Guide 3 of 5)

Intercultural Assessment: Involves the following:

Family Life Cycle: Use the Cultural Food* genogram and Migration Map** to consider life cycle events and experiences. Clinicians should consider a 5 or 6-generation genogram to capture trauma transmission from slavery/forced migration and history of famine and starvation. In practice this may be unrealistic but clinicians can ask what the family/young person know of previous generations regarding migration etc. It is worth exploring the histories of colonialism, slavery and racism and how these impact on identities in the family. Gather a rich story of the illness experience and its impact on the individual, family and wider relationships

Cultural Psychoeducation: Offer standard psychoeducation about eating disorders as well as asking about and being aware of:

- *South Asian females are disproportionately at risk of completed suicide, so this must be asked about (Campion and Fitch 2015)*
- *Gender, power, racism, migration, acculturative stress and oppression impact on the development of the eating disorder*
- *Early eating behaviours of child*
- *Gender roles in the family*
- *Family view on their ethnic identity and how this may be changing*
- *Family view and knowledge of mental ill health*
- *Food preparation, roles and rituals*
- *Religion and spiritual beliefs*
- *Barriers to seeking help: fears re confidentiality, previous experiences, stigma*
- *Link between fasting for religious reasons and onset of eating disorder*
- *Different and changing views on body image*
- *Menu plans to reflect cultural/religious norms*
- *Many ethnic groups socialise through ritual of food and this may present difficulty for minoritised female struggling with food. (Ramadan/Eid). A small study revealed evidence of eating disorders being triggered by Ramadan (Akgul et al 2014)*

    */** See separate guide
    *Cultural food stories are those stories that connect the person to their culture. These questions might also highlight the absence of cultural food due to it not being available. Stories therefore may be further back in family storytelling and invoking these stories may bring forth a sense grief and loss

Table 17: Culturally Informed Guide 4: Intercultural therapy for Minoritised Women with Eating Disorders

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Culturally Informed Guide 4: Intercultural Therapy for Minoritised Women with Eating Disorders (Guide 4 of 5)

After assessment: Intercultural Therapy: Consider

- *Shame and culturally held beliefs about mental disorder by family members may work against a successful engagement and may lead to non attendance and therefore place individual at increased risk*

- *If parent/s did not attend initial assessment, how will the clinician consider engaging with them and taking into account their cultural context*

- *Continue to develop the narrative of the Cultural food genogram/Migration Map and the mini ethnography*

- *Be aware you may trigger previously untold or unheard stories that do not initially appear to be connected to the presenting eating issue but are relevant and useful for engagement*

- *Be sensitive in your exploration of the history of cultural food stories* as they may carry strong and ambivalent meanings and may tap into multiple losses, hunger, trauma or abuse*

- *Stories of cultural heritage and racism often are underplayed. Consider how these conversations can be made transparent*

- *Give consideration to collectivist cultures, it is a developed nations narrative that it is desirable for a young person to have independence at aged 18*

- *Continue with NICE Guidance (2017) treatments and integrate culturally informed intercultural practices*

- *Be mindful that treatment approaches deemed effective for white European families may not fit for minoritised families/service users (Pakes and Roy Chowdhury 2007)*

- *Families may be unsure about sharing private matters with a stranger (Ma 2008)*

  *Cultural food stories are those stories that connect the person to their culture. These questions might also highlight an absence of cultural food due to it not being available. Stories therefore may be further back in family storytelling and invoking these stories may bring forth a sense grief and loss

The Cultural Food Genogram and Migration Map

Hardy and Laszloffy's (1995) Cultural genogram is a useful template for undertaking this genogram. The guide below is a prompt to develop a cultural narrative of the family history regarding food and migration. As I mentioned above, I have suggested a five or six generation genogram. This is the long view, to enable the continued scaffolding of knowledges and skills as the therapist zooms in and out of the family context, looking more closely at the present whilst also zooming to the past, renaming, remembering and knowing stories in a different, more appreciative way. It is within these stories that the legacy of colonialism, slavery and racism can be privileged alongside stories of illness narratives and a different understanding becomes available. Clinicians can then begin to formulate how these narratives are implicated in the eating disorder.

Table 18: Culturally Informed Guide 5: The Cultural Food genogram and the Migration Map

> *Culturally Informed Guide 5: The Cultural Food* Genogram and Migration Map (Guide 5 0f 5)*
>
> - *What do you remember of the food you ate when you were a young child? Did you eat*
> - *food from your parent/s cultural heritage?*
> - *If not, why not?*
> - *What did you like/not like?*
> - *What kind of food did you and your family eat to celebrate (explore festivals and*
> - *religious dates that are important to the family)*
> - *Who shopped for the food, was it available locally, who prepared it and served it? How was this talked about?*
> - *What were the emotions associated with this food, what do you remember about how cultural food was talked about*
> - *What kind of foods were they able to buy here and what kinds of foods were unavailable to them?*
> - *Did anyone go hungry or experience famine?*
> - *How do your parents refer to food when they were growing up? (Availability, were they ever hungry, did the community help to feed families)*
> - *How did you celebrate with food before you became unwell?*
> - *What did you first notice about your changing eating behaviour?*
> - *What do you know about how your parent/s came to this country?*
> - *Where are their ancestors from? How many moves have they made?*
> - *How would your parents or people form your culture understand anorexia or bulimia? What would it mean to them? Would they recognise it as linked to emotional or psychological states?*
>
> - ***Develop these questions with additional generations, grandparents, great grand parents great, great grandparents. You may learn of multiple migrations as you go further into history and therefore of multiple losses, deprivations and traumas including language, hunger and famine***
>
>   **Cultural food stories are those stories that connect the person to their culture. These questions might also highlight an absence of cultural food due to it not being available. Stories therefore may be further back in family storytelling and invoking these stories may bring forth a sense grief and loss*

I have engaged with a number of theories about how/why minoritised women experience the distress of eds. I began the study acknowledging that clinically we are seeing women of colour experiencing eds in a culture where it has been presumed that they do not. The storytellers described vivid experiences of eds, of not being noticed or taken seriously. Once identified, often following a crisis, the storytellers shared mixed experiences of being treated with cultural sensitivity. I argued in the discussion that further research is necessary to collect better data about the impact of acculturation, discrimination, trauma, migration and family values on body dissatisfaction, (Smolak et al 2001). In this inquiry the women have been challenged by, and transcending the notion of living in two cultures, have

successfully navigated a path towards recovering.

I offer the guides above as a way of giving back, of talking back to dominant discourses and as a step on a journey to help clinicians to feel empowered and skilled in working across diversity in the ed field. Moreover, I want the academic discourse to talk back to me so I can speak out and stand up and speak up for minoritised women with eds. Thus bringing minoritised women with eds out of the margins, to become visible and voiced.

I end the study with the standing up resistance dialogue from Tara and the talking back resistance of Harriet.

> *K just before we finish, I wonder whether you think your cultural heritage/identity has helped you or hindered you with your process of recovering?*
>
> *Ta on the one hand there is the myth of the strong black woman, which is just that really, we strive and we are in pain, there is a whole legacy of slavery and all that, but there is strength in the women in our family and that kind of goes back a whole century really, those stories are really kept alive […] they are very strong and also my dad's sister who was quite a matriarch*
>
> *K so is there something about family values that have withstood time?*
>
> *Ta yeah they would all be described as strong women and also even another generation back who emigrated to [..] my grandmother, you know, was quite an enlightened woman[..] so yeah, there are different kinds of strengths around, kind of woman based really and it has definitely been a resource in tough times,[…]*

Tara spoke with a polyvocal voice, speaking for many minoritised women talking back and resisting victimhood.

I asked Harriet how things changed when she went to university. She told me that she went back to where she had worked as a teenager in a fish and chip shop and this is what they said to her;

> *H they were like, god when you left you were so shy you didn't say anything, you came back, you got boobs and a bum and attitude and that was pretty much it, it was quite an accurate way a very blunt way of describing it, but it was true for that first year at uni, I suddenly came back and I was a bit more like, actually I'm not gonna do that, I would stand up for myself a bit more so yeah*

These words are a brief snapshot of examples of the storytellers' capacity to resist and talk back to dominant narratives and hold their own in the process.

In concluding, since I started this study, the wider political context is beginning to acknowledge culture in eds, including the new NICE guidance (2017), the latest commissioning guide for ed service development, (Campion et al 2015) and the latest Diagnostic manual, DSM 5, (APA 2013). As I mentioned above, NHS England training recently addressed culture and I had the opportunity to discuss my findings. I have been asked to address conferences to present my findings, the Chief Executive Officer of our Trust wants to attend our Diversity Dialogue group so there is much to be excited about. I also feel caution as I know that minoritised persons are less likely than some years ago to have roles in executive and non executive boards in our health service, (Kline 2014) and without change at the top, we know services for minoritised persons may be served less well. To counter this, I now routinely talk of race/culture/ eds in many settings, I belong to the Black and Minority Ethnic network at work and am a mentor to minoritised Clinical Psychology trainees. I hope these connections and developments alongside the learnings from this study will help to further shape culturally informed ed services.

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Appendices

Appendix A: Participant Information Sheet

Version 4 February 2014

<u>Title of research project</u>: In the margins: Minoritised[53] womens' narratives of recovering from an eating disorder

<u>Introduction</u>

My name is Kamala Persaud and I am a family therapist[54] in CAMHS. (Child and Adolescent Mental Health Service). I am undertaking some research as part of my Doctorate in Systemic Psychotherapy.. I am researching stories of recovering from an eating disorder of women in the black and minority ethnic population.

I would like to interview women aged 16 and over, from any black, minority or mixed race background who have recovered or are recovering from an eating disorder. I would need to interview each person for up to 2 hours. The interview will be audio recorded. I will be interviewing 10 women in total.

I would like to invite you to take part in a research study. Before you decide, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. If there is anything that is not clear or if you would like more information, please ask. Take time to decide whether or not you wish to take part.

<u>What is the study about?</u>

In my work as a family therapist specialising in working with people who have an eating disorder, I have noticed that I am seeing more girls and women from a variety of cultural and ethnic backgrounds. There is very little known of this group of people in terms of their experiences of dealing with an eating disorder or how culture might play a part in recovery. I would like to find out more about this so that I can think about how to improve my practice in helping other people.

<u>Do I have to take part?</u>

Taking part is entirely voluntary. It is up to you to decide. I will describe the study and go through this information sheet, which I will then give to you. I will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at any time, without giving a reason. This will not affect the standard of care you receive now or in the future. You might wish to discuss it further with family, friends or professionals. You can also contact me to ask any questions by using my contact details below.

<u>What will happen if I take part?</u>

I will arrange to meet with you at a convenient location. I will ask you some questions about your recovery journey. The

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[53] 'This term emphasizes the process of becoming a minority, rather than the idea that ethnicity and culture are fixed entities

[54] Family therapists are also known as 'systemic psychotherapists'. We work with young people and their families

questions are designed to find out about your strengths and abilities in recovering. I will ask about your cultural /ethnic origin and some questions about food in your family. I will audio record this so that at a later point I can make a transcript of our conversation. This will then be analysed for significant themes, issues and ideas that will help me in my practice as a therapist.

Will what I say remain confidential? *

Yes. Any written material will be anonymous. Identities of people and places will be omitted. The final dissertation[55] will only contain a write up and analysis of themes from the interviews and will not contain any identifying information. Recordings of the interview will be kept in a locked cupboard at my place of work/study and will be destroyed at the end of the study. All information on the computer will be password protected.

*You need to be aware that if there are any concerns about risks identified by me as a result of your involvement in this research, that I will need to notify someone such as a family member/your GP or a professional involved in your care.

The Data Protection Act 1998 requires that I pay close attention to its guidance with regard to the obtaining of consent, the storage and security of data (that is the record of what you tell me in the interview). At all times I will ensure the information is anonymised so I will not include your name, date of birth or other identifying features, in order to protect confidentiality.

What are the possible benefits of taking part?

Whilst there will be no intended clinical benefit, I would hope that in taking part, you will find the questions interesting and helpful. I cannot promise the study will help you but the information I get from this study will help improve the treatment of black and minority people with an eating disorder. It is through studies like this that the health service can decide what sorts of services need improving, so your contribution is really important.

Are there any down sides to taking part?

You may find some of the questions quite personal. You are of course free not to answer any questions that you feel are too personal. If you feel distressed by any aspect of taking part in this research I would recommend you discuss it first before deciding whether to go ahead.

What if there is a problem?

If you have any concerns about any aspect of the way you have been treated during the course of this research study, then you can contact my supervisor. Her name is Karen Partridge and her contact details are below.

You can contact B-eat adult or youth helpline: Adult 0845 634 1414 or email help@b-eat.co.uk and if you are 25 or under, you can call the B-eat youth line on 0845 634 7650 or email fyp@b-eat.co.uk . In addition, you can also contact http://helpfinder.b-eat.co.uk/ for details of local support or self help groups in your area.

Has the research been approved by any committee?

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[55] The dissertation is the document I will produce based on the analysis of all the interviews and the relevant literature that I use to help me write up the study

The NHS Ethics committee has approved the study. I also have permission from Sussex Partnership NHS Foundation Trust and North East London Foundation NHS Trust, as well as permission from some charities to recruit participants for my study.

What will happen to the results of the research?

Research takes time, often years to complete. The results of the research may be presented at conferences and published in academic journals. I want to reassure you that wherever the research is presented, there will be no personal details and nobody will be able to identify who you are. In addition I would like to ensure service users also get to hear about my findings. This maybe in the form of a poster or via a social media website. Thank you for taking time to read this information sheet

Research being conducted by: Kamala Persaud

Title: Systemic Psychotherapist

Work address: The Aldrington Centre (CAMHS) 35 New Church Rd, Hove, BN3

Telephone number (messages can be left for me) 01273 718680

Email kamala.persaud@sussexpartnership.nhs.uk

Supervised by: Karen Partridge

Title: Consultant Systemic Psychotherapist

Work address: Tavistock Centre, 120 Belsize Lane, London NW3 5BA

Telephone number: 02089382352

Email: kpartridge@tavi-port.nhs.uk

Appendix B: Consent Form

Title of the research project: In the margins: Minoritised womens' narratives of recovering from an eating disorder

Consent Form   **Initial Box**

I agree to take part in the research project, which explores narratives of recovering from an eating disorder.

I have read and understood the information sheet.

I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

I understand my participation is voluntary and that I am free to withdraw at any time without giving reason, without my care or legal rights being affected.

I understand that all personal data is held and processed in the strictest of confidence, and in accordance with the Data Protection Act (1998). I have been informed that all information will be anonymised.

I understand that my name and any other identifying features will not be used.

I agree that the data collected will be used in the process of completing a Professional Doctorate degree, including the dissertation and any future publication.

I understand that if there are any concerns about risk identified by the researcher as a result of my involvement in this research, that the researcher will need to notify someone such as a family member/my GP or a professional involved in my care.

I agree to be audio taped and the interview transcribed.

I am aware that direct quotes made by me may be used in the final write up of the dissertation. The quotes will be anonymous and not identifiable in any way.

I have read and understood everything written above and have chosen to consent to participating in this study. I have been given enough time to think about this and agree to comply with the instructions and restrictions of the project.

18 and over **I accept**   **I do not accept**

For under 18's the researcher may also wish to inform a family member/carer AND/OR a professional/GP of your taking part.

Under 18   **I accept**   **I do not accept**

Name of participant……………………………………. signature……………………………………..

Name of person taking consent…………………………..signature……………………..………………

Appendix C: Poster Advert

ARE YOU INTERESTED IN TAKING PART IN SOME RESEARCH? ARE YOU FEMALE, AGED 16 AND OVER?

ARE YOU BLACK, ASIAN, MINORITY ETHNIC OR MIXED RACE?

ARE YOU RECOVERING FROM EATING DIFFICULTIES?

IF YOU ANSWER YES TO ALL OF THE ABOVE, I WOULD LOVE TO HEAR FROM YOU! PLEASE EMAIL OR CALL ME FOR FURTHER DETAILS

kamala.persaud@sussexpartnership.nhs.uk

01273 718680

KAMALA PERSAUD RESEARCHER DOCTORAL STUDENT UNIVERSITY OF EAST LONDON

Appendix D: Interview Protocol

4th (and final) draft interview questions May 2014

A **Food/Cultural genogram**

In the family: story of growing up, socialisation process, messages received about culture, gender, food, appetite, body

Story of food in family life – celebrations, rituals, contradictions

Outside the family – ecological niche, bicultural? Assimilate? Culture clash? Strong ethnic identity? Discrimination?

B Recovering

Story of 'recovering'-how does participant describe this process (healing?, living with?)

 Treatment

Role of family

Role of culture

C Strengths and capabilities

Individual –pride, hidden abilities, looking back toughest part of journey?

Family/cultural – pride, cultural resilience (from socialisation process)

D **Future dreams/hopes**

Goals, who most appreciative? Next steps

Appendix E: Transcription Notations

The transcription notations used were as follows:

(.) Untimed pause, which is noticeable but too short to measure

(2) Time pause to the nearest second

Word Italic – emphasis placed on words by speaker

(Overlap) Overlapping utterance

…… Speaker trails off

(Indistinct) Inaudible

(Laughs) non verbal communication

KP researcher contribution

{…} Section of extract left out

From Burck C Multilingual Living (2005b)

Appendix F: Letter of Invitation

Kamala Persaud Researcher

01273 718680

Dear

Thank you for your interest in participating in my research project. I value the unique contribution you can make to my study and thank you in advance for your commitment of time and energy for this.

I am enclosing a sheet, which explains why I am undertaking this research. I hope it answers any questions you may have.

If you would like any more information before deciding whether you would like to take part, please feel free to contact me on the above number where you will be able to leave a message for me.

If after you have read the information sheet you decide you do not wish to take part, ==(I want to make it clear that you should not feel under any obligation or pressure to take part)==, I would appreciate if you could let me know within two weeks of receiving this letter by leaving a message on the above number. I will not contact you again.

If I do not hear from you in that time period, I (or a colleague known to you) will follow up this letter with a telephone call to you to see if you are willing to take part.

Yours sincerely

Kamala Persaud

Researcher

October 2013 version 2

Appendix G: Letter of Favourable Opinion

NHS

Health Research Authority

NRES Committee South East Coast - Brighton and Sussex
Health Research Authority
Ground Floor, Skipton House
80 London Road
London
SE1 6LH

Telephone: 02033117294
Facsimile: n/a

31 October 2013

Ms Kamala Jeanette Persaud
Systemic Psychotherapist
Sussex Partnership NHS Foundation Trust
35 New Church Rd,
Hove
East Sussex
BN3 4AG

Dear Ms Persaud

Study title: **In the margins: minoritised womens' narratives of**
                          recovering from an eating disorder.
REC reference: **13/LO/1177**
IRAS project ID: **105947**

Thank you for your letter of 08 October 2013, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator   Danyal Enver, (nrescommittee.secoast-brightonandsussex@nhs.net).

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

0

31 October 2013

Ms Kamala Jeanette Persaud
Systemic Psychotherapist
Sussex Partnership NHS Foundation Trust
35 New Church Rd,
Hove
East Sussex
BN3 4AG

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Ethical review of research sites

NHS sites

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Evidence of insurance or indemnity		01 August 2012
Interview Schedules/Topic Guides	1 - Questions	19 July 2013
Investigator CV	Kamala Persaud	18 July 2013
Letter of invitation to participant	2	02 October 2013
Other: Summary CV for Supervisor	Reenee Singh	
Other: Email Correspondence - Awaiting corrected IRAS form		26 July 2013
Participant Consent Form	2	02 October 2013
Participant Information Sheet	2	02 October 2013
Protocol	1.0	19 July 2013
REC application		31 July 2013
Referees or other scientific critique report		02 July 2013
Response to Request for Further Information		08 October 2013

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/LO/1177	Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at http://www.hra.nhs.uk/hra-training/

With the Committee's best wishes for the success of this project.

Yours sincerely

P.P.

Dr   Simon Walton
Chair

Enclosures: "After ethical review – guidance for
                    researchers" [SL-AR2]

Copy to: Dr Reenee   Singh
                   Gina Declemente, Sussex Partnership NHS Foundation Trust

Appendix H: Example of Analytical Practice
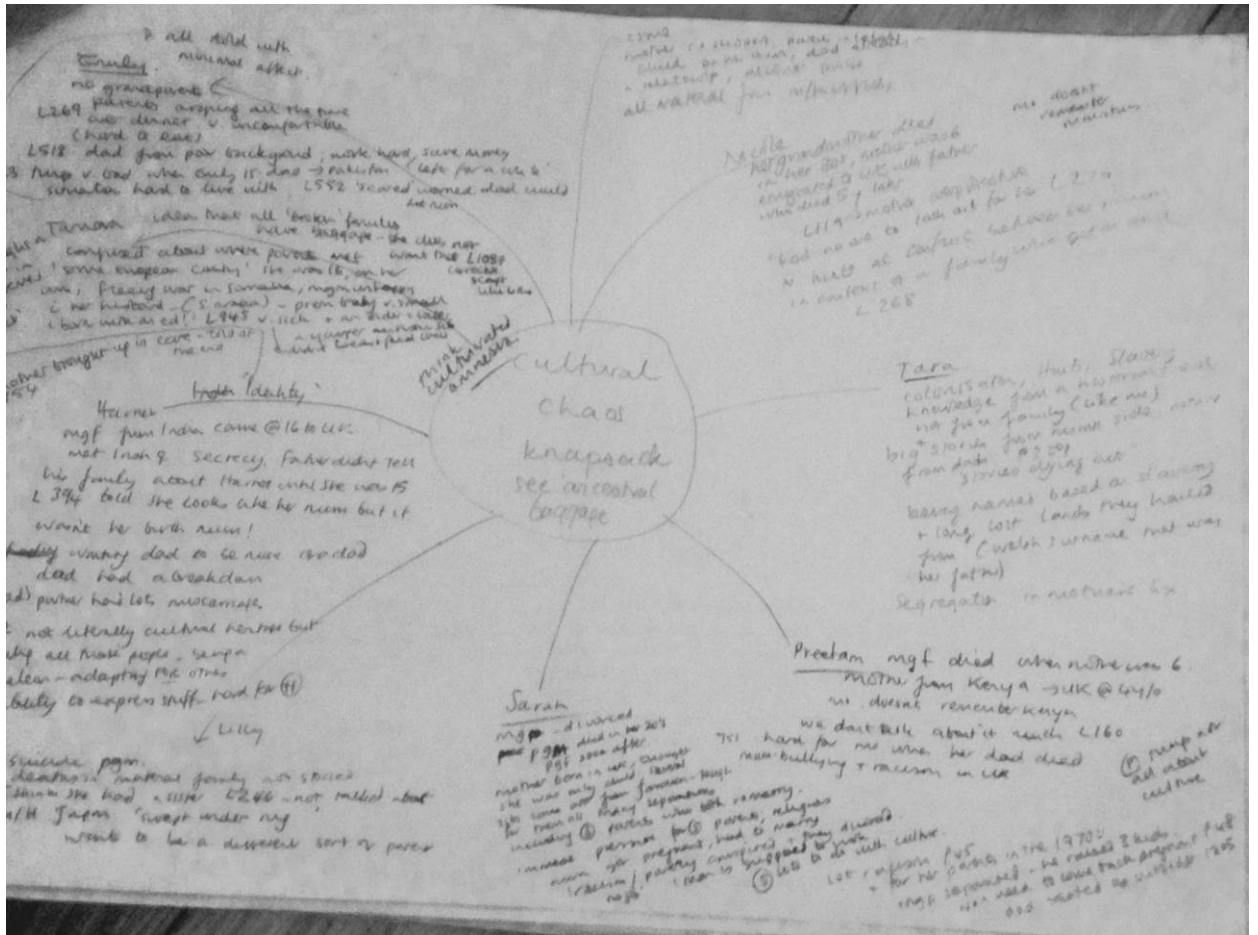
Appendix I: Lilly Short Play

Ethnographic Creative non-fiction story

This story is grounded in ethnographic data, thus the content is grounded in real events and experiences told to me in the form of a qualitative interview by Lilly.

Susan and Rita are fictitious characters, created to add dialogue and make transparent Lilly's thoughts and feelings about her eating disorder, her family, her culture, her recovering and her hopes for the future. Many of the sentences are verbatim from the transcript

Lilly 18 British/Japanese

Rita 17 British/Muslim

Susan Irish/ English 17 (Brought up by her Mother)

-What's up with you? Not eating these….

Susan begins to take the chips from Lilly's plate

Rita watches and smiles as she crams the food into her mouth.

-Bet you weren't allowed to do that in the hospital did you?

-Don't talk about that. Thank God I'm not there anymore!

Susan makes a blessing with her right hand and mumbles a recitation

Lilly looks at her friend and says,

-Yeah, Rita don't talk about hospital it makes me ill. People are so fucked up in there. I hated it. Thanks Dad!

Rita shakes her head

-You're dad's a pig too, is he?

-The biggest swine you ever came across!

-Why did he send you there?

-Because he's also the pushiest parent alive !

Susan is quiet as they abuse their fathers, finally she says

-Well at least you two have got a Dad!

-Take mine, now, says Lilly.

She stands up and walks to a water machine and fills a plastic cup

-Anyone else?

She looks across at them and both women nod,

-I used to drink so much water all the time, she says

-Why? Susan asks,

-To stop feeling hungry at first and then I don't know. I just seemed to crave it all the time.

Lilly sips her water,

-and you know I didn't even care about being thin,

Susan frowns

-You what! You didn't care about being thin?

-No it was more about my mum who is obsesses about food in her Japanese way. I think I reacted against it.

Rita gulps her water down in one and says,

-Inshallah* – I need to watch my water intake…

She places the empty cup on the table in front of her and says,

-I bet you did care about your weight!

-I didn't Rita, when I was my mum used to spend hours preparing food and pack me katsu curry for lunch but I wanted jam sandwiches on thick white bread. I didn't think about if it made me fat, I just wanted to have what the other kids had

-What's katsu curry?

Says Susan.

-It's Japanese style curry innit, Lilly?

-Yeah and my mum makes chicken katsu with rice so it really is healthy but…

-But what?

-Well, when I was in primary school can you imagine what the others were like?

-Tell us, says Susan

-Probably the same as when my dad made me take chapatti's in for harvest festival!

-Oh my God he didn't did he, Rita?

-He bloody did! Go on what was it like for you Lilly, with your catsup curry?

-Katsu not catsup… it was, well the other girls were like,

"Ooh my what's that smell? You pooed in your knickers an' look she's put it in her lunchbox!" – an' the boys were even worst!

It was so embarrassing. It was hard enough at school although no one actually said anything about me being mixed race, sometimes I just made myself the butt of a racist joke so nobody else could.

A Sikh man wearing a full beard and a Kasekee* with a Kara on his right wrist walks into the canteen.

-Is that your dad, Rita? Says Susan

-What? Oh no he's a Sikh, Dad's a Muslim.

Anyway, carry on , says Susan. Were you actually anorexic, I thought that was just like models and stuff?

Didn't you do PSHE, anyone can get it, retorted Rita, adding, we have to starve for Ramadan but why did you starve yourself?

Do you know what, I really wish I knew, I did start off with a bit of a diet, cos well I didn't even care about being thin which is quite funny because everyone assumes that is what its all about. I just went on a shitty diet cos I was a bit chubby and my dad said I needed to exercise. Really what I needed to do was eat less huge bowls of rice. Mum said Japanese girls are always bit chubby then they get slim, but I was fed up waiting but it is also quite funny really. My mum, who it totally obsessed with food in her Japanese way, food is like life, she says, she just spends hours planning and cooking to feed us and there was me at my worst, being afraid to eat her food!

So tell us what the mental hospital was like, Says Susan,

Rita pokes Susan in the ribs and says to Lilly, what this thicko means is what was psychiatric hospital like?

You two don't give up do you? Its really hard to talk about but also it did save my life ,thank god I'm not there any more. Just thinking about it makes me want to gag, it always smelled so disgusting and the people in there were so ill, like born that way, my god they were so fucked up, like real personality issues and schizophrenia and like putting scissors in their arms and peeing on the floor, it was very animalistic. I felt so different from the others, like they were born that way, I had a choice, all I had to do was eat

Susan looks puzzled and asks, is it that simple then, you have choice whether or not you eat and the others in the hospital don't?

That is so harsh, if it were just that simple, you wouldn't have ben in hospital for like a year or whatever, surely its more complicated? Questions Rita

And also you say you are only angry with your dad, but it was your mum giving you all the food so that doesn't make sense

yeh I know. It is really complicated. I couldn't be angry with my mum she is just so, so, I don't know, so cute, so sweet, so funny, I just love her to bits, it is hard to be angry with her. But my dad is so pushy, I told you before he bought me a table tennis table for my 9th birthday because its his favourite game. He kills me, I can't stand him.

Why's he's like that?

I dunno, my mum says he had a really good childhood, his mum was such a great mum and my aunties are really nice, I don't know what happened to my dad. Maybe he was really affected by his mum's suicide when I was like two

oh that is horrible! Does he ever talk about it?

Not really

what about your mum, what were her family like? Susan asks, changing the subject

that is such a weird question because I have absolutely no idea. I didn't even know she had a dead sister. I have absolutely no idea about her life. She is so clever and funny, she must have had a good childhood I think, but she never says anything

oh yeh, says Rita, I saw something on tele about Japan and eating disorders and I was really surprised that they have quite a lot of girls with anorexia there. You wouldn't think so would you? I thought it was just here, you know in England and America with all the stuff about models and being thin and all that

yeh I know, me and my mum googled it and it is slyly really common there but they sweep it all under the rug and it doesn't get talked about, a bit like my mum. But they actually die there, lots of young girls die. Here the treatment is horrendous especially the inpatients but I don't think I would be alive if I was in Japan or if I had not had the outreach team. They did actually save my life

it's a bit like my dad, he never really talks about Saudi Arabia, just that we have to be good Muslims. Its like a sin not to eat food that you are given because we are taught that there are many children that don't eat and that's why we fast too, to remind ourselves of our fortune and to think of others less fortunate that us

so what would happen if you had anorexia then?

I don't know, he would probably read the Quran to me. My mum would say we shouldn't have let you go to that school you should have gone to a Muslim school.

how does your mum cope like not having a family? asks Susan

I don't know, she just gets on with it.

Sounding tearful, Lilly says, I hate that everyone around me is dead. My mum's parents, her sister, my dad's mum. I felt dead when I was ill and in some ways I think my dad is dead, to me at least

but surely now they must be really pleased you have done so well and will go to uni and stuff,

yeh they are but did I have to get so ill first, with all that pressure to be the best. If I got 98% dad would ask about the other

2%.

he sounds like my dad, grimaces Rita.

They just heap pressure on you. But I can understand why my dad does that. He just wants me to have a good life

Yeh I know, my dad says that too, but isn't up to me what sort of life I have? When I have kids, I will let them do what they want, well to an extent, I would want them to be good people, make their mistakes, I would help them on their path, let them pick what they want to do, let them find their spirit

you sound so passionate about doing it differently, I bet you will be a great mum announces Susan

aw fanks! At least we have got away from talking about my family!

yeh but you have been really open. I don't think I've seen you close to tears before, you usually act quite tough about it all. Maybe that's a sign of recovery

maybe. Though you sound like a bloody therapist now. I think if you do start to think about it all you do get upset and I don't like to do that, like I stopped treatment towards the end as I couldn't keep going, I prefer not to talk. I think at first I was recovering for everyone else then I just thought, 'let go', so it started as a diet cos I wanted some control, but I didn't want to be a freak, like when we first met if you offered me something, I didn't want to go 'nnn' I had to go 'yeh sure' even if I freaked out in my head, now I eat what I want , yes Susan I am watching you, go and get your own chips!

In the end its not enough jus to gain the weight and still be like completely fucked in the head, so I just started to ask myself why am I even bothering with this, I didn't even look properly anorexic by then, I am not saying I am completely over it but pretty much. When I go to uni and I am free, I just need to make sure I don't slip back

You're such a hardcore party animal, those skinny days are over!

we will come down and see you. If you are in Bristol and I am in Bath and Susan, are you going to Exeter, they are all really near

god we can tell you are going to study Geography! muses Lilly

I feel like I really understand a bit more about what you went through and it makes me think about that lecture we went to about gender and mental health and the pressures on women to fit ideals in work and appearance, like we need to be superhuman and yet we don't really talk about women like us . We aren't all white British middle class are we?

Yeh, you and Rita have had had to deal with stuff as kids at school as well

yeh, in CAMHS they say its nothing to do with your family but to me , it was everything to do with my family. I got sick because I couldn't bear being controlled. I didn't have a mind of my own

you certainly do now!

They all laughed

Have you been forgiven for the tattoos yet?!

Just about, mum said they wouldn't be welcome in Japan and I said, well I 'm not in bloody Japan and she should be pleased because they are Japanese art. Funnily enough dad didn't really mind them, I think he quite liked them actually

They chatter on, deep in conversation about whether eating disorders are caused by the media, or the family or the brain or all three or even something else nobody has even thought of

It is possible for this conversation to go on for many more minutes, hours even days.

It is not possible to finalise, these questions are in the air, the experts don't know, I don't know, Susan . Lilly and Rita don't know.

*1 "In the name of the Father, and of the Son, and of the Holy Spirit"

*2 Inshallah - God willing; Deo volente; expressing the speaker's wish for a given future event to occur, especially in an Arabic-speaking country or Islamic context.

*3 Kasekee (small turban) also. A Kara is a bracelet worn on the right wrist.

Appendix J: Preetam Full Transcript

K there is a clock there, it will be up to two hours, no more

P ok

If you need to have a loo break or some fresh air, or a drink or a snack (pointing to apples on the table and water) if you are feeling any sort of discomfort, just let me know, these are my prompts, you will see me go a bit blank and think 'what am I meant to be asking

P laughs

K have you done research yourself?

P not for many years, part of my undergraduate, but not anything since, so

K and you are an assistant psychologist?

P assistant psychologist, yeh

K with a view to?

P yeh I 've applied this year for a doctorate, so I find out tomorrow if I've got a place

K oh gosh!

P yeh, I got an interview last year but none so far this year, it, its just like that

K I have heard you can try quite a few times

P yeh, and even if you get an interview, like I got one last year, doesn't mean you are guaranteed an interview this year, clearly

K and will you be in London?

P I had an interview in Leeds last year

K oh right

P but that made me realise that I don't want to move up to Leeds so this year just London and Midlands courses because that is where I am from

K oh right, cos you mentioned Birmingham, so either here or there

25   *P yeh*

26   *K ok, good, so it's roughly in two areas, the first area is family stuff*

27   *P ok*

28   *K around food and family and a bit of history, body image and those sorts of things and the second bit is, ehm,*
29   *kind of more future looking so some of the stuff you have just talked about will be covered as well, so I am*
30   *going to do a family tree so I have got a record of that so in terms of confidentiality I am not even going to put*
31   *your name on it, I will give you a pseudonym, is there a name you would like to be called?*

32   *S I have a pseudonym because I work for SLAM and I have been treated in SLAM, so I might as well use that,*
33   *which is my grandmother's name which is Preetam*

34   *K ok, so that is you, how old is you?*

35   *P 25*

36   *K Ok so tell me a bit about your family and where you grew up and*

37   *P I grew up just outside Birmingham, the eldest of three*

38   *K of three, uh huh*

39   *P my sister is 23 and I have got a brother who is 11*

40   *K ok and they are all the same parents?*

41   *P yeh same parents, they are still together, so my mum I s51and she is a teaching assistant*

42   *K right*

43   *P in a primary school and my dad is 55 and works in finance*

44   *K uhhmmm and do they still live in the Birmingham area?*

45   *P yeh*

46   *K were you born there?*

47   *P I was born in the Black Country actually in Dudley, when I was 6 months old we moved to Solihull, just*
48   *outside of Birmingham*

49   *K and where do your parents originate from?*

50   *P so my mum was born in Kenya and when she was 4, she came to Birmingham, so she grew up in*

51 *Birmingham, she doesn't remember anything about Kenya and my dad grew up in India, in the Punjab and he*
52 *came to England when he was 20*

53 *K oh right*

54 *P then a few years later they got married*

55 *K s your mum was from Kenya but is she of Indian descent?*

56 *P yeh originally, her family are originally from India*

57 *K would it be the Punjab or where was she?*

58 *P yeh I think it was the Punjab as well*

59 *K and in terms of religion?*

60 *P all Sikh's*

61 *K all Sikh, yeh is that something that is practiced in your family?*

62 *P ehm, yes and no, like we don't go to, like the temple very week but I don't know, I think I am more in terms of*
63 *my culture as opposed to religion because there are a lot of things that I kind of value but that's not set down in*
64 *my religion, it is more cultural, like, like being quite family orientated, those sort of things, ehm, I guess they*
65 *kind of go hand in hand, ehm, so yeh a bit of both*

66 *K I guess some of the Sikh values might be the same as the cultural values, where might they differentiate, is*
67 *there any sort of differences?*

68 *P I don't know, I guess there's not really because, in terms of a lot of religions it is quite open, it doesn't dictate*
69 *a lot, it doesn't like say you can only eat halal meat or you cannot drink alcohol o anything, its quite vague so*
70 *yeh, I guess, whatever way you want to interpret that but yeh, I am proud to say that I am `Sikh and Indian*
71 *heritage., ehm, but first and foremost I am British*

72 *K yeh, first and foremost, is that how you see yourself*

73 *P yeh*

74 *K how do you do you describe yourself on monitoring forms?*

75 *P British Indian*

76 *K that fits, its that way round*

77 *P I think definitely, I cant ignore the Indian bit, I don't want to lose it, I cant speak my mother tongue but I am*

78   aware of it and I can understand it, ehm, yeh that is something I do not want to lose, that I am quite proud of

79   ehm, and yeh, I guess how my parents came here and the hard work that they put in when they first came to

80   England, or you know, like my grandparents did, I   think you know , by just saying I am British or English , kind

81   of loses sight of that

82   K denies a part of you almost

83   P yeh

84   K how interesting, mmm, what would be the first language?

85   P Punjabi

86   K ok, so do you want to say a bit more about living in your family and growing up

87   P we had lots of family nearby, my mum is one of six and my dad is one of five

88   K so they are all in the UK

89   P on y mum's side, my mum I she youngest and they all live locally except one that lives in Yorkshire

90   K ok

91   P the second youngest auntie, we share the same birthday, she would, because she lived around the corner,

92   because my parents were working full time, I went to the same school as her children and she'd pick up me

93   and my sister after school and she would take us to school in the morning, so she looked after us quite a lot

94   K do you still have contact with her?

95   P they have moved to Cheltenham now, so no too far, but we don't see them as often but definitely she would

96   feed us and we would all go out together, and people would be, oh you poor person, you've got five daughters,

97   so yeh quite close to her growing up

98   K and are you close to your cousins now?

99   P a lot of my cousins, all my mum's siblings have all got two or three kids who are all a fair bit older, I think the

100   oldest was 17 when my mum was born, the second youngest was 7 or 8 so and there was a big age gap, so

101   like although I am the oldest, I don't feel like I am because I have got older brothers and sisters in terms of my

102   cousins which has been quite nice and even now, the ones that live in London, I see quite a lot, like they look

103   out for me if I needed them to

104   K really. I like the idea of them being older brothers and sisters is that something specific to your family, kind of

105   way looking at things or is that more of a general cultural

106   P I think probably both because I guess that not everyone is as close to their family, often people just stop

107 talking to their family or you don't see them a s much, but definitely like I am a lot close to my mum's side but

108 culturally you do call your cousins brother or sister, for Punjabi's you don't call them cousins, I guess, more out

109 of respect, like I would say I have got a nephew and a niece even though they are my cousins children, they

110 are not technically my nephew and niece but, ehm

111 K does it symbolise some sort of closeness?

112 P yeh definitely

113 K rather than the correct names for them, yeh, right, really interesting, are your mum's parents around? No my

114 mum's dad died when she was 6, he had throat cancer

115 K gosh, 35-40 years ago

116 P yeh, it was difficult in those times, they had just come to Birmingham from Kenya and my grandma was a

117 single mother of six, ehm, and then she died when I was 4, my mum's mum I didn't see a lot of her

118 K do you know how she died?

119 P heart attack

120 K neither of them would have been particularly old

121 P I don't know how old they were in those days, so I imagine she got married quite young and she died when

122 she was about 30, I don't know

123 K do you know what life was like for them in Kenya?

124 P they had a shop in Kenya that my granddad ran with his brother, mm, I don't know, my mum does not

125 remember a lot of it, my aunts tell good stories and stuff, like things they did, they were a lot older, they didn't

126 come over until they were 15, 16

127 K mmhm

128 P like they say they cant go back and visit, because it is such a war zone, its sad, they wanted to show their

129 kids where they grew up

130 K mmm

131 P cos they have still got like a link to Kenya, but my mum hasn't, she doesn't remember any of it

132 K no, no, I'm not sure, were the Kenyans, I know the Ugandan Asians were asked to leave, were the Kenyan

133 Asians?

134 P yeh

135   *K and not allowed much time given to plan it, it was quite quick*

136   *P I think they sent some of my older aunts over first, ehm, because they were older and they already had an*
137   *uncle who was living here and they stayed with them and the others came over later*

138   *K is there much of a story, of almost forced migration, do you know*

139   *P we don't really talk about it very much, that would probably be my older, like the eldest aunt, she is not very*
140   *well so I missed out on a lot of those stories, my cousins probably, my mum, she was shielded from a lot of it*
141   *because she was so small*

142   *K so its not something your mum ahs learned about from her sisters?*

143   *P no*

144   *K I guess the other, r thing that springs to mind is the food differences the Indian influence then going to Kenya*
145   *and having different vegetables, do you know much about what they ate*

146   *P yeh it was quite different, my aunt would pick up exotic fruit and say this is what we used to eat in Kenya and*
147   *stuff, uhm, (clears throat) but yeh, I don't know a massive difference, my mum doesn't remember so,*

148   *K and her style of cooking when she came to England, what was she drawn to?*

149   *P I don't really know, I have never asked her*

150   *K and now?*

151   *P heavily into Indian food, she doesn't cook that often but*

152   *K and your dad?*

153   *P he can cook but he is usually working late so he doesn't usually*

154   *K do you want to ay something about your dad's family*

155   *P yeh, he's got a younger brother who lives in India and then he's got another older brother who lives in*
156   *Birmingham and an older sister who lives in Birmingham as well and then another older sister who lived in*
157   *India until a few years ago and now lives in Canada*

158   *K and what about his parents?*

159   *P so his dad passed away shortly after my parents got married, so a few years before I was born*

160   *K uhmmm*

161   *P and then my dad's mum died when I was 11*

162   *K o you know how they died?*

163   *P I don't know how my granddad, oh no I think my granddad died of a heart attack as well and so did my*
164   *grandma, I think*

165   *K gosh*

166   *P probably other health issues as well*

167   *K yeh, its kind of a common narrative, I am of I am descent as well and you do hear stories of heart attacks, so*
168   *he (dad) came to this country when did you say?*

169   *P when he was 20, he finished studying in India and then came*

170   *K right Do you know how him and your mum met?*

171   *P ehm, so my uncle already lived here and so ehm, and he was really good friends with one of my mum's*
172   *brother in laws and so they got introduced that way*

173   *K so she was in her 20's*

174   *P yeh she got married when she was 21*

175   *K so what do you remember of, what was your favourite food when you were growing up?*

176   *17.03 mins [7] I don't know, ehm, I remember quite liking paneer, like the Indian cheese, ice cream, uhm [3] I*
177   *don't remember what else (laughs)*

178   *K nothing springs to mind? Did you have western food? Or Indian food?*

179   *P both, a bit of both, no I can't really remember much about food*

180   *K I was thinking what you were saying about the importance of family and*

181   *P mmm*

182   *K and culturally, I was imagining, my mind was imagining part of that would be meeting other relatives and*
183   *having group gatherings and often that is around food*

184   *P yeh*

185   *K so I am wondering what those events were like, weddings or other celebrations around food what you would*
186   *have been drawn to or interested in*

187   *P I don't know, yeh there would have been a lot of food but it would probably have been mostly Indian food, I*

188   *don't know, I don't think I really thought about it that much and when I did start thinking about it that's when I*

189   *started avoiding things so*

190   *K what age was it when you became conscious that you were starting to avoid food?*

191   *P 11 or 12*

192   *K uhuh, so before that food was just fuel*

193   *P yeh I didn't think about it, I didn't dislike it, I just didn't really think about it. I must have thought about it a bit,*

194   *because I went to school at 5 and said I was a vegetarian, I was eating meat up until then, and my parents*

195   *were like 'oh well she says she is a vegetarian ' so yeh, that's all I remember (this all sounds a bit painful)*

196   *K so you became vegetarian*

197   *P yeh , my mum is vegetarian, she became vegetarian when she was in her teens, but the rest of the family*

198   *eat meat*

199   *K so from the age of 5 you were a vegetarian*

200   *P yeh*

201   *K that's quite unusual isn't it*

202   *P I love animals*

203   *K was your mum's vegetarianism religious?*

204   *P no she just doesn't like the taste of meat*

205   *K so what was happening at around 11 that has brought that to your consciousness about food?*

206   *P I don't know, I had always been known as the tall lanky skinny one, my sister was shorter and chubbier,*

207   *chubby cheeks I had just started secondary school (pause) I had no idea what triggered it off but there were*

208   *loads of things going on*

209   *K what kind of things, family things, school things*

210   *P both, my mum had a miscarriage at the end of year 6, just as I was starting secondary school and then she*

211   *was pregnant again in year 9 with my brother, like a few years later, we were doing loads of work on the house*

212   *that took like ages to do so it was just noise and mess constantly, nowhere private to have, ehm, [4] and I just*

213   *started to feel really low and as a result of that I lost my appetite, I lost a lot of weight, yeh, it was just, yeh, I*

214   *was feeling quite stressed and lots of things going on that I didn't quite understand or couldn't get my head*

215   *around*

216   *K mmm*

217   *P I didn't want to bother people with it, like my mum was upset because she had had a miscarriage or like you*
218   *know she was trying to sort out work in the house or whatever, my dad was really busy, ehm, and if I couldn't*
219   *understand it how could I explain it to other people, I just didn't try, ehm, I didn't try to vocalise it, verbalise it, I*
220   *just expressed it*

221   *K are you able to say the kind of things that were going on in your mind or in life that were troubling you that*
222   *you couldn't find the space or didn't know how to*

223   *P I don't know, I think I was finding it hard to have friendship groups, usual things*

224   *K mmm*

225   *P ehm, I don't think it was like one specific thing it was like, once that sort of thing starts snowballing, if you are*
226   *not eating then you are going to feel more low, uhm, and if you are not sleeping then you are not going to feel*
227   *great either, it was tied in together so much so it was difficult to kind of think, it was like chicken and the egg*
228   *that hey kind of both, like my mood, my not eating and everything else that was kind of going on all kind of kept*
229   *each other going, ehm, yeh, I think it all just lead to me feeling really low that I didn't have a word for it, I don't*
230   *know it was like a depression or anything , a twelve year old does not get depressed, at least that is what you*
231   *are told, about at school , like if people had noticed it was like 'its just your hormones, you'll grow out of it' so I*
232   *think a lot of it was quite minimised , I think understandably from their point of view , what they would kind of*
233   *expect*

234   *K what kind of people, teachers?*

235   *P yeh teachers and my mum, like she noticed but it was just like, yeh, hormones, it will pass, but obviously it*
236   *didn't, it went way past that, by which point it had been going on for a long time and I 'd ben low for such a long*
237   *time, it makes you like feel more hopeless, its all so interlinked*

238   *K and when did you first get help?*

239   *P when I was 13, 14*

240   *K mmm*

241   *P I saw the school nurse for a bit but because I was under like 16, 18 there wasn't really a lot I could share with*
242   *her because she would have to break confidentiality and I did not want that so, like she must have known, I*
243   *think because I was self harming all the time, I was, I didn't, I couldn't stay like a full day at school, I would*
244   *always pretend to be sick and go home early and school jus t kind o f let me ehm, I wasn't doing homework or*
245   *anything but nobody kind of pulled me up on it, they let me plod along , up until that point I had been such a*
246   *studious student they were like , 'its fine, she can coast along for a bit ' so nobody really noticed, ehm, and*
247   *then I saw the school counsellor for a bit in year 10,ehm, and then got referred to CAMHS , ehm, but like my*
248   *mum dug in her heels a bit about that, she did not want me to be referred there*

249   K what do you think her reason was?

250   P she was worried of that kind of impact that that would have on kind of like, me, like kind of having that on my
251   records, ehm, and I think she also thought it was kind of unnecessary because the Preetam she saw in the
252   evenings was different to kind of actually how I was feeling and uhm, different to what the school were seeing
253   and different from what my friends were seeing

254   K gosh, lots of different selves

255   P yeh I know, my mum did like say it was a bit like Pandora's box with all these different things coming out and
256   one person saying like 'you are my daughter, I think I would know if you are feeling sad,' ehm, but yeh, she
257   didn't. ehm, so yeh by the time I did like get help with CAMHS I think I was fifteen anyway and they were like
258   rubbish or I wasn't, it wasn't like a good fit and my parents weren't really on board with any of it so they were
259   like, cancelling and rearranging appointments for months later, like not being like collaborative with the whole
260   thing so yeh like I got discharged and re referred like three times before I turned seventeen , so yeh

261   K so what do you make of that as you look back on that process what do you think they should have done
262   differently either CAMHS or your family or?

263   P I think it is difficult because I can see it from my parent, well my mum's perspective and she went through
264   something similar when she was my age but in those days you wouldn't have talked about it s o she wouldn't
265   have got, like, help, like that kind of thing and stuff, I think she just, she could only advise from what she
266   experienced and what she was aware of, I don't blame her for anything and I think even if I had a really
267   amazing team in CAMHS if I wasn't really ready to talk and to be completely honest about things it wouldn't
268   have been helpful anyway

269   K uhm, uhmm

270   P but they also made some good decisions, when I was 16 I had taken lots and lots of overdoses between like
271   14 and 16 but I took one, quite big one ehm, and my parents found out, ehm, and like when I went to A&E and
272   stuff, ehm, and then I saw CAMHS they were like we are deciding whether or not to send you to like an
273   adolescent unit but no, we think that being at school and being around your family is more important and that is
274   going to help keep you kind of like on track and also if you want to take an overdose you are going to do it
275   wherever you are and I was like 'yeh' but I later worked as a support worker in an adolescent unit , ehm, and I
276   think that was the best decision they could have made to have not admitted me to a unit , you just lose like a
277   year of your life

278   K mmm

279   P and your friendship groups and everything so at least this way, I had like a focus I was having to kind of
280   function

281   Kmmm

282   P ehm, so no, so , and what's happened has made me 'me' I wouldn't have had the experiences or the skills

283   *and whatnot if I didn't have those , that time, so yeh*

284   *K and the idea of being taken away from your family, would that have been a really difficult thing? If it had been*
285   *insisted upon?*

286   *P I think my parents would have found it really difficult, I would probably found it a bit of a relief, I wouldn't have*
287   *to hide and pretend things ere ok, ehm, but I would probably feel so guilty that I wouldn't be at home to like*
288   *help with like my little brother or like to do, anything, ehm, yeh and actually it was easier to just minimise it, like*
289   *'no, no things are fine' like things aren't actually that bad, it wasn't meant to happen ehm, yeh, like yeh, I'm fine*
290   *being at home and I can do other things , like I need to be doing or I wouldn't t want to be doing , its easier*

291   *K mmmm, I guess I'm wondering whether that kind of thinking about kind of placating the family rather than*
292   *making*

293   *P oh definitely*

294   *K rather than what you perhaps, I mean I can really hear what you a re saying about not wanting to be in an*
295   *adolescent unit, having worked in one, but you know, whether it could have been potentially helpful as well?*

296   *P yeh I think it could have been helpful but I also probably think I wasn't ready to accept the help that they*
297   *probably would of tried to help me to get, it would certainly have been a waste of money so yeh I don't, yeh*

298   *K and how was your dad through all this, you have talked about your mum about how a mum should know how*
299   *her daughter was feeling, what was your dad's take on things?*

300   *P we didn't really talk about it, except like when I came back from hospital after I 'd taken an overdose, he was*
301   *like 'your mum has been worried sick about you, how could you have done something like this to your mum?' it*
302   *was a bit, like clearly I had done all o f this to upset my mum, ehm, and he just kind of threw money at it, go*
303   *shopping, whatever you ask for, that was more his way of dealing with it, ehm, when I was, when I was 17 or*
304   *18 when I was doing my A levels, the ehm, I didn't like the adult services I was with so I saw a private*
305   *psychologist for a bit and my dad came to the first session and he was just like , she's like clever and beautiful*
306   *, like she is amazing, like I don't understand how she can say she doesn't like herself, I just don't know how*
307   *she can say that, she like works for free, she volunteers, like her sister, she wouldn't get out of bed if you didn't*
308   *pay her, like she wants to help other people, like she is so caring, like blah, that upset me more that he couldn't*
309   *see what I was really like and ehm, all he could see was like this perfect daughter which I guess puts more*
310   *pressure on you, so definitely I am like the apple of his eye, ehm but it was interesting to see what he , what*
311   *he perceived, ehm and how that was so very different from what I saw and believed as well*

312   *K and how you felt*

313   *P ummm*

314   *K I hear that narrative a bit from young women who say almost, it is not alright for me to be upset or angry or*
315   *unwell because, you know I've got a nice house and I have got nice parents and*

316   *P mmm*

317   *K you know as if you need to have the reverse, you know a traumatic time a traumatic experience in order to*
318   *validate*

319   *P yeh*

320   *K your experience*

321   *P mmm*

322   *K from your dad's point of view, he couldn't see what you had to worry about*

323   *Yeh, yeh from what he saw was somebody that, yeh, not necessarily that I hadn't had some bad experiences*
324   *and I had everything materialistically but he was just like 'you are a nice person, how can you not see that' ehm*
325   *yeh*

326   *K and how do your parents do comfort and care towards you and your sisters, sister and brother is that*
327   *something, either culturally or specific to your family that you would like to be different?*

328   *P I don't know they were both hot and cold growing up, like my dad had a quick temper, like he doesn't now, so*
329   *that was always a bit you know 'what kind of mood would he be in when you came home?" but on the other*
330   *hand knowing that he cared about you very much and him and my sister were quite similar in like personality*
331   *and temperament whereas I'm similar to my mum, so like my relationship to my dad is very different to my*
332   *relationship my sister has with, like she'll, like all the way through growing up she would like answer him back ,*
333   *she'd be a bit rude and stubborn but she is so similar they argued quite a lot , ehm, where as I wasn't ever like*
334   *that ehm, but yeh, I think that was difficult, yeh, cos I was like his first born, I was like his baby and he couldn't*
335   *understand what was going on and yeh, ehm, so yeh, the way I think my dad coped showed his love and care*
336   *was to give you money , yeh*

337   *K what about your mum?*

338   *P like she was really inconsistent, with little things like, like she would have been told by whoever, that I had*
339   *lost weight and ehm I would be like yeh I am struggling, she's, and so we'd go for lunch and I would sit there*
340   *like, and not eat any of my food and she wouldn't say anything or like we would be at home and I would scrape*
341   *all my food into the bin and she would be like 'humm, oh, ok' I don't know if I was doing it to get a reaction from*
342   *her as in there was nothing from her or like when I'd been taking , I was on medication, ehm, and at the time*
343   *she was really anti it but this was when I had come out of hospital so it was a condition I was allowed to be at*
344   *home that I would be taking some kind of medication ehm, and I was like mum I want you to look after it and*
345   *make sure I take it every day , ehm, in case, like you know if I do something stupid or I'd stop taking it but then*
346   *she would be really resistant to giving it to me every day and I was like, actually , why am I having to prompt*
347   *you ten times I don't like taking it , you are making it more difficult for me to take it so I'm kind of like, I didn't*
348   *need her to look after it per se but it was like my way of kind of getting her involved in some of my treatment*
349   *ehm, and so, it*

350   *K mmm*

351   *P yeh and then some times she'd be fine about it, she'd be really good, ehm, and I'd think she really*
352   *understood and if I was finding it really difficult she would go with me at 10 o'clock at night to go to Sainsbury's*
353   *to find like cereal bars that I'd be happy to eat so stuff like that and then at times she would be completely*
354   *furious*

355   *K gosh*

356   *P so yeh, quite inconsistent*

357   *K yeh, so what about other members of the family, aunts, uncles, were they aware of anything?*

358   *P no*

359   *K not at all?*

360   *P my mum spoke about it a bit with one of her sisters who she is quite close to , ehm, but not in a lot of detail ,*
361   *ehm, yeh that was it, I spoke to one of my cousins about it, who is the same age as me, ehm, yeh that was it ,*
362   *my sister had an idea about what was going on because she overheard things but nobody properly told her*
363   *until she was like, 16, 17*

364   *K mmhm*

365   *P even though she knew uhm, you know, my brother came to family therapy at Maudsley last summer and like*
366   *although he knew, he'd been to visit me in hospital, in two years ago, two years ago I was in psychiatric*
367   *hospital , he came to visit me there and like he's not thick he knew what kind of hospital it was but like nobody*
368   *properly spoke to him and then we had a chat after one of the family therapy sessions and he was like 'yeh I*
369   *knew that was going on' and I said 'yeh I know you did, I don't think you are stupid' its just that no one talks*
370   *about any of it properly*

371   *K and is that, in your experience, a feature of families where there is eating disorders in general, or would you*
372   *say its in relation to a different cultural approach, or a bit of both?*

373   *P its probably a bit of both, like, you know, I have got friends who are like when thy were first diagnosed their*
374   *parents would like, read up on all the information they could, you know, and follow all the instructions to a ' t'*
375   *that they were given and then there were families like my parents who turned a blind eye for a long as possible*
376   *hoping it would go away, so yeh, I don't, yeh a bit of both , for my parents, pretending nothing was happening ,*
377   *ehm, and I think also, because I was getting such conflicting messages its not all their fault some of the blame*
378   *was on me because they would hear one thing from like a doctor and I'd be like 'no no everything's fine' so it*
379   *would be exaggerated so my parents were, I guess, well who do we believe ? Well we would rather believe our*
380   *daughter because she also seems a lot better we don't want to think are like 'we have to lock up our knives' I*
381   *think, so I can understand why they did some of that as well*

382   *K and whom would they be able to connect with for any support or guidance, through the temple or other*

383 *relatives, would there be anyone they would turn to?*

384 *P no*

385 *K so they would have to figure out for themselves*

386 *P yehhh*

387 *K would they talk to each other about it do you think?*

388 *P yeh they must do, anyway I know that they do , thinking about it, they would be up all night talking and like*
389 *my mum did get some support from her sister , who she'd spoken to but yeh, not as much as they needed*

390 *K I mean, in terms of thinking culturally, how might mental health conditions be thought about*

391 *P it seems it is just one of the things that isn't spoken about, uhm, yeh, I'd remember having CAMHS*
392 *assessments and they would ask like a family history and they would be like 'no, nobody has problems,*
393 *everyone is fine ' when actually, like, I know a few of my aunts and several of my cousins have had , you know,*
394 *depression and anxiety and stuff, and my mum was depressed when she was a teenager , uhm, and also like*
395 *she must have had eating issues , she was just like, really really slim and anaemic at one point and needed a*
396 *blood transfusion and you don't just get that anaemic through like you know, eating properly, so yeh, it is*
397 *definitely there but she would never acknowledge it so I think it is , yeh don't talk about it*

398 *K is there a connection between your mum's attitude towards food and you saying you don't kind of think about*
399 *what food was like, you know, it doesn't sound like it was a central, ingredient, you know, a central theme in*
400 *life, it was something you just did*

401 *P yeh I think for me, it wasn't but for everybody else it must have been I guess for like most people all your get*
402 *togethers and stuff are based around food*

403 *K mmm*

404 *P I think in my head, it wasn't something like, oh great I get to play with my cousins or whatever, or like se my*
405 *aunts that was the focus, oh what am I going to eat*

406 *K and how now do you feel about food?*

407 *P a lot better, there might be times when I can think about how am I going to manage food and on occasions it*
408 *would get in the way whereas now, I think last t week we had a surprise 60th for my uncle and you know, there*
409 *was lots of food and stuff and it was something like, it doesn't bother me as much I was able to eat how much I*
410 *needed to eat, not keep thinking about it, especially as it was like a buffet, o I was like I am not going to use*
411 *this opportunity to like binge or just not eat, I am going to eat what I need to and then I was able to just put it to*
412 *one side and like focus on catching up with my cousins and stuff, it was a million times different to what it had*
413 *been like a year ago , so that's nice*

414 *K was there any expectation you know, around females and body image and what you were supposed to look*
415 *like*

416 *P no I don't think so, we were essentially just two sisters for a long time because my brother came so much*
417 *later and we were both very different about how we dressed and how we looked and yeh, it was all fine*

418 *K were you ever compared, as you were different shapes and sizes? Favourably or unfavourably*

419 *P yeh, no I don't think, they were like oh she is tall and slim she could be a model or look how cute she is with*
420 *her chubby cheeks so they would talk about it but in terms of that's positive about my sister and that's positive*
421 *about me so yeh, it wasn't in a negative way*

422 *K no and what about exercise or values about being slim/healthy, was that part of the narrative?*

423 *P no but I think I did a lot of walking I was quite active, I wasn't into sports as such, my dad was into sport, he*
424 *would have liked us to be, but we weren't that interested in it but it wasn't something that was pushed so yeh,*
425 *no, ehm and I like, my parents   talk abut wanting to do, like wanting to be more fit and healthy but don't ever*
426 *get around doing it*

427 *K and what about things like education and you know, what was expected of you being the eldest or*

428 *P I don't think things were explicitly said, you know like you have to get educated but there was definitely a*
429 *pressure, quite implicitly because I had so many cousins who were all older than me who were all really*
430 *successful, in my eyes you know, so like, I didn't have the option to not go to university, it didn't cross my mind*
431 *because all my cousins went and had got degrees and were working in big companies and when we'd all get*
432 *together we'd be talking about the news, and clever stuff and all I could talk about was what I saw on TV so*
433 *that was what I aspired to cos they were my role models essentially , so yeh, it was never like you have got to*
434 *go to university or you have got to study this or you have got to get good grades but I guess I was bright and I*
435 *could get decent grades and I kind of expected that I would go to university because I didn't know anybody that*
436 *didn't but obviously in that gap between my cousins going to university and me going to university it was a 100*
437 *times more competitive and you had to get 3 A's and stuff whereas they could have gone t uni and did go on*
438 *lower grades and that kind of thinking hadn't followed through to me so it they had all done it and had walked*
439 *into a graduate job really easily then it must be easy uhm, but, they would have had to work really hard I didn't*
440 *speak to them in the working hard bit I just saw their success, I put more pressure on myself because I wasn't*
441 *aware realistically that ehm, yeh, that this, quite fortunately that my family were not that fussed, , , and they*
442 *were like we want you to be happy my sister did law, they would have been happy if she practiced law but she*
443 *decided she wanted to be a maths teacher and they are just as proud of her, so yeh it was quite nice to know*

444 *K and you want to be a clinical psychologist*

445 *P yeh*

446 *K and what do they think of that?*

447 *P I think yeh, I think they are like, happy with it, as long as I am happy, ehm, yeh, I think my sister is probably*

448   *more stressed about it, like 'well how many years are you gonna apply for it, you need a plan b or whatever' so*
449   *yeh, that's my sister, my parents are probably fine with it all at least*

450   *K did racism feature in growing up?*

451   *P it was quite fortunate, it was quite an affluent area, too posh to be racist it definitely wasn't a lot of non white*
452   *people in like my primary school or my secondary school really there was a lot more when I went to college*
453   *and university but it was also something I didn't ever think about , nobody had really drawn attention to it , it*
454   *didn't differentiate me from any of my peers, like the first time I remember I was working in Worcester when I*
455   *was like 20 and I was like out with a patient and someone shouted something racist towards me , that really*
456   *shook me because that was the first time that it had ever really happened. I think it was fortunate because we*
457   *lived on the edge of Birmingham which was so multicultural and where I lived, people just accepted it, they*
458   *took it in their stride, ehm, so yeh, it was really fortunate hm, yeh like, I don't even remember the odd*
459   *occasions, like you know, 'you Paki thrown at you or something'*

460   *K mmm*

461   *P that, it wasn't something that happened very regularly, yeh, and jus the way I was brought up I think , nobody*
462   *paid that much attention to it, there was that sense when someone has been racist towards me, where there*
463   *has been a prejudice because of it its taken me by surprise, like I remember, one of my mangers when I had a*
464   *part time weekend job in a shop, ehm, she'd been really rude to me for months and it was only s few months*
465   *later that I was told that it is because she is quite racist so I swapped my shifts so I didn't have to work with her*
466   *, but like, that hadn't even been an idea that crossed my mind , I was thinking am I rubbish at my job all these*
467   *other reasons that I had as to why she wouldn't like me but none of them was because of the colour of my skin*
468   *so I think I was quite fortunate*

469   *K so the school issues were nothing to do with race or culture as far as you was concerned?*

470   *P no I had a lot of friendship issues but that was with like, yeh Asian and white friends that I had, uhm,*
471   *mhhmmm*

472   *K did any of your friends notice your mood, your change of behaviour, your eating?*

473   *P yeh but they didn't really know what to do and I think because they, cos I wasn't , I wasn't at school a lot or I*
474   *was seeing the school nurse or I was seeing the school counsellor, they jus t assumed I was kind of getting*
475   *support and help that I probably needed , so they weren't too worried, I think they jus t kind of accepted that I*
476   *was going to not eat any lunch, they stopped inviting me to go to the canteen to buy food , ehm, yeh, so that's*
477   *just, yeh they just kind of adapted to it, ehm, yeh*

478   *K cos one of the things that I have come across in the literature is ehm in terms of black and minority ethnic*
479   *people getting a diagnosis around eating disorders can be a long time coming*

480   *P mmm*

481   *K other things get noticed first and particularly Asian women are stereotypically seen as slim anyway, slight*

482   *build anyway, did any of that feature?*

483   *P I think that is what took longer for me to, yeh, because the first time I was diagnosed with an eating disorder,*
484   *so I would have meted the criteria for anorexia but by the time I had reached services, ehm, when I was 15, I*
485   *think I was in CAMHS, the first time I had a proper psychiatric assessment, by that point I was bingeing and*
486   *purging like ten times a day*

487   *K gosh*

488   *P I'd gained lots of weight so the first diagnosis I got was bulimia, ehm and then, when that kind of shifted and I*
489   *was restricting again I was already known to services for having an eating disorder even though I didn't really*
490   *agree with it but I think if I had first come to services at like 14, 15 or to y GP they would have found it difficult*
491   *to diagnose me because I had always ben naturally slim as well and my mum would have gone I was skinny at*
492   *her age they would just have thought it was genetic ehm,*

493   *K what do you make of that now, as you reflect back?*

494   *P I don't know, its not really a period that I remember very well either, I don't have a lot of pictures of it, I've got*
495   *like the odd weight numbers in my head, but ehm, I also wasn't being weighed regularly but I had lost a*
496   *considerable amount of weight, I guess, yeh, people didn't pick up on it and I wasn't aware it was a problem I*
497   *needed to speak about , I knew my mood was low but I didn't think that there was an issue with food or my*
498   *weight or anything, I think that came later , ehm yeh , but I think it would have been difficult for people , I kind*
499   *of noticed that as such*

500   *K what do you think, have you got any ideas, you know that GPs might think about now, from your experience,*
501   *that they ought to attend to this or that or ask this sort of question?*

502   *P its difficult because you don't really get regular height and weight checks in the UK whereas in other*
503   *countries you do regardless of, like you know., cultural background, ehm, I think that is the only way you can*
504   *really tell if someone*

505   *K the sort of changes across the age range*

506   *P yeh like if they are not gaining weight in accordance with their height or whatever, I guess that is the only*
507   *way you can really tell , yeh I think as well, like the kids are off at school during the day, you don't know if they*
508   *are eating in those hours or not, because I was still always eating breakfast*

509   *K you were visibly seen to be eating*

510   *P I was eating breakfast and I was always eating dinner with the family but I ate nothing during the day and*
511   *then later I stopped eating breakfast but I was always eating dinner it might have been small er portions but I*
512   *was eating one meal a day so it was very difficult for anyone to know that I wasn't eating during the day, so*
513   *yeh, say if my mum had taken me to the GP I'd have said, yeh, I am eating during the day and because my*
514   *school hadn't picked up anything they weren't aware that I was or wasn't eating*

515 K its certainly in the diagnostic manuals, they talk about body image issues, body dysmorphia whatever, and
516 that's not necessarily, I dont know if its true in your case, necessarily a feature in all cultures

517 P no

518 K if someone had asked you about your shape and size, would you, how would you have answered?

519 P it was something I became aware of as I got older, the illness had gone on for a lot longer, I definitely know I
520 didn't restrict my eating because of how I felt about my shape and body

521 K mmm

522 P it as just that I had no appetite because I was really low in mood

523 K yeh

524 P I consequently lost a lot of weight, uhm, and then became more aware of how much I was eating and how
525 that made me feel, ehm and I didn't want to feel rubbish when I ate so I didn't eat properly, uhm, so yeh that s
526 something I came later, probably as a by product of being underweight and you know, being brain starved, so it
527 was difficult to kind of know,

528 K how id d you end up in hospital was that to do with eating disorder or suicidality or self-harm?

529 Recently?

530 K how any admissions have you had?

531 P ehm, I was in hospital twice when I was younger, just a short admission to general hospital because of
532 overdoses ehm, and then, I was doing quite, I was doing all right for a few years and then when I came to
533 London I did well for like a year or so and then my mood started dropping, ehm, and then my eating kind of
534 went out of the window as well and then, and then I was referred, up until that point I had just been in the
535 general mental health services then I was referred to the Maudsley eating disorder service, it was the first time
536 it was specifically targeted and focussed , they decided I did have a problem with my eating, it wasn't just
537 because of my mood or whatever else my mood just kept dropping and then I ended up having to go to
538 medical hospital for a week to get like physically stabilised

539 K gosh

540 P and then very very reluctantly agreed to be admitted so they could get like the right medication and stuff

541 K was this as an adult

542 P yeh as an adult an adult ward for a few months and then, so that was just purely to treat my mood really
543 which it did, it helped I got sleep and rest and everything and then I started the day care programme at
544 Maudsley which was for 9 months or something so that was good, so the in patient sorted my mood out and

545   *then I got to be a day patient to really work on my eating which is something I had never done before, ever so*

546   *that was good, really helpful and I went back to work and they just gave me like outpatient support*

547   *K and had you moved down here to study or to work?*

548   *P I came here after university to work, I got offered a job here*

549   *K so you moved on your own to London?*

550   *P yeh!*

551   *K that's quite a big step isn't it*

552   *P yeh, but I had stayed at home to go to University cos I had gone to Birmingham and I was in much better*

553   *headspace to move out*

554   *K yeh*

555   *P at 22 compared to being at 18, and my parents wouldn't let me move out at 18 for university, cos I'd been*

556   *unwell so yeh*

557   *K and you said your plan is to stay in London or Birmingham*

558   *P yeh it depends what happens*

559   *K so tomorrow is a big day for you!*

560   *P yeh, I feel mentally ready but I am in no rush at all, I'm enjoying my job and all those bits alongside it so I am*

561   *happy to wait another year or so, so yeh, no rush*

562   *K and what's ehm, going back to work contingent on, is that your health?*

563   *P no , its like a long story, uhm, I started a new job after I finished day care and I accessed my notes and I got*

564   *suspended for it because we use the same on line system, uhm, yeh (laughs) so yeh, it is a bit to do with my*

565   *health, uhm, yeh*

566   *K is it a possibility you wont be able to go back or?*

567   *P yeh, like they have not really been very communicative with me*

568   *K right*

569   *P uhm, yeh, I [4] I've no idea*

570   *K you've got a lot on*

571 P yeh cos I don't know if that means They will just stop me from working or if it is something that will be on my
572 record forever which would be difficult other jobs

573 K and your training

574 P yeh, my training cos it is all in the NHS, so yeh, I have no idea I might find out next week but yeh I don't
575 know, I am planning another career path, I have no idea

576 K and your training did they ask about your mental health, did you have to disclose stuff like that?

577 P you don't have to in the application form it is a bit like a UCAS form, you can put on it if you want to, I guess
578 it will come up more on the occupational health form but that will be fine, I have not really had that problems
579 before, because I am quite stable but something on your employment record like this would have more of an
580 impact I think

581 K have you got a good defence as to why you did it?

582 P I don't, who wouldn't want to do it, there was a lot of anxiety around at the time, there was lots of stuff going
583 on when I finished the day care, I put in a complaint against day care, so I was quite anxious, in terms of how
584 they were thinking about me, ehm, so I kind of, I don't know, I am not justifying what I did part of it was just to
585 get, to quell some of that anxiety but obviously that never works, why you might be doing mood and behaviours
586 and to help reduce it, ehm, so yeh, there was like reasons , yeh, I dunno

587 K gosh

588 There are so many paths and maybe you don't have so much control over the options

589 P yeh

590 K a difficult time

591 P yeh

592 K and wha tare you doing for BEAT?

593 P I don't rally have a role, I just, because I have been off work

594 (Pause while I look at schedule)

595 K anything else to say about your family or food before we move on? Has there been anything as we've talked
596 that has sparked off any new ideas?

597 P I guess it makes me think how little I was aware of food when I was younger, I have not really ever thought
598 about, I probably like, its always something I can't remember at all, I don't think It was because it was bad or
599 anything ,like that, its just because, I don't know probably made up for it by thinking about food so much in the

600 *years in between I think when I became unwell when I was 10 or 11 that is, this is what I know compared with*
601 *before like*

602 *K well it is interesting to hear that your mum was probably struggling with eating issues as well, I am jus*
603 *thinking of that migration at 4, its quite a big thing isn't it, it is potentially a big factor in people's stories*

604 *P yeh definitely I think she found it more difficult when her dad passed away*

605 *K mmhmm*

606 *P and I know she had a lot of bullying and racism when she was at school growing up , like this was*
607 *Birmingham in the 1960's and '70's*

608 *K mmhmm*

609 *P uhm, which definitely had an impact*

610 *K and in terms of self-confidence now how is she?*

611 *P a lot better, I guess she has learned to be, she is a lot more confident, she is quite loud, bubbly , put on a bit*
612 *of weight, and stuff, yeh , its very different its kind of like the story I hear about her when she was younger, the*
613 *pictures you use when she was a moody, skinny looking teenager , yeh*

614 *K does she like her work?*

615 *P yeh, she has worked at the same school since she was like, 22*

616 *K and how do your mum and dad get on*

617 *P fine, yeh they fluctuate like any couple but ehm, yeh they get on well*

618 *K and when you said at the beginning about family life being important what were you referring to?*

619 *P I think just having them around, I think, one thing we always had was we ate together around the table, ehm,*
620 *we all ate together at the same time we all ate the same food, I think that's very important because you just, I*
621 *don't know like, my mum would like to have the gossip from school, or you know, you just hear a bit about*
622 *whatever was going on, that's, that's like really important as well, ehm, and I don't know, just making time for*
623 *family stuff, ehm, yeh*

624 *K yeh, cos you said how busy your dad was, but he found that time to*

625 *P he was less busy when we were younger*

626 *K ahuh*

627 *P I think we did get to a time when we just had to eat without my dad as it would get so late, ehm, like its fine*

628 *now cos we are older, but I don't live at home anyway so obviously he was at home at the weekend but you*

629 *know, I think making time for that has been really good*

630 *K yeh and your sister are at home or has she moved away?*

631 *P yeh she is at home, as well the school is only a few minutes away*

632 *K and so what's food like now when you go back home fro weekends, how do they respond to you, your*

633 *parents?*

634 *P I get quite controlling around food when I am at home but like I also think they don't eat balanced and*

635 *healthy food and I am used to just cooking for one so I do what's easier for me, and I base it on the meal plan I*

636 *had in day care and stuff, its easier, they don't, what's helped, its just like I do what I need to do so like I have*

637 *my snacks and stuff, I don't get stressed if they are not eating at the same time or they are going to eat*

638 *something else later, I do what I need to do to kind of like keep eating regularly and stuff, ehm, and then I will*

639 *cook dinner, quite a bit if I am home , ehm, yeh, not too much out of control now cos I think its just quick and*

640 *easy*

641 *K what do you cook?*

642 *P like anything*

643 *K for your family?*

644 *P like pasta and stir-fry's*

645 *K and your mum and dad are ok with that?*

646 *P they are fine with whatever you give them, my sister doesn't really like cooking and it just gives my mum a bit*

647 *of a break I think and it makes it feel easier for me (laughs)*

648 *K pauses, looks at prompts*

649 *K I don't know if you have heard of Appreciative Inquiry*

650 *P mmm*

651 *K a method of questions that are all focussed on   a more strengths based type of question so this is about you*

652 *in your position now, looking back over your journey of recovering, what do you think, what are your personal*

653 *strengths that you draw on to get to the point you are at now?*

654 *P stubbornness!*

655 *K yeh?*

656   *P ehm, yeh*

657   *K would you have been described like that as a younger child?*

658   *P yeh, definitely, yeh stubborn, quite feisty, definitely like, you know, being told you should defer a year of A*
659   *levels, of university or whatever, I do everything I can to prove them wrong which kind of helped me get the*
660   *grades I needed so I could go straight to university or whatever else, ehm, yeh, just wanting to prove them*
661   *wrong*

662   *K and where did you get that from?*

663   *P my dad*

664   *Yeh*

665   *P yeh just bloody mindedness, yeh, even if it's not in your benefit, yeh*

666   *K its so interesting, I can think of occasions when I am working with families and I say to the young person with*
667   *eh eating disorder, 'you might want to take a year out.'*

668   *P laughs*

669   *K and you'd be going 'no'*

670   *P yeh 'how dare you suggest it'*

671   *K how interesting, so stubbornness, stubbornness can be positive cant it?*

672   *P yeh when I'd stopped using it as a way to punish myself*

673   *K yeh*

674   *P so yeh*

675   *K is there anything else you can think of in your armoury?*

676   *P [10] ehmmmmm [3] I guess it is that kind of personal inner strength, like resilience, I don't really know how*
677   *you get that, but I think it is something I developed I think that's definitely, even though now with everything*
678   *that is going on, its kind of like, I know that in some shape or form, things will be ok, what I need to focus on is*
679   *making sure physically I am ok enough to like, you know, see it through to the end*

680   *K yeh*

681   *P uhm and ehm, yeh*

682   *K is that something like a positive mindset?*

683   *P I don't know, I kind of think, cos I have had those experiences and even ore recently kind of having an*
684   *episode of depression and low mood, ehm, just being aware you don't always feel like that, ehm, but you do*
685   *always come through it I think that has been really useful for me to know and then you can draw on like, those*
686   *positive bits you've had in between, you know, those bits when your mood has been brighter and those*
687   *experiences that you have had and then, so although I have actually been unwell for, like you know, more than*
688   *half my life, it gets broken up, there have been moments in there that I treasure quite a lot, ehm, so yeh, I cant*
689   *be so all or nothing that as perhaps I was before*

690   *K was uni a good experience?*

691   *P ehm, [3] no*

692   *K no*

693   *P my final year was but it was difficult to get through my first two years, ehm, but again I think that was just that*
694   *kind of like bloody mindedness, I will*

695   *K through gritted teeth*

696   *P yeh yeh exactly*

697   *K wow, so a bit like your dad*

698   *P yeh! Perseverance*

699   *K mmm, yeh, who would ehm, anybody on here (pointing to genogram) who would know that you were*
700   *capable of that effort, that determination to get through the difficulties you have been through?*

701   *P probably my immediate family, I don't think it is a thing they think of a lot because I think they have kind of*
702   *compartmentalised it, put it in a box, like Preetam is fine, like that happened a long time ago, but ehm, they will*
703   *mention it, occasionally, like, my sister will as well, she will say, the experiences that you have had, how do*
704   *they impact on your work now, it must help in some way, ehm, yeh that you have still managed to get your*
705   *grades and stuff so I think that, yeh, being aware of it*

706   *K its like that cliché, and I don't mean it to be, but how sometimes things that have been difficult can turn into a*
707   *resource*

708   *P yeh*

709   *K in terms of the work you might end up doing, having that personal experience*

710   *P yeh, have you done the Tree of Life?*

711   *K yeh*

712   *P yeh it's a bit like that*

713   *K yeh its a lovely exercise*

714   *K mm, yeh, I'm not very good at remembering these questions, ehm, this might not be something that is*
715   *connected but do you think that there is anything to do with your cultural heritage that has enabled your*
716   *recovering process?*

717   *P I think that kind of perseverance and that hard work has, from my parents anyway, cos I know that, like all*
718   *my family have put in a lot of hard work and effort to get to where they have got now, like the house and all of*
719   *that, like the experiences that we've got, like my parents have had to work long and hard for what we've got,*
720   *that is something that I value and appreciate, ehm and I think as a result they want to make things easier for us*
721   *, they don't quite understand why I want to live on my own in London , why I need to spend half my salary on*
722   *rent when I could be living at home and saving up all that money, so that's a bit , like that was a bit, a cause of*
723   *friction for a while cos they just couldn't understand why I didn't want to be at home and why I am making*
724   *myself stressed over money and I'm like 'I am not making myself stressed over money and I can get by I can*
725   *understand they do not want me to go through eh experiences that they had to go through, ehm but actually*
726   *that's, I don't know, that's given me some independence and a lot of skills as well, ehm, yeh, ehm yeh, they're*
727   *important*

728   *K considering where they have both come from and their families, they have probably lost things in the*
729   *process, financially and materially*

730   *P yeh like you know, there is a lot, any holidays and those sort of stuff ehm, yeh, their priority was you know,*
731   *getting a house in a good area for their kids and family*

732   *K solid foundation*

733   *P yeh*

734   *Mmm, what are you most looking forward to as you go forward and develop your talents and skills that you are*
735   *already talking about?*

736   *P I don't know, I guess to share them with other people, I guess so much of being unwell is you just isolate*
737   *yourself so much and actually now it is really great because I have been splitting my time between my parents*
738   *and London I can like 'I am going to be in London this week, so I text a few people to see if they are around so*
739   *I can meet up with them and you know, like when I was suspended from work sharing that was it with one or*
740   *two people whereas before I would not have spoken about it, ehm, yeh to anyone, yeh, not that it is a nice*
741   *thing to share with other people , its difficult but it just means I have got support around me and you are less*
742   *alone and I think that has helped me stay on track as well so it is definitely something I want to continue doing*
743   *because it means you experience things in a very different way than I would have done when I was younger I*
744   *would have bottled everything up*

745   *K I was thinking that, it really is quite a striking difference*

746   *P yeh*

747   *K being open and sharing, even coming here is an example of that difference and your sense of sharing things*
748   *with other people can be beneficial*

749   *P yeh and like, also just, being, I don't know, honest with how I am feeling rather than just saying 'I'm fine' like*
750   *you know, being actually 'yeh I am really stressed, what might happen on Monday with my work, ehm, again*
751   *that's normal, people will be like they would find it weird if I didn't say that but I would never have spoken about*
752   *it, at all also being like, "I am really enjoying being off work' but that makes me feel like this way because I*
753   *should actually be at work, or whatever, but be more honest with how I am feeling , probably more to myself ,*
754   *ehm, but I think that has been so important , as well, jus to name feelings , if I am feeling sad, to actually*

755   *K another stereotype might be the cultural pressure to achieve and succeed be in a regular job and you are*
756   *kind of in this zone going 'well there are other things of value as well, there are friendships, lifestyle*
757   *independence that maybe slightly different from the map that was expected*

758   *P yeh that took a few years for my parents to get their head around and I have been really fortunate that I have*
759   *been allowed to kind of put my foot down, like it was difficult because they were really really, like, yeh*
760   *especially when I have been in hospital, they were like 'right, you need to come home and whatnot, you have*
761   *had your time in London, your time to be independent but you need to come back and I have been like actually*
762   *no, I know you are always there, I don't take you for granted but you know I appreciate having you there but*
763   *actually I have got a life and friends ands tuff that I do have in London that I don't have in Birmingham and that*
764   *is important to me now and I am not prepared to give it up just yet and that's not to say I don't care about you,*
765   *I am never going to come back home , not necessarily live at home but yeh, that was difficult for them to kind*
766   *of get their heads around especially because my sister lives at home and she Is really happy being at home*
767   *ehm, yeh, no I couldn't*

768   *K what helped them because that must have been quite different for them, the position they were in*

769   *P yeh, ehm, I think the family therapy helped, we didn't like have many sessions but, it kind of, I was able to*
770   *see a bit more where they were coming from and I think a lot of that kind of, like I don't know, like that kind of*
771   *emotional abuse they were giving me to come back home was just out of love and care for me they weren't*
772   *doing it just to b spiteful ehm, it was because they didn't want me to be getting stressed or you know, like*
773   *worrying anything about money or being, having to live alone they were like if you were at home at least you*
774   *have got support, if you have had a long day at work you have already got people at home who can like cook a*
775   *meal for you or whatnot, I was like I really do appreciate where you are coming from but actually I am ok , I*
776   *think as time has gone past, gone by and I have gotten more well, ehm, they have been able to see that and*
777   *that's been more important they value it a lot more than me being at home and not well*

778   *K so really respecting your decision making*

779   *P yeh for now, but that has taken a long time coming but actually it has been really good they haven't been like*

780 *well you haven't got work so you might as well be at home permanently then until you hear back from work, it*
781 *has been like no I am going to go back to London for a week and they're a bit like 'why?' and I was like 'well,*
782 *planned to see friends or I need to do this ' and they're like 'oh that's fine then let me know when you want me*
783 *to drop you at the station' and that's been really nice because that's meant that they are a lot more open to me*
784 *coming home for a few day and then go aback to London for a few days rather than completely pushing them*
785 *away or like feeling trapped at home , like if I go back home for the weekend I am going to stay there forever!*

786 *K it sounds like a nice equilibrium you have got between them*

787 *P yeh and that has helped an awful lot, yeh I don't know what's helped with that and a bit of that would have*
788 *been cultural that you know, 'your family stays together, don't move a way but that was just my parents and the*
789 *experiences they had had cos loads of my cousins have moved off and their parents haven't, cried for them to*
790 *come home but, yeh I guess I just also needed to remember that I have been unwell if someone has been*
791 *poorly you are going to want them near to you*

792 *K they are going to be more protective aren't they?*

793 *P yeh and I guess I hadn't given that really much thought, jus thinking they were mean and controlling but,*
794 *hhmm*

795 *K and what are your mum and dad hoping for you longer term what's their wish for you?*

796 *P I guess in terms of my job just be happy in what I am doing if that is or isn't the doctorate, you know, even if I*
797 *decided I wanted to retrain as a teacher they would be perfectly happy, uhm and they'd support me uhm, but*
798 *yeh, I guess t hey want me to settle down as some point, yeh*

799 *K settle down, meaning?*

800 *K get married, have a family all that ehm, again like, yeh they have been great, like no rush my sister is getting*
801 *married, 18 months time, like she wanted to get married now, like her and her boyfriend have been going out*
802 *for ages but they were like fine, yeh that's fine, there is no pressure like on me, like 'your younger sister is*
803 *getting married so you have got to' that's been good as well, like do what you want*

804 *K and would there be any expectation about what kind of boy you would marry, would it be a Sikh boy*

805 *K I think they would be a lot happier if it was, it would make things easier, but I don't know, I do know like my*
806 *dad especially would be like 'as long as you are happy I'm happy', my mum would probably be more upset*
807 *ehm, but again I think they'd, yeh they wouldn't, they would want me to be happy*

808 *K what are thy like about you having a boyfriend now?*

809 *P I think they would be really happy if that were to happen! Just because I have not really had any*
810 *relationships I have always been, well not really in the right headspace to relax for that to happen, so for them*
811 *that would be kind of sign of getting better*

812   K and is that something you would like to get to the point of, to feel

813   P yeh, laughs

814   K anyone in the pipeline?!

815   P no!

816   K none of your friends you are meeting tonight?

817   P no, because all of my friends are in serious relationships, engaged or recently got married, ehm and any
818   friend of theirs that are single, there is a reason they are single!

819   K so what do you actively need to do to realise the next steps of your dreams?

820   P keep doing what I am doing, stay healthy and well, yeh, cos I won't ever be able to survive a doctorate or
821   whatever I decide to do, yeh, ehm, just keep being, I don't know, I don't know because there are so many
822   things up in the air at the moment, I don't know, you will have to ask me in a few weeks, I will know a little bit
823   more

824   K is there anything that could hinder the next steps?

825   P I guess yeh, if, because I have been suspended, if I am dismissed ehm, I don't know what that will mean in
826   terms of the consequences, I don't know how far reaching that would be, ehm, I don't know

827   K oh dear, how do you cope with that on a day by day?

828   P I don't think about it, its more like extended annual leave as such, yeh, I think also knowing that if I am
829   dismissed my family will always be there for me and I can always go back home and they would be more than
830   happy to have me home until I get back on my feet while I work out what it is I am going to do

831   K that must feel some comfort

832   P yeh definitely, you know there is that security, ehm, yeh I think I would be a lot more stressed if I didn't have
833   that, If I was like right I might lose my job and I wont be able to pay my rent what's going to happen I've got
834   nowhere to live, actually it's a bit like I have got a plan

835   K definitely and where do you think you are in terms of recovery, recovering, I am not sure what term to use,
836   what words would you use?

837   P I don't know it took me such a long time to accept that I did have an eating disorder and that was only like in
838   the last few years, uhm, even being able to say it out loud and relate that to me, uhm, like, I could, like my
839   throat would physically close up, I would try to say the 'A' word out loud, I just couldn't do it, uhm, then I think,
840   so now it just feels quite strange saying that, I am kind of getting better from it, I have got my head around the
841   fact that it has been a problems in my life for so many years, uhm, yeh, I d, I dunno, (laughs)

842 *K is it a word you would use would you describe yourself as recovering from an eating disorder, some people*
843 *talk about healing or living with*

844 *P yeh I guess I am living with but also recovering from, I think it is living with, kind of, allows for the fact that it*
845 *is something I need to keep tabs on, like , so now with all this stress going on , I have got to be more aware*
846 *that I am eating*

847 *Regularly, I am eating sufficiently, cos it is something that like now more than ever that could easily slip quite*
848 *quickly, like just skipping snack for a few days, like missing meals, so I think yeh recovering from means you*
849 *are on a journey I don't want it to be like on my shoulder forever, I think it wont always be so prominent but I*
850 *think it is something I will always have to be aware of*

851 *K so at points of stress. You mentioned the other day that you had an appointment, is that some follow u?*

852 *P yes, I have got more follow ups, monthly, like I would have been discharged now, but I don't think, with work,*
853 *they will give me a few more follow ups which is good ehm, but yeh*

854 *K has that been CBT?*

855 *P yeh, but I have had lots of different types over the years but what has actually ben most helpful this time*
856 *round has been like a block of 24 CBT sessions, annoyingly because I hate CBT then I worked in IYAPT and I*
857 *had to like it, it's been really helpful actually and I had all those other skills to look after myself whilst I was*
858 *challenging all the behaviours*

859 *K have you got any thoughts or tips about culturally specific ideas around treatment*

860 *P I think definitely having like family involved and I think that is something so difficult to get a hold of , ehm, and*
861 *also stop making assumptions, ehm, I know my parents hated it, like when we had family therapy the first few*
862 *times and they'd all be like, 'well is this cultural then? "But like no, a thing my mum would talk about all the time*
863 *was like why is Preetam living in London and yeh a bit of that was cultural but a lot of it was more just my*
864 *parents experiences of growing up and that, because that, yeh, so that was more just in terms of anybody's*
865 *experiences and so I can imagine if that was anybody else and that wasn't because I was a female or that my*
866 *parents were Indian, that was just because they did not want me to go through any more stress , so yeh, that*
867 *would really irritate my parents, like when I was younger people would be like 'oh is it because your parents*
868 *had an arranged marriage?' 'No, I don't want to kill myself because y parents had an arranged marriage'*

869 *K so cultural stereotypes in treatment?*

870 *P yeh*

871 *K and I can really register what you are saying and hopefully I have tried in this interview to say is it to do with*
872 *cultural aspects or is it to do with your family idiosyncrasies*

873 *P yeh I think that's it definitely making assumptions and stereotypes and immediately you have lost that*
874 *connection you have got with someone, and you are like, right, you don't understand, ehm, yeh, I think that has*

875 been difficult like over the years, ehm, it probably didn't help with my mum trusting professionals because they
876 would be like maybe because it is because there is, you know, a cultural difference between you and your
877 daughter and that is why she cant talk to you, absolutely no that wasn't it, it was because she was my mum
878 and I did not want to upset her , it wasn't because she was she was from a different generation or culture, like
879 she is British, she grew up here essentially, we are quite like minded , yeh, it wasn't because I couldn't speak
880 to my mum, ehm, yeh

881 K I think you conveyed that really well actually, your description of how you got on with your mum was kind of
882 typical of so many teenagers

883 P I think that's it, yeh

884 K rather than distinguishing culture, yeh

885 P yeh I think more of it was about me wanting not to upset or worry my parents, to be like the perfect daughter,
886 ehm and that wasn't cultural that was like because I was a girl and I should be seen and not heard or
887 whatever,

888 K mmmmm

889 P and my sister is quite different, like you know if she is unhappy, she will slam doors and swear at you but that
890 was never my personality and we've been brought up by the same parents so its definitely not cultural its more
891 personality, yeh I was more sensitive and aware of how people were feeling, not wanting to do anything to
892 exacerbate it

893 K but what comes through culturally is the cultural heart of the family and this kind of lovely sense of you are
894 all kind of connected

895 P yeh

896 K across perhaps even in laws as well, that feels a bit different

897 P e like my sister's wedding we want to keep it really small but

898 K its impossible!

899 P its impossible because they have all got two or three kids, they are all married now and we know their in laws
900 and so you do you not invite them or they've got kids as well, so yeh, like

901 K that comes across quite strongly and the other thing that comes across is the success your mum and dad
902 have made, given the, you know, its not a straightforward situation to raise children in this country with the
903 culture we are in Britain, it's not an easy culture, its got lots of positives but if you have come from different
904 circumstances and to get on with careers and raise children, it's a challenge

905 P yeh I have been quite fortunate with my parents because they have been the youngest out of their siblings,

906　*they have been a lot more laid back in parts like when we were younger and we wanted to go out, if we wanted*
907　*to go out to a club or whatever they would be like 'that's fine, you can do it', I never chose to do it, but my sister*
908　*would and like you know they were perfectly fine with it so it was very much different personalities, I did not*
909　*want to go out, so yeh, we weren't stopped*

910　*K and you had mixed friends*

911　*P yeh and even in terms of how we dressed and everything, if I was going to see some of my family members I*
912　*would dress like respectfully, I probably wouldn't wear a short skirt and bare legs but yeh my parents never*
913　*stopped me*

914　*K well I think I have covered everything I wanted to cover, is there anything that stands out for you that I*
915　*haven't asked about*

916　*P no I don't think so*

917　*K well thank you so much*

918　*P thank you*

919　*After I turned off the recorder, Preetam added a few thoughts that I asked if I could record what she was saying*
920　*so we turn it on again*

921　*K say that again!*

922　*P yeh just that cultural differences didn't have that much to play a part in it, I think it might have had a little to*
923　*do with in terms of me developing like depression and low mood and whatnot, ehm, but probably, I don't think*
924　*so actually, it might have hindered a little bit in terms of getting some help but I think that was more, anybody*
925　*who's parents who grew up in the time period that my parents did when they did not talk about it*

926　*K or wouldn't know what to look for*

927　*P no, its not talked about whereas I have been quite open with my little brother, like you know, if someone is*
928　*talking about suicide on TV, even when he was like 8 or 9 I'd be like right 'do you know what that means? Like*
929　*sometimes people get you know, I think its different because that's my job as well but also I want him to be*
930　*aware of those words so if he does feel depressed he can come up to me and say 'I'm feeling very low, I'm*
931　*feeling very sad'*

932　*K use words*

933　*P Exactly*

934　*K thank you that is really helpful*

Appendix K: Excerpt from Sarah's Transcript

Excerpt from which Gee's poetic form is created

Kamala 'do you want to say something about your mum and dad? Growing up?'

Sarah laughs; 'my mum and dad, they got married because my mum was pregnant with my sister, so I don't think that is ever really a good start, to get married, if your not, if its not, love there I don't think people should get married but 30 years ago was a very different time so [..] because they went to church, there was a lot of social pressure'

Kamala 'mmhm'

Sarah' in the church community to be a woman, pregnant without being married, married out of wedlock that's what I am trying to say, so they got married, it was difficult for them, my mum said I came along 2 years later and they were happy by that point, then my mum, no my dad lost his job so when we were when I was in primary school I cant remember the age'

Kamala what was he doing?'

Sarah 'he, first of all, he had his own business, he had a partner that he grew up with, in Jamaica, they came over about 3 months apart from each other to the UK and very close and they went to church together and my mum went to church and that's where they all met, but he opened a business with him and his business partner stole the money'

Kamala 'gosh'

Sarah 'kinda left our family bankrupt, so after that my dad, he had a lot of jobs to get back on his feet, but he went through a period of about 18 months without a job , I remember he used to clean trains and everything'..

Kamala' what was that like for the family?'

Sarah it broke up their marriage because erm my dad grew up from a Jamaican household where a man is supposed to work that is the cultural

Kamala to provide

Sarah 'to provide, its cultural identity and I don't think my mum , she had gone back to college and done some courses, she went back to uni when I was in my teenage years but she had enough qualifications to get an administrative position. I don't think my dad could handle her bringing in the money while he didn't have a job'

Kamala' wow'

Sarah 'my mum she said to him, when things are bad you don't have to break up this is something we can work through but he couldn't get his head around not being the traditional, stereotypical male role and that's what kind of broke them up and erm, they had problems at church and my mum went to the church because we are very closely tied to the church at the time and my mum asked (aksed) for marriage counselling because they were going through a rough patch but they didn't give it'

Kamala 'would that be a typical thing for the church to do?'

Sarah 'erm well, in my church, I am an Adventist, you have to have marriage counselling before they allow us to get married'

Kamala 'right'

Sarah 'so they sit down with you, perhaps 6 sessions minimum and they talk to you about what to expect in marriage'

Kamala 'right'

Sarah 'and just to give you some tips and guidance like conflict resolution, I guess'

Kamala' and that would have happened'

Sarah ' they would have had that before hand when she was getting married and when she was married and she asked (aksed) them for more but they didn't. My mum said they had the perception of our family that we were the kind of perfect family 2.4 children and really involved in church and they didn't, then my mum got involved, they didn't really like my mum at church, she ended up leaving'

Kamala 'right'

Sarah' and that put extra strain on the marriage because we were so closely tied with church   an so my dad

left'

Appendix L: Excerpt from Tamara's Transcript

Kamala asks about recovering and if her cultural background has been helpful or not-

Tamara answers,' except for the weight thing, no'

Kamala asks again, asking if she has stories from her family that might have helped

Tamara: 'maybe, I don't know, I think it might be, like I always had, what I have noticed with eating disorders is very like, not self absorbed but you are kind of in your own world really just thinking about yourself and like, the way I see some people talk to their mum's, like I was always so embarrassed in front of my mum, like they are so rude to their mum's I was just like, they want their mum's to think it is normal not to eat but I am so scared to say to my mum because in her culture like that's not , not accepted but it would upset her like I have never said to her 'I'm gonna starve myself, I'm not gonna eat' because I know it would upset her but what I was gonna say was , oh yeh, that was what I was going to say , like I have never said it to anyone, in hospital, like cos I don't want o offend them but I have always thought that like , maybe its because I am black but I have had this thing in my head, I used to feel so guilty because there is children starving in Africa and I don't want to eat and I have never heard anyone else say that in hospital , they are all like, its all about me , like what about the starving kids in Africa and not just in Africa, but obviously I think of Africa cos I am from Africa, so I always think in my country, in Somalia right now there is people starving , not eating and like, don't have any food , I am just throwing away food

Kamala asks if she could talk to staff about this

Tamara:' no, I could, I did talk about it with staff but I couldn't mention it to other patients because it might upset them and they might be like 'oh should I think that, I don't want to upset anyone that was one of the reasons that I wanted to get better because I jus thought, 'what am I doing with my life, like I am so lucky I have two arms that work I have two legs that work, I have food, I have a roof over my head, like and I just think of all these, I know it sounds really cheesy but I just think of all these starving people in the world and they would do anything for some food , I cant watch those adverts they make me cry, like they literally, I get tears in my eyes and I just think and I am just sitting here, like the other day , I remind myself that on a bad day like I'm I don't want to eat then I am like where are all those people that want to eat and you have food in front of you so just eat but it's a good thing to say when , like it stops the excuses because you know you make excuses well it kind of helps that I think about it in a selfless way ,like if I start thinking 'well I don't want to eat that because then , like, I don't know, I might put on weight ' like if I start thinking that then it completely feeds into I never want to feed into my eating disorder ever, like I want to be as normal as possible, so when I have a struggle, its good though , cos it really does help

Kamala asks if she is identifying something about her heritage that is helpful

Tamara: ' do you think?' 'But I've noticed that is culture, even when I was at secondary school, going round my black friends house and my white friend's house, two completely different things, like, my black friends, you go in, you say 'hi' to their mum 'how are you 'but like in a respectful way they are not like 'hi you alright'? They are respectful, 'hi how are you?' and we are like 'oh I am just going to be in a my room,' same with my house, oh I am just going to be in my room, go to my white friend's house 'mum you're such a fucking bitch' just like 'excuse me?' I'm like are you allowed to talk like that to your mum? And I am just like, and even when I was in hospital, people were going like, 'fuck off mum' and I'm like if `I said that, like I have never even, not even about getting in trouble for it, I would never say that to my mum, cos my mum taught me that , its like a cultural thing , how I was brought up , when I hear people talk like that to their mum I am like , oh my, like how can you call your mum a fucking bitch, like oh my god, but I don't say anything sometimes I am just, 'you shouldn't talk to your mum like that, ' ,' oh why she is used to it?' Should she be used to it?

Appendix M: Tamara Interviews Kamala

T are you married?

K yeah

T any kids?

K yeah 3 daughters

T wow, how old?

K 25, 21 and 13

T ahh, 13, little baby, so still married, how long have you been married?

K yes 30 years

T 13?

K 30, three o

T wowwww, are you still in love?

K I suppose so, what is love! Yeah we get along

T you get along, oh that's good, I hope that's me one day I always think when people get married that they kind of

K well it changes over the years, you become different people

T yeah

K as long as you can have a connection

T do you still have a giggle?

K yeah yeah

T that's good, does it feel like, is it different from when you first met, do you still feel like when you first met

K yeah, we are really different people, really different

T like in a good way?

K yeah in a good way

T like you still match

K like I would say I am an introvert and he is an extrovert he loves being out all the time he loves to be busy and I like a lot of quiet, it doesn't matter

T but that's good though cos people balance each other out

K yeah yeah

T yeah some people are like 'oh he's really quiet and she is really loud' but they balance each other out what if you have two quiet people or two loud people, like how's that gonna work?

T do you believe that when you meet the person you just know?

K well I do for me because I saw him over there and I said, 'you are for me'

T really! I think when you know you know

T I think he's for me

T yeah, like yesterday, I was so drunk though, he was ringing me he was saying he wanted to get married some day and I started crying, like stop it you make me cry, cos I never thought he's ask, I never thought anyone would, you know, put up with me like that, so yeah, like he is serious, I don't know if people are being serious but I think he is being serious, its so weird to think you have met that person , cos when you are young you are always wondering who's it gonna be and then you are like , maybe that's why I was crying , I know who it is now

K it's nice, a nice love story in there out of all this difficulty

T he is very understanding, like, he's so funny, he's like, when I am having a go for no reason, not at him, well kind of at him he's like 'I know you are angry about something else ' I am not shouting at him but I am being moody and he is like 'you are not angry at me you are angry at something else, there is something else bothering you ' is he a therapist or something?

K its quite smart of him

T I'm like that's true and he's tell me what's really wrong, don't have a go at me, I am like, he is really understanding, he has saw all my self harm, he didn't care, he was like ' I still think you are beautiful'

K and you have got to start to internalise that and believe it

T recently I have started to think I am not that ugly a person, there might be ugly people than me but I am not like really pretty, I wouldn't say I am pretty I would say I am, you know

K well there is that whole thing of beauty in the eye of the beholder isn't it, your beauty comes from inside

T that's true

K the kind of person you are

T that's true

K its not just what we see on the outside I know young people are obsessed with how they look on the outside

T I don't care about that stuff anymore, like when you are young it s like 'oh my god, my boyfriend is so good looking, now, its like, obviously there has to be an attraction there but

K it can be about ideas cant it, it can be the way they think the same rather than what they look like

T exactly me and him are so alike we are both sarcastic

K laughs at the same jokes

T yeah we laugh at the same jokes we are so sarcastic like sometimes we stop and are we being serious or are we being sarcastic, he's always calling me, how's your day been what you been doing

K well we digress a little, its fine, its nice getting to know you

Appendix N: Creative Non fiction Writing: Esme's Train Journey

Scene: Train Journey to Birmingham, Esme is on her way to see her father and half siblings. She is travelling on her own. She has recently spent Christmas with them and is now on half term break

Sound effects of a busy railway station:

Esme clambers on to the train and Ruth her foster carer, shouts, 'Have you got everything, have you got your ticket?

Esme reassures her and tells her not to worry, she will see her soon.

Esme looks for seat 28a, finds it and puts her suitcase up above on the rack. She struggles to do it and a woman nearby asks if she needs help.

'Oh thanks its ok, I think I can manage' she says, finally slotting it into place. She takes off her backpack and puts that next to her suitcase. She sits down with a big sigh, puts her water and lunch in front of her on the small table and leans back.

Phone ringing

Esme jumps up realising her mobile is in her backpack. She bumps her knee on the woman sitting opposite.

'Oh I am sorry.'

'Don't worry, its fine' the woman smiles then looks back at her newspaper.

The phone has stopped ringing by the time Esme reaches it and sees it is from her dad.

'Hi dad, yes I am on the train, yes I have my lunch, no, I don't need a snack too as I will be there by the time I need a snack so stop worrying. I will see you soon. No it only takes 2 hours, trains are fast these days dad' Yes I have got a drink, stop fussing!

Esme sits back in her seat. The woman opposite smiles and Esme smiles back.

'I probably sound like that when my daughter is coming back from uni too' she says.

Oh I'm not going back from uni, I am still at college' replies Esme.

'Oh no I just meant about how parents worry about their children however old they are!'

'That's true', replies Esme.

'My name is Elspeth', the woman says.

'Esme', says Esme. 'Are you going to visit someone?'

'Well I teach at Birmingham University but I am only part time so I live down here near my mum.'

'Really, what do you teach?' inquires Esme

'History '.

'Oh I used to love history, especially when we did the Egyptians'.

'I teach modern history, you know the wars and so on'.

'I didn't really do much of that '.

'So what are you doing at college?'

'I am doing beauty'.

'Oh right,' says Elspeth, glancing out of the window.

Esme wonders why Elspeth looked away. She wonders about her choice. The last time she saw her dad and Mary, Sonya and the others, she felt like they thought she should study something else, but nobody said anything.

'Its all right for them, she muses to herself, they have all had a really good education. What with Mary training to be a midwife and their mum being a social worker. She knew she just wasn't as clever as them. Didn't her dad say he was really proud of her no matter what she chooses to do? Then why was she having these doubts? Its funny that Elspeth mentioned history cos that is what she had really been interested in when she did manage to get to school, in between being in hospital.

Esme looked out the window, her mind wandering back to times she was trying to forget. She loved her mum but knew her mum was not well enough to look after her. She remembers when she was a little girl that she and her mum would spend hours together when she should have been in school. She remembered not being interested in food, not eating much but being afraid of knives. She did not know why.

Memories for Esme were mainly bad and try as she might, she could not rid her mind of them. They just kept popping up. Like the time her dad came to visit when she was about seven and how she begged him to take her with him and how he said her mum wouldn't let him. Or the time her aunt peered through the letterbox shouting for her to come to the door so she could be taken to school and then her aunt realising she wasn't washed or dressed. Why didn't anyone truly help her and her mum? Why did she have to resort to her imagination and pretend she was in a bed and breakfast preparing lunch for when her mum came home and the times when her mum didn't come home or came home with different men. As she looked at the fields and rows of tidy houses, she wondered about who lived there and what their lives were like. She wondered what Elspeth's life was like and her daughters.

Elspeth looks at the young woman siting opposite her. She looks deep in thought. Elspeth notices she is a fair

skinned black or mixed race girl. She wondered what mix she is. She often wondered about this because her students were very multicultural.

'Would you like one?

  Esme looked up, startled out of her thoughts. Elspeth was leaning over with a box of Celebrations. 'We still have loads left over from Christmas' she says.

 'Oh, ehm, eh… sorry what did you say? Esme says

 'Would you like a chocolate? I don't want to have to take them home'.

Thousands of fleeting thoughts rushed through her brain. 'My legs are already too fat', 'I prefer protein to fat and sugar', 'Its not on my meal plan,' 'It would be rude to ay no'.

'Oh yes please' said Esme, leaning forward and putting her hand in the red container.

'Take a few, you can get away with it, you are so slim'.

'Thanks' said Esme, unwrapping the shiny gold paper and popping it straight into her mouth without a moment's hesitation. She knew if she hesitated, she might not be able to eat it.

Deep down she knew this was the right thing to do.

'I used to suffer from anorexia you know', blurts Esme

Elspeth flushes and says, 'Oh really, sorry, should I not have offered those to you?'

Esme smiles, No its fine, I have got to cope with those sorts of situations, its just that I have been really ill, that's why my dad was being so protective'.

Elspeth struggles for something to say, that doesn't sound insensitive or condescending.

'But you are better now though?' she says hesitantly

'More or less, it does take time, its just my mum didn't know how to really look after me, she was quite ill and nobody really helped us. Esme says quietly

'Do you live with your mum?' Elspeth asks

'No, I have been in care for ages but I am going to live with my dad when I am 18. I cant wait' replies Esme

'That sounds great, I bet he cant wait either'. Smiles Elspeth

Elspeth clears her throat and says, 'can I ask you a bit of a weird question?'

'Yeah go on then' smiles Esme.

Elspeth says, 'Its just that I thought that it was white girls who got anorexia?'

Esme says 'I know what you mean, I am the only mixed race person I know who had it but it does seem to be a bit of a thing, I'm not sure really, about how we are brought up differently, I know it is something to do with that, but I don't really know'

Elspeth says 'Sorry if I am being too nosy'.

Esme says 'No its fine, I think it is good if people do try to understand, like the girls I live with. They really annoy me because they can eat what they want, they don't even have to have breakfast and then they moan about being fat, then when I am there, they say, oh sorry Esme'

They both pause a moment, taking time to allow the conversation to settle. Esme is pleased she has been open, Elspeth is struck by how warm and open Esme is and wonders how she learned to be like that.

Elspeth absent mindedly opens another chocolate and pops it into her mouth, thinking of her own daughter and how they both at times moan about being fat and going on the odd diet here and there, all in the name of 'being healthy ' of course. She smiled to herself

'So' said Elspeth. What do you...'

Can I ask you? Says Esme

They both laugh. 'No you go first', said Elspeth.

Esme takes the plunge and asks, 'Well I was wondering what you needed to do history at university?'