Informed Orienteering; a Study of Navigating Systemic Positioning Dilemmas Within the Field of Anorexia.

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I declare that the work contained in this thesis is entirely the work of Nigel Jacobs

Signed:

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Abstract

Systemic Psychotherapists, versed in working from a social constructionist and feminist perspective, can encounter positioning dilemmas when working within the high risk field of anorexia. A common discourse of anorexia is that it has a relationship to issues of control, feelings of subjugation and lack of agency. For professionals, when working within the dominant psycho-medical domain immediate physical risk can be reduced, but so can the client's sense of agency. On the other hand, if the therapist works within a social constructionist domain agency can be increased, but so might physical risk.

Using semi-structured interviews, qualitative data were collected, recorded and analysed from eight systemic family psychotherapists who were currently working with anorexia in a variety of clinical settings. Focus was given within the dialogically constructed interviews to the positions that the participants took within the discourse of anorexia, both theoretically and in action. Positioning dilemmas and issues of power dynamics were given particular focus.

The data were analysed using constructivist grounded theory, with three main theoretical codes emerging inductively from the axial codes. The findings that emerged are arranged as a hermeneutic circle of influences upon the positions taken, and encompass history, context, view, position, action and response. The positions of expert, unsettled and not-knowing were identified. Finally the actions of comfort, support and challenge emerged from the data.

The participants varied from each other and within their own positioning, with context of client age and chronicity seemingly having a strong influence on how social constructionist positions could be taken in the face of physical risk. The influence of their own and other professional and personal discourses also had bearing.

In this study, the findings suggest that an *informed orienteering* approach (a term that I coined based on dialogic principles, Shotter's concept of withness and orienteering and Mason's thinking on working within safe uncertainty) can help systemic therapists position themselves within discourses about anorexia. My *informed orienteering* approach allows incorporation and attention to both the psycho-medical and social constructionist positions, whilst accounting for issues of power, particularly through feminist critique and the thinking of Foucault and Bourdieu.

Implications for the field of family therapy are considered, as are recommendations for future research.

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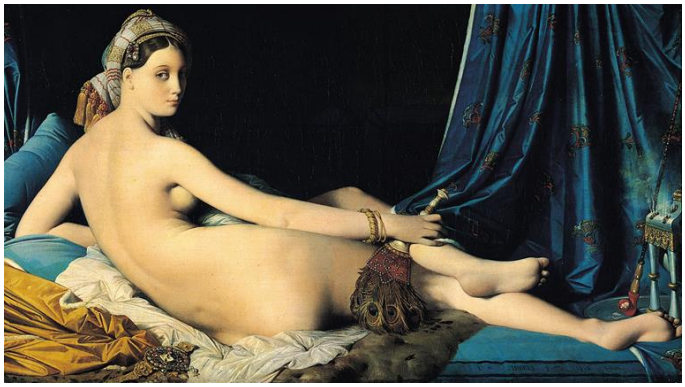
In the work that follows I will present both an academic account alongside my reflexive thinking and case examples, as footnotes. Case examples are fictional but represent common facets of the families that I work with.

"It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of light, it was the season of darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us, we were all going direct to heaven, we were all going direct the other way. . . " (Dickens, 1859, p5)

"for there is nothing either good or bad, but thinking makes it so: to me it is a prison." (Shakespeare, Hamlet, act 2, scene 2, line 1350.)



(Ingres, 1814)[1]

1 Foreword

Suffering from anorexia, having a 'loved one' who is suffering from anorexia or working to treat anorexia is to be within a world of confusion, complexity, complications and contradictions. A world, for some, of the best of times, for others the worst of times and, for some, both the best and worst of times; a world in which strong emotions and expressions of distress abound. This is a world in which notions of good and bad are omnipresent and often fixed within monologic relationships[2].

[1] The painting 'La Grande Odalisque' depicts a concubine, apparently awaiting the Sultan, and was painted with purposely distorted proportions (by the addition of 3 extra vertebrae) in order to conform to a male stereotype of female perfection. Her face has been interpreted to reflect the complexity of the subject's emotions. It might also be regarded as a metaphor for the relationship between bodily distortion, male dominance and the expression of distress.

[2] Distress in the family can be presented in varying degrees. For parents and partners there is often, but not always, great concern. For the sufferer there can be varying degrees of expressed concern ranging from apparent contentment through to high expressed distress. One of the first tasks in therapy can be to explore the varying levels of concern and distress, and understandings of the perceived risks of anorexia and the various notions of good and bad of anorexia.

Through several years of working as a systemic family therapist within an eating disorders service I have found that no singular approach appears to be adequate. From my experience I move here, I move there and, as I move through time, the nature of the specific form of anorexia that we are discussing becomes visible to me and to the families I am working with[3]. The various models and theories at my disposal assist with my perceptions, guiding me towards the facets that are important to notice in the moment. In my experience, no paradigm leads to *the* understanding of anorexia, merely *a* subjective one that is one of many options. There is, in a sense, no 'cure' for anorexia, for it is not a medical problem but one of coping with life's turbulences, in which the physical is merely a symptom of the emotional, and 'recovery' generally means not acting out the impulses, rather than totally losing them, for they can reappear in times of stress[4] (a recent report suggested a 63% relapse rate within an average of six years' duration (Price Waterhouse Coopers, 2015)). In my experience what can, however, be achieved is a rebalancing, a little less impulse here, a little more control there for the 'sufferer' which, over time, can lead to life *as if* anorexia were gone[5].

As I move around *within* the complexity of the 'sufferer' and the family I make use of signposts, a process I shall later develop as *informed orienteering*[6], which I will locate within a dialogic frame of reference. A dialogical form of hermeneutic phenomenology (after Heidegger (Plager, 1994)), in which what might be seen as paradoxical and contradictory becomes viewed as a unity and is inspired by those philosophical thinkers who were interested in the effects of language, notably Bakhtin (1981), Vygotsky (1978) and Wittgenstein (1953). Systemic practitioners and models have built upon this thinking to embrace the notion of human systems

[3] My stance has evolved over time as I have progressed from my beginnings of little experience and knowledge, through the certainties offered by various theoretical positions, to my current position of informed uncertainty.

[4] This statement is based upon many clients' accounts, which I have encountered, with a long history of anorexia.

[5] In first starting to work with anorexia, I was concerned to remove it from the lives of my clients. I found, however, that this did not fit with my clients' aspirations and left little space for collaboration. Later, I learnt to contribute to conversations about regaining influence over anorexia, which led to conjoined efforts to rebalance the relational influence between anorexia and my clients.

[6] A development in my research influenced by Shotter's notion of a 'point of orientation' (2011b, p20), when working within a context of high physical risk.

as interactional and mutually influencing linguistic systems[7]. What I will explore in this thesis concerns what constitutes the signposts and landmarks that aid *informed orienteering*; the multiplicity of personal, professional, societal and cultural discourses, and how family therapy colleagues orientate within the domain of anorexia. To this end I interview systemic colleagues, who are working with anorexia, to engage in a dialogue with them about their thinking and consider how it is similar and different from my own, in order to further develop and add to practice-based evidence (rather than working from a point of evidence-based practice). I seek to explore a theory of interaction between the therapist and 'sufferer' that encompasses contradictions.

This work has, in part, been inspired by the currently largely undeveloped work (personal communication) of Julia Hepworth (1994; 1999), which explores a similar theme with generic mental health professionals. In her work, Hepworth remarks that "the tension between psycho-medical and feminist ideologies has not yet been resolved in relation to anorexia nervosa" (ibid, p.64). In part, I am seeking to research whether this tension is resolved in current family therapy practices and, if so, what strategies are used to facilitate this. Hepworth also sought to understand how discourses and constructions around anorexia affect subject positions, which is key to my research question. I depart from Hepworth, however, who offers social constructionist narrative therapy as a means of navigating the tensions of positioning, preferring to propose a more dialogic process to manage the tensions. In doing so, I attempt to avoid recreating a Cartesian dualistic split between the psycho-medical and social constructionist.

In my own practice I find myself moving between two primary polarities, often holding more than one in a both/ and manner (rather than an either/ or dichotomy) . At one end are normative concerns over the physical wellbeing of my client, the psycho-medical. In this domain are medical descriptions of health and normative descriptions of weight and eating (alongside those psychological paradigms that pathologise the behaviours of others[8]). At the other end of my positioning I find myself taking a social constructionist view, being concerned with how normative discourses often subjugate women, and

[7] The work of Lakoff and Johnson (2002; 1981) also suggests, from a cognitive neuroscience perspective, that language is developed through interaction with our environment and contributes to the embodied mind, rejecting a Cartesian mind/ body division.

[8] Whilst I would hope to not be drawn towards pathologising and un-systemic descriptions I do, at times, defer to medicalised descriptions of risk.

how such subjugation or lack of control is responded to[9]. In working with families and fellow professionals, in a multi-disciplinary team, I find that there is rarely consensus over the positioning between the polarities; between the dominant, psycho-medical discourses of anorexia as madness and the subjugated discourses of anorexia as a primarily female, often self-defeating, form of protest (see, for example, Gremillion, 2003; Hepworth, 1994; Orbach, 1988). This thesis is concerned with anorexia as it affects women, given that they comprise the vast majority of my clients. As such this work requires a gendered reading and understanding of the literature and my analysis. The data is unclear on how many "sufferers" are male, although most estimates of diagnosed patients would indicate around 10%, with up to another 20% being undiagnosed, predominantly due to concerns over stigma (Zhang, 2014). The literature frequently draws links between gender, anorexia and power, which I discuss later.

In conversations with systemic colleagues, I find that we have similar positioning dilemmas in a context in which anorexia has the highest mortality rate of any mental health diagnosis (Franko et al., 2014). It is my observation that, at times, family therapists (including myself) versed in social constructionist perceptions of medically pathologised behaviours, resort to the dominant medicalised descriptions abandoning, in the context of high risk, alternative discourses, particularly those of women's behaviour which exist in a context of cultural, social and psychological subjugation[10]. The dilemma in my own practice is how to hold onto descriptions of anorexia as an expression of women's subjugation and feelings of insecurity, whilst incorporating medical descriptions at times of high risk, which has the potential to further subjugate and alienate me from my clients, and ignore the underlying emotional dilemmas. Feminist critiques of mental health diagnoses frequently point out that women's behaviour is often pathologised, with context being ignored. For example, Shaw and Proctor write of the diagnosis of borderline personality disorder that it "individualizes and pathologizes women for their responses to oppression, because of its fundamental failure to locate and understand distress within its social context." (2005)

[9] In practice I attempt, as a systemic social constructionist, to move from anorexia as occurring naturally or needing someone to blame, to seeing it as a relational phenomenon.

[10] I often find myself taking a systemic stance as a rejection of other discourses, before coming to the realisation that a systemic stance needs to account for a multiplicity of views, including those deemed to be 'anti-systemic'. This is significant to my research dilemma, in which I occasionally need to adopt medically determined positions that involve power practices, which I fight against.

If, following a Goethean perspective, we can start from "within the midst of our embedding in the complicated flow of local circumstances" (Shotter, 2013, p361), I propose we have a starting point for *informed orienteering*. By having an understanding of the range of polarities within the treatment of anorexia, using a diverse range of paradigms and theories of change, together with an ability to move through them in a dynamic way, and a preparedness to embrace withness thinking (Shotter, 2012a), the ground can be prepared for a dialogic process in which all voices, including that of anorexia, can be considered. This parallels, at least in part, the dialogic treatment of schizophrenia in Scandinavia, where the inclusion of a polyphony of voices in an open dialogic process with all familial and professional agents present, has brought significant results in a return to health and social inclusion (Seikkula & Arnkil, 2006). By adopting the dialogic process of *informed orienteering* there may be potential to adhere to the range of systemic therapies and to encompass the psycho-medical in a manner in which risk is decreased and agency increased, which I later discuss as being core to the successful treatment of anorexia[11].

The practice of exposing power is central to this thesis. I consider family therapy to be inherently principled in that it is not only concerned with assisting others in distress, in an ethical manner, but also with disclosing issues of power practices, subjugation, marginalisation and discrimination as contexts for suffering. In adhering to these principles it is necessary not only to 'treat', but to do so in a way that does not reproduce the very power abuses that were involved in contributing to the multi-faceted genesis of anorexia. It is essential to resist entering into a power struggle with the client that becomes visible as a struggle between the use of anorexia and therapeutic knowledge and skills. I am in accord with McIntosh when she states of her practice "I want, then, to distinguish between earned strength and unearned power conferred systemically. Power from unearned privilege can in fact look like strength when it is in fact permission to escape or to dominate" (1998). The privilege that I carry as a white male therapist can, even unwittingly if not exposed, perpetuate the very feelings of subjugation that were linked to the development of anorexia.

[11] In writing this I have realised that my original systemic training involved considerable dialogic positions, which I abandoned in my early work with the uncertainty and risk of working with anorexia. It is only as my experience and confidence has evolved that I have returned to adopting a more dialogic form of therapy.

Defining the other as suffering can lead to colonization of the other[12], if care is not taken to truly listen to the voice (and ambivalence) of the other. For example, a recent (generalised) article in the Australian press about the harm of sex working to the workers themselves, prompted a massive online critical response from the sex workers with comments such as "I don't need rescuing" and (that's) "not our lived experience" (BBC Trending, 2015). Palacios (2013) makes the point that when trauma (which she defines as experiences of being without language, and which are applicable to the experience of anorexia) is defined through a discourse of victimhood and patronising accounts of suffering, then these "approaches towards trauma and witnessing colonize, once again, the excluded other and reduce the ethical dimension to the limits of existing power-ridden cultural practices". In exposing the power issues at stake, whether in the therapeutic relationship (for it would be naïve to believe that power can be dispelled in therapy, merely exposed and destabilised), the family system, wider community or cultural discourses, therapy can contribute towards a context in which the felt injustices of the past and present can be revealed, paving the way for new collaborative and equal relationships. My proposition is that through this process, if set within a dialogic frame, the possibility to hold to anorexia less lightly and explore new forms of agency can develop. In considering my research question "What do family therapists consider when positioning themselves within discourses about anorexia?" I seek to further understand how to contribute to encompassing, within an overarching dialogic position, often clinically contradictory discourses in a manner that does not proliferate power practices.

In the literature review that follows in Section 2, I discuss, initially, a description of the positions between the polarities in the treatment of anorexia, how these are influenced by the quest for agency, and offer some initial thoughts on navigating these and potential dilemmas. I then move to briefly review the psycho-medical and social constructionist paradigms in practice. Following, is a consideration of issues of power and hegemony within the discourses and practices surrounding the treatment of anorexia, together with some rarely used perspectives on power within systemic

[12] I therefore use the term "sufferer" with reservations in this work, but wishing to differentiate between the "identified patient" and the other family members, not wishing to further colonise. Throughout my practice I have struggled with an appropriate term, varying between sufferer, patient and client. I have concluded that this dilemma needs to continue as I explore this within individual relationships.

therapy. I later consider, within systemic practices, the theories involved in describing anorexia, the positions these invite and the epistemological dilemmas that may be experienced by the therapist. It is also an opportunity for me to discuss my own reflexivity (which will add to the embedded reflexivity in the main body of the work), essential as I am taking a social constructionist position. Section 3 describes my chosen methodology, constructivist grounded theory, and Section 4 the findings from the structured interviews. Section 5 contains my discussion of the data and literature. Finally, I discuss my learning and suggestions for future research and implications of this thesis for clinical practice and training.

2 Literature Review

2.1 From Positioning To Orienteering

2.1.1 Introduction

Anorexia, or self-starvation, is a presentation that evokes numerous positions and discourses within both family and professional systems. When viewed as an attachment strategy (Crittenden & Landini, 2011; Kozlowska & Hanney, 2002; Ringer & Crittenden, 2007) a way of keeping oneself secure (and there are many alternative descriptions), it can be seen to be extreme and inflexible, not necessarily responding to current contexts but driven by historical contexts and failures in keeping safe[13]. Such a strong certainty is often perturbing to others within a family system and invites similarly fixed positions, promoting polarities, whether those of extreme certainty ("if she/he just ate it would all be OK") or extreme powerlessness ("there is nothing we can do, but keep quiet")[14]. Dialogue is silenced and monologues become the norm. These polarities can also extend to professionals working in the treatment of eating disorders. Ugazio (2013, p181) explores the range of polarities in anorexia, describing juxtapositions such as

[13] I regularly offer an attachment theory description of anorexia to families. This seems to assist parents, partners and sufferers to understand the inexplicable rather than descriptions of madness. For example, when Mary attended her first session with her partner Mark, he was furious with her. After a conversation about the diverse strategies with which humans keep themselves safe, including looking at the couple's varying strategies across time, they came to a greater understanding of anorexia and expressed emotion decreased significantly.

[14] Families often come with two juxtaposed communication styles, of anger or silence, which become exaggerated over the duration of anorexia. Both anger and silence can lead to a lack of dialogue.

success/failure, strong willed/yielding, adapting/resisting and self-efficacy/inadequacy, all of which can be played out in therapeutic encounters. Harre and Van Langenhove (1999, p22) in describing the discursive and, I would suggest, recursive nature of positions state:

> Whenever somebody positions him/herself, this discursive act always implies a positioning of the one to whom it is addressed. And similarly, when somebody positions somebody else, that always implies a position of the person him/herself. In any discursive practice, positioning constitutes the initiator and the others in a certain way, and at the same time it is a resource through which all persons involved can negotiate new positions.

Thus it can be demonstrated that the act of discourse can invite positions in both self and others, in keeping with the social constructionist notion that social life is a co-constructed linguistic encounter, where meetings are symbolic of the historical structures that preceded them. The discourses that occur in descriptions and attempts to explain anorexia range along a continuum from the psycho-medical descriptions of 'madness' and subsequent health failure, through to social constructionist descriptions, where a multi-verse of ways of being exists with equal validity.

Positioning theory (Harré, Moghaddam, Cairnie, Rothbart, & Sabat, 2009; Harré & Van Lagenhove, 1999) is a constructionist paradigm, where positions are seen as rights and duties within cultures and micro cultures. Positions are relative to other positions and can be taken up, rejected, abandoned and contested. Rejecting the notion of causality, positioning theory sees the relationship between meanings as the organizing principles of social encounters. These can exist in both talk and action (Harre, R cited in Campbell & Groenbaek, 2006).

A position can be viewed as a fixed point and, whilst useful in having a notion of where one is and what is being invited in others, can also be a restrictive concept when applied to the field of therapy. There is potential to replicate the fixed positioning of anorexia, through Cartesian dualistic descriptions (which falsely separate mind and body), rather than introducing the notion of fluidity and inter-connectedness through positions and, consequently, this can contribute to a combative relationship where each side attempts, with often increasing intensity, to justify their own position.

Campbell and Groenbaek (2006) attempt to resolve the dilemmas which come from taking a position that can evoke polarisation, by introducing the idea of transcendent positions. Harre states of this work:

> The nature of a conflict can be expressed in terms of the polarized positions, but if the practical work of the consultant is confined to attempts to reconcile or even choose between such positions, there is little hope of resolution… A transcendent position from which the contradictory positions can be viewed makes possible the transformation of first-order dialogue into second order dialectic, facilitating radical positionings. (Harre, p xiv in Campbell & Groenbaek, 2006)

I would suggest, however, that whilst this makes explicit the ability to reposition to a more meta level, it can still be viewed as a move that replicates the strategic nature of anorexia, lacking fluidity, thus replicating the pattern of communication in a system where anorexia has become embedded. Indeed, taking a dialectic position implies the finding of a truth rather than exploring the both/ and contradictions that can co-exist. I am drawn here to the pivotal work of Anderson and Goolishian (1988), where the idea of listening to be prepared to hear and hearing the "rightness of what is said rather than the pathology" (ibid p.13) is adopted. In this invitation to a dialogic communication, the authors move from a cybernetic[15] description of human systems to an understanding of the realities created in discourse. I will later suggest an adoption of Shotter's concepts of withness (2011b, 2012a)[16] and the need for orientation (2011a), to resolve the dilemma of positioning. I will propose the embracing of *informed orienteering*, in order to move beyond the view that a position needs to be taken, but that an ability to orientate oneself through multiple positions, holding all in mind whilst foregrounding some at any one moment, is required in order to safely increase dialogue, which contributes to the creation of alternative skills for facilitating agency in the context of anorexia. The ability to move beyond a dualistic either/ or position in a collaborative manner whilst attending to risk forms much of my later argument.

Considering agency is critical to understanding the dilemmas involved in taking a position on anorexia, to which I now turn.

[15] Family systems theory evolved from early thinking around self-regulation systems, the science of cybernetics, in which individuals within families were seen to be acting recursively and in a circular pattern with each other

[16] My attraction to Shotter's work did not begin with a theoretical position to follow, but rather to his writing as a reflection of many parts of my own practice, as it has developed over time in many therapeutic relational moments.

2.1.2 The Quest for Agency

An early understanding, which defined the "central dogma" of anorexia was given by Bruch, describing both anorexia and obesity as an attempt at self-autonomy and a quest for agency, which becomes self-defeating (Saukko, 2008, p38). Saukko, however, points out that such a view point is located in a historical and political context and is not a psychological universal (ibid, p10).

At the psycho-medical end of the polarities, professional positions are medically orientated or premised on descriptions of deficit and potentially decrease agency in the patient, at the same time as also decreasing *immediate* physical risk, in the case of medical interventions (I state 'immediate' because my own practice experience is that the decrease in agency often results in an increase in anorexic behaviours when the psycho-medical positions lose power). In seeking to understand the loss of agency that can result from a medicalised position, it needs to be understood that descriptions of anorexia bring with them problematic notions of agency. To the outsider anorexia can appear disempowering and yet, as Warin (2010, p11) demonstrates, it is dangerous to subscribe to descriptions of both medical and feminist discourses of anorexia as being debilitating and reducing in agency, if studies are to understand the complexity of anorexia. She makes the point that descriptions of anorexia as disempowering can ignore the transformative and empowering potential of anorexia, as described by some 'sufferers', and how the power of anorexia can become productive and embodied.

If anorexia is viewed as a form of embodiment, Butler (1988) would urge us to regard it as both an expression of agency and, at the same time, an expression of gender subjugation, in which the anorexia becomes an expression of the contradiction between agency and subjugation[17] (and goes some way to explain the ambivalence found in so many cases of anorexia). Butler regards gender as being a performative act in which performance creates gender, through repetitive actions; what is viewed as fixed identity is constructed through performing dominant gendered discourses. Through her thinking gender is regarded as an action (an embodiment) and, if gender is constructed through actions, there is a possible locus of change in disrupting cyclical patterns of action

[17] Sufferers regularly describe how anorexia is their friend and is a relationship they wish to continue. For example, for Angela the effects of her early experiences of abuse were mediated through the feelings of control that anorexia gave her, stating "she was there for me when no-one else was. It's too scary to try to let go of her".

(2002). Anorexia can, in instances, foster a feeling of empowerment and autonomy, offering a means of self-expression and yet paradoxically, because it becomes clear over time that anorexia also demands servitude, the sufferer is in a double bind of ambivalence.

At the constructionist polarity agency is potentially increased through the adoption of acceptance of a multi-faceted view of ways of being, however physical risk is increased. In taking a position a fixed point can develop, which ignores the aforementioned dilemmas of agency.

One person's agency can be another's subjugation and it is often the case in families where anorexia is present that the seeking of agency has led to power struggles between individual family members, especially between the 'sufferer' and family. An early systemic description of family dynamics in the context of anorexia, through the lens of structural family therapy (Minuchin, Rosman, & Baker, 1978), which although may be regarded as old fashioned does, however, give account of power relationships within families where anorexia is present. Based upon normalised views of family interactions it addresses concepts such as enmeshment and hierarchies within families.

The quest for agency can be usefully considered through the notion of a basic human need for recognition. The work of Honneth is useful here (1995). He proposes that recognition is fundamental to the development of self. Taylor (cited in Anderson, 1995b) states "Due recognition is not just a courtesy we owe to people. It is a vital human need". Honneth's approach draws upon object relations theory and is concerned with how self-realisation is fundamental to developing as an autonomous, individuated person. He proposes that realisation is developed through inter-personal processes of recognition. There are clear links between this thinking and agency. Recognition is seen to be fundamental in developing self-confidence, self-respect and self-esteem; three attributes that are seemingly consistently lacking in 'sufferers' of anorexia.

Self-confidence is seen, by Honneth (1995), to develop through the Winnicottian concept of "good enough" (1992) parenting. Failures in normal developmental tasks,

through absence or abusive experiences[18] or, alternatively, through enmeshment and a failure to progressively differentiate, can lead to a lack of self-confidence. As anorexia progresses loved ones often take positions of anger or defeat, which in itself moves further away from good enough relationships. This links to Bowlby's concept of secure base (1988), an interpersonal and systemic process of attachment in which both care-giver and cared-for are in a reciprocal relationship (Stern, Bruschweiler-Stern, & Freeland, 1998).

A lack of self-respect is linked to a lack of rights and Honneth (1995) sees this as a deficit of feeling, a sense of being treated with dignity, which assists to develop a good self- opinion. Where rights are felt to be denied this can (although does not always) lead to feeling disrespected. Given the potential for detention under the mental health act, this has clear implications for the treatment of anorexia to add to a lack of recognition and diminishment of a sense of agency. It may be that anorexia offers self-respect, through the ability to do the 'extra-ordinary', where none existed before, and that the ever-present threat of legal sanctions at extremes of starvation further diminishes a sense of recognition.

Honneth (1995) regards a lack of self-esteem (which he views as entitlement to equality of treatment from others) as synonymous with a lack of solidarity with others. This clearly suggests that a potential source of self-esteem can be solidarity with anorexia or the pro- anorexia community, for Honneth locates self-esteem in accomplishing something that is valued for the common good. The solidarity for the gaining of such esteem might be viewed as a confusion and exaggeration of normative discourses of thinness, supported within a pro-anorexia community (which may be embedded within a specialist eating disorders inpatient unit). At the same time, whilst self-esteem may be gained through starvation it may also be gained through resisting anorexia. The ambivalence towards anorexia can be seen both in sympathy towards the suffering of fellow patients and a desire for them to build physical and emotional health, and competition for who is the thinnest. In my experience it is common within inpatient

[18]Physical and/ or sexual abuse is reported in a significant number of cases of anorexia with some estimates as high as 40% of cases (Castellini et al., 2013; Dworkin, Javdani, Verona, & Campbell, 2014; Gordon, 2000).

units for patients to regard themselves as being healthy and others as far thinner and suffering. This often creates both competition and solidarity.

I would propose that, whilst Honneth (1995) does not himself discuss eating disorders in his thinking around recognition, circularity potentially evolves in the treatment of anorexia through the themes of self-confidence, self- nrespect and self-esteem (Figure1), and that the responses to anorexia, if not felt appropriately by the 'sufferer', decrease recognition and increase anorexia.

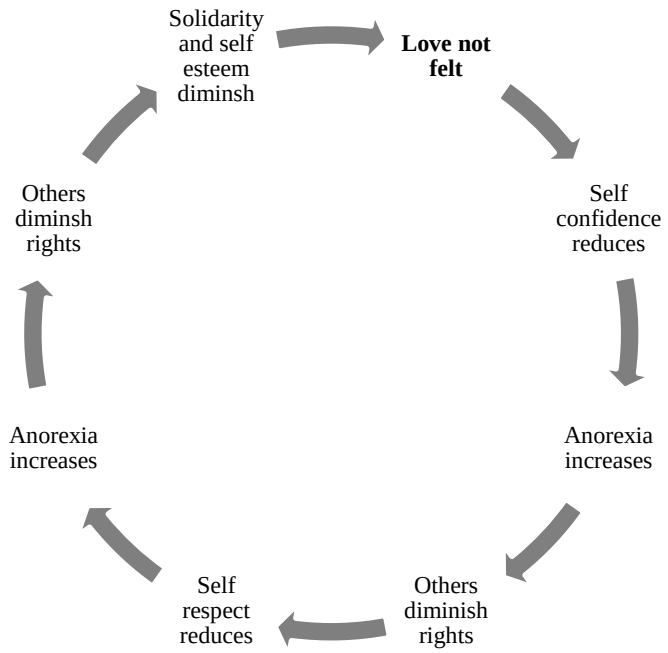


Figure 1 Circular pattern of decreasing recognition

I propose that a dialogic position is one in which due recognition is given to all others, and that this may be a way to punctuate the circularity. Dialogue is not necessarily concerned with agreement but it is a process that embraces the notion of respect for, and recognition of others. Whilst Honneth (1995) is not proposing a theory of change it follows that a dialogic relationship is one in which self-confidence, respect and esteem may potentially emerge, through recognition.

There is a need here to emphasise differences often found in treatment between young people and adults. Often the emphasis within young people's services is greater on

recovery (especially if within the first three years, when recovery is statistically more likely) than management of anorexia. Where the emphasis focuses on food there can often be both distress and underlying relief at attempts for the parents, or others, to take control and responsibility for the eating. Part of the complexity of the process of recognition and gaining agency then becomes considering whether distress also contains relief. Many clients have reported such relief, in hindsight; it would however be both patronising and colonising to take this as assumed.

To further understand the discourses around anorexia, and ideas around agency and its relation to issues of power, it is useful to describe the historical context.

2.1.3 Historical Constructions of Anorexia Nervosa

At the heart of the dilemmas of positioning is the construction of anorexia nervosa.[19] Anorexia becomes the arena for discourses, which offer varying perspectives of 'good' and 'bad', both of the nature and existence of anorexia itself, and what to do about it. Anorexia, literally meaning 'without appetite' (modern Latin from Greek, an orexis), has a long documented history reaching back to the twelfth and thirteenth centuries, then referred to as anorexia miribalis (for constituting a 'miracle of existence') (Hepworth, 1999, p14). There are many notable cases of women fasting as part of an ascetic religious devotion. St Catherine of Siena (1347-80), for example, reportedly existed on little food and survived on a few spoons of herbs each day (Brumberg, 2000, p43). Hepworth (1999, p14) makes the point that in the 12th and 13th centuries' religious context women's devotional practice was to undertake Eucharist devotion, rather than consecrate (which requires "worldly power") and that "even women's participation in religious ceremonies had to be sanctified by male clerics". As in subsequent centuries, women were defined as 'the other' by men in power; the actions of devotional women being interpreted by male clerics. Walker Bynum (1991), states that the fasting practices of these women saints approximates the diagnosis of anorexia nervosa in modern times. Brumberg (2000, p5) warns, however, against avoiding generalisations about the existence in past times of anorexia nervosa. She believes that "just because a behaviour occurs across cultures or time does not necessarily mean that it has the same cause" and that 'appetite' is transformed by cultural and social systems.

[19] I use the term "nervosa" as an exception here, being concerned with the implications of defining women's struggles as those of hysteria.

In moving to the Middle Ages, Hepworth (1999, pp 16-18) contrasts the position of the earlier saints with the witch-hunts. Early male interpretations of women's starvation posed little threat to social stability and so held these women in high esteem. In the middle ages, from a feminist perspective, the healing practices of witches threatened the dominant male knowledge and consequent authority. In the sixteenth and seventeenth centuries the notion of 'hysteria' to explain female behaviour emerged. This was demonstrated not only in the definition and treatment of witches, but of women's behaviour and 'nervous diseases' generally. The notion of hysteria links these definitions with later explanations of women's self-starvation.

Eighteenth century emergences of discourses of madness are documented by, amongst others, Foucault (1971). He argues that the segregation of groups of leprosy sufferers built a discourse of contagion and uncleanliness, which later added to definitions of insanity. During the seventeenth and eighteenth centuries the poor, criminals and the deranged were forced to live in institutions vacated by lepers (Hepworth, 1999, p19) and contributed to the medical discourses of madness. Madness became seen as false reason (Foucault, 1971) and the insane were considered to be displaying the bestiality of early human development and, as such, required punishment and internment rather than care and understanding.

Against this history, anorexia 'nervosa' as a concept and diagnosis, was defined in 1874 when Sir William Gull (working in England) reported on his observations of self-starvation by young women. At the same time Dr E. Laseque (working separately in France) reported on 'anorexia hysterique', which became a common clinical definition in France and Italy (Hepworth, 1999, p26).

Gull and Laseque both drew upon contemporary constructions of femininity, which viewed women as lacking in the 'male' qualities of logic and reason, and continued the tradition of female subordination, with white, upper and middle class women (from within which group diagnoses of anorexia were drawn) being viewed as being naturally fragile, passive and irrational (Sayers, J cited in Hepworth, 1999, pp., p28).

Gull (who is primarily credited with the naming of anorexia) and Laseque, originally sought to find aetiology in the perceived inherent nature of women as irrational. In

drawing upon the dominant discourses of their time they obscured any explanation, contemporary to today, of women's protest at their marginalisation and subordination.

Moving into the 20th century, hysteria as an explanation of female behaviour continued to grow with the influence of early psychoanalytical thinking. Feminist critique, (for example, Dane, 1994), makes the point that 'hysteria' is often the only form of protest available to women. Showalter (1987, p129) states that the terms 'hysteria' and 'feminine' became virtually interchangeable in the late nineteenth century. Freud understood hysteria to be a form of revolt (Ramas, 1990, p152) but by the mid-twentieth century understandings of anorexia nervosa, with its roots in hysteria as an unconscious symptom of distress, were being forgotten by the psychiatry movement. Guntrip (1961, p36) points out that in their psychiatric text Mayer-Gross, Slater and Roth ignore the unconscious in stating "anorexia is hardly so much a symptom as a guiding principle of life". Gilbert and Gubar (1980), in their key feminist text, describe how prominent 19th century female authors were restricted to portraying woman as either angelic or "madwomen in the attic". Illuminating this as being subjugation through male inaccurate and dichotomous representations of women, they highlight the need to reject both false representations, seen in the presence or absence of female hysteria.

Against this historical backdrop, a number of discourses have arisen to give explanation to the behaviour described as anorexia nervosa.

I will now turn to psycho-medical descriptions, in which anorexia is regarded as a form of psychological and medical problem.

2.1.4 The Psycho-Medical Polarity

Mental health services are dominated by psychiatric and medical models and diagnosis in the form of the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders DSM IV (2000) and the emerging but somewhat contentious DSM V, (see, for example, Cosgrove & Wheeler, 2013) and The International Classification of Diseases 10 (ICD 10), the diagnostic manual of the World Health Organisation.

In the UK, the dominant diagnostic tool in eating disorders services is currently the DSM V which incorporates criteria from DSM IV with minor, but significant changes. DSM IV describes anorexia nervosa as:

A. A refusal to maintain body weight at or above a minimally normal weight for age and height (e.g. weight loss leading to a maintenance of body weight less than 85% of that expected, or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).

B. Intense fear of gaining weight or becoming fat, even though underweight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.

D. In postmenarcheal females, amenorrhea, i.e. the absence of at least three or more consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g. oestrogen, administration).

Changes from DSM V are:

> Criterion A focuses on behaviors, like restricting calorie intake, and no longer includes the word 'refusal' in terms of weight maintenance since that implies intention on the part of the patient and can be difficult to assess. The DSM-IV Criterion D requiring amenorrhea, or the absence of at least three menstrual cycles, will be deleted. This criterion cannot be applied to males, pre-menarchal females, females taking oral contraceptives and post-menopausal females. In some cases, individuals exhibit all other symptoms and signs of anorexia nervosa but still report some menstrual activity. (American Psychiatric Association, 2013)

It can be seen from the above criteria that the primary identifiers are physical presentations with no description of underlying emotional factors. As such, it contributes to a physical symptom-orientated discourse.

The Minnesota experiment of the mid 1940s contributed greatly to medicalised understandings of the effects of starvation.

2.1.4.1 The Minnesota Experiment

Between 1944 and 1945 an experiment was undertaken into the effects of starvation by a team from the University of Minnesota. Designed to form a definitive understanding of starvation and famine, it was also intended to contribute to Allied famine relief, post Second World War. Thirty six men, drawn from a pool of conscientious objectors, were subjected to twenty four weeks of severe food restriction, with the effects monitored over many physical and behavioural indicators. Whilst clearly such research would not pass today's need for ethical approval, the results of this research had, and continue to have, significant impact on medicalised understanding of the effects of anorexia nervosa. No account is made for the difference between male and female responses, despite the research excluding women.

The resulting report, The Biology of Human Starvation (Keys, A., Brožek, J., Henschel, A., Mickelsen, O., & Taylor, H. L, 1950), showed that prolonged food reduction increased incidents of severe emotional distress, depression, hysteria and hypochondriasis. The participants showed a preoccupation with food, including attempts to hoard. Libido was suppressed and the participants became isolated and withdrawn. There was a reported decline in ability to concentrate and judgement was severely impaired. Physical signs included reduced temperature, respiration and heart rate (Tucker, 2006).

This research not only contributed to physical understandings of starvation, but pervades today in beliefs that patients who are starved are suffering a lack of cognitive ability due to the effects of starvation on the brain. In my experience, this often presents as health professionals explaining patients' beliefs as the result of anorexia, closing down other explanations, such as perspectives that may be contrary to health care discourses. It also contributes towards prescription drugs and re-feeding as integral to treatment.

The search for medical understandings of anorexia continues today, notably with links to autism and Asperger's syndrome.

2.1.4.2 The Asperger's Syndrome Hypothesis

The medical construction of anorexia is currently being expanded through neurobiological research looking at brain function in instances of eating disorders. Treasure, Head of the Maudsley Eating Disorders Service, and an influential figure in eating disorders research, has cited the possible connections between anorexia and Asperger's syndrome (as cited in American Aspergers Association, 2009). Treasure states that:

> This distorted pattern of processing information has a strong similarity to autistic spectrums. It has even been described as the female form of Asperger's. Traits that may appear present in childhood, such as obsessive-compulsive disorder or over perfectionism, can often indicate a vulnerability to developing an eating disorder later in adolescence. (ibid)

Treasure also describes how 'sufferers' of anorexia suffer from poor ' set shifting', the ability to shift between various mind sets and tasks, and that ideas become fixed in the mind. This is linked to similar traits in the diagnosis of Asperger's syndrome, particularly cognitive inflexibility.

Whilst Treasure also points out that cultural and societal factors contribute to eating disorders (for instance media images affirming the 'beauty' of thin bodies) investigations into cognitive traits and neurobiological functioning underpin medical understandings of anorexia. For some, the search for aetiology lies in the direction of a genetic influence, with international research being undertaken to trace a genetic connection (Scott-Van Zeeland et al., 2014). Recent research into genome decoding, however, seems to dispute such a hypothesis (Dring, 2014), although Dring's work is itself contentious (discussed later). Treasure also turns, in the Maudsley Hospital model, to seeking the support of families with treatment.

2.1.4.3 The Maudsley Model

The New Maudsley Model (The New Maudsley Approach, 2013; Treasure, 1997; Treasure & Alexander, 2013; Treasure, Smith, & Crane, 2007) focuses upon recruiting families and carers to assist in treatment. It is acknowledged globally as a significant method of treatment for anorexia. Treasure and her team work closely with families to assist in their skills development in dealing with eating disorders. As such, whilst

conforming to an individualised pathology, it is a model that moves towards acknowledging the relational nature of individual descriptions, the bedrock of systemic thinking.

Eisler (in Eisler, I & Dodge L. 2014) states that the method "draws on a range of family therapy models and integrates them." He also differentiates between the Maudsley model as practiced in the USA (Lock, Le Grange, Agras, & Dare, 2001) and the New Maudsley model, as practiced in the UK, which has stronger emphasis on engagement of the young person and parents. The method focuses greatly on helping families and carers to understand where they are positioned in relation to anorexia (which is described as being separate from the patient, a belief rather than a technique developed within Narrative Therapy (White & Epston, 1990b)). Various types of positions, described as various animal traits (dolphin, rhino, etc.) are used to assist families to reposition themselves in relation to anorexia, whilst at the same time learning new skills in encouraging recovery. Whilst naïve in the descriptions, being reductionist in ignoring the complexities of individuals' traits, the model is popular with both professionals and families and carers. As such, the model and the Maudsley team generally are a powerful discourse in contemporary constructions of anorexia.

2.1.4.4 NICE Recommended Treatments

Within the UK, clinical practice is steered by guidelines from the National Institute for Health and Care Excellence (NICE). NICE guidelines for anorexia (2004) [20] indicate a variety of psychological and medical interventions. The guidelines state that "Therapies to be considered for the psychological treatment of anorexia nervosa include cognitive analytic therapy, cognitive behaviour therapy, interpersonal psychotherapy, focal psychodynamic therapy and family interventions focused explicitly on eating disorders.". Medication should not be used as "the sole or primary treatment for anorexia nervosa." NICE also states that "The aims of psychological treatment should be to reduce risk, to encourage weight gain and healthy eating, to reduce other symptoms related to an eating disorder, and to facilitate psychological and physical recovery."

[20] Published review due April, 2017

In stating that family interventions should be focused explicitly on the eating disorder the guidelines appear to promote the view of anorexia as being a non-contextual presentation of illness, which is contrary to how family therapists would usually work, in looking at inter-psychic processes and relational patterns through time and context, including that of subjugation.

I will now turn to the social constructionist polarity (which might also be described as the psycho-social), in which anorexia is often regarded as being a symptom of power subjugation, influenced by dominant discourses of appearance and success (see, for example, Jones, 2014).

2.1.5 The Social Constructionist Polarity

Social Constructionism is premised on the belief that that which exists is given meaning through culture and language (Gergen & Gergen, 2004). In this manner, the notion of reality becomes a process of subjectivity where a world view is not a truth, but a linguistic creation. This allows for the existence of many conflicting and opposing beliefs, all of which have validity within their own subjectivity. Social Constructionism illustrates that dominant cultures define what a norm is and, in so doing, shape the behaviour of social participation. This, in turn, allows for the resistance of such discourses and a search for subjugated constructions[21] (Burr, 1995) .

In systemic family therapy, the influence of social constructionism grew in the early 1980s, slowly moving the paradigm from descriptions of cybernetic interactions and strategies to focus on meaning. This was greatly promoted by the Milan Family Therapy Team and subsequently Cecchin's introduction of the concept of maintaining curiosity, as a way in which to move beyond any one reality (1987). This, in turn, preceded a focus in systemic therapies on both the verbal and non-verbal linguist practices, which create rather than describe realities (Andersen, 1987; Anderson, 1997; McNamee, 2004; Shotter, 1993b). At the same time, and strongly through the influence of feminist critique (Goldner, 1985; Hare-Mustin, 1987; Jones, 1993; Weingarten,

[21] In my experience this is essential when working with anorexia. For example in my work with Natalie and her husband we explored gendered constructions of 'successful' women professionals and the paradox of needing to adopt male constructions of attributes, such as "strength" and "determination" in order to be a successful woman in a male dominated academic environment, and how this might be different using female constructions of success.

1991), the systemic profession became more open to accounting for issues of power. A strong influence became that of Foucault, introduced primarily through the narrative therapy of White and Epston (1990b).

Narrative therapy introduced the concept of externalisation, where the problem is seen as the problem, not the person (White & Epston, 1990a). This has become influential in the treatment of anorexia, where patients and their families are invited to separate the patient from anorexia (though the patient retains responsibility for resisting the anorexia). Whilst narrative therapy is a social constructionist paradigm (and is concerned with the use of cultural and societal power discourses and practices to subjugate individuals) it still, in keeping with a psycho-medical perspective, regards anorexia as a problem[22]. From a social constructionist stance it becomes necessary to enquire to whom it is a problem. Such is the complexity that there is not a consistent answer to this, given the agency that some patients reportedly feel anorexia affords them. In the quest to increase agency, social constructionist therapies can fall into the trap of promoting dominant notions of agency. Systemic therapists cannot work in a moral vacuum and are, themselves, the carriers of dominant social constructions which, at times, privilege 'health' over 'agency', as if the two were separate. A counter-argument is that the feelings of agency that anorexia can afford are themselves the result of the subjugation of the patient. Thus one enters a double bind, in which exploration of 'true' ideas of agency become forever contested. In order to explore the dynamics of power behind this double bind the works of both Foucault and his contemporary, Bourdieu, prove useful. I will proceed to a discussion of their perspectives in the following sections.

Social constructionist therapies are not only concerned with the manner in which social discourses shape the meanings and beliefs held by individuals, but the manner in which power exists within such constructions, and it is to considering issues of power that I now turn.

[22] To my mind, all social constructionist therapies can be used as a technique in which the underlying philosophical position is lost. Narrative therapy has great strengths in resisting dominant discourses but can, if used as a technique rather than a philosophy, become its own dominant discourse.

2.1.6 Hegemonic Positioning

2.1.6.1 Defining Madness

The medicalisation of personal suffering has its origins, according to Foucault, in the ever-increasing process where "human existence, human behaviour and human body are re-framed as medical issues" and where subsequent professional power is applied to individuals (Samuelsen & Steffen, 2004, p7)[23]. In 'The Birth of the Clinic', Foucault (1975) contends that the medical profession gained power through the use of scientific knowledge, in order to define what was the 'norm' and what was 'deviant' behaviour. Currently, the ability to define pathologies through such diagnostic manuals as DSM V continues to imbue the medical establishment and psychiatry specifically, with the power to define the norms against which individuals are measured. Through generating such norms psychiatry is able to influence the discourses, which are used in general societal conversations, and thereby directly influence the way in which individuals comply with these norms (Eckermann, 2013, p10). The language the medical profession uses, the language of the clinic, promotes power over the patient, denying alternative discourses and, as stated by Place (cited in Eckermann, 2013) "it would seem to me that any language that denies sub-texts must be diminished in its capacity to effectively treat illness. Especially anorexia nervosa, which I believe is *first and foremost a language problem*" (my italics), a position that mirrors my clinical experience[24]. There is a clear link between language, knowledge and power and the power to define and limit another through language is the arena of colonisation (Văcărescu, 2003) and anorexia. This follows de Beauvoir's contention that women are culturally constructed as man's other (1972).

[23] It will be clear from what follows that I take a stance against power practices in all forms. This comes not just from a social constructionist professional position of what is 'right' but a childhood in which I felt at the mercy of both overt and covert power practices. The paradox is that, as a white male, I can also be a purveyor of power practices through both my gendered and racial identity.

[24] Vanessa was an inpatient in our service. She had been brought into the unit with all but the final stage of a section being completed under the Mental Health Act. Whilst she rapidly gained weight and physical risk had diminished to within acceptable bounds, a locum psychiatrist used language in meetings with her that implied her liberty could be taken away if she did not "comply" with treatment. The medicalised descriptions of her behaviour and use of state power further decreased agency and increased her feelings of helplessness, which were part of her difficulties in the first place. This was in stark contrast to a previous psychiatrist who had also trained as a psychotherapist and attempted to reject medicalised descriptions of behaviour and explore meanings behind behaviour and the context in which anorexia had developed, often to great effect.

This power to define is not merely restricted to the psychiatric profession, but exists and is misused in more general medical settings, for example in the practice of forcing caesarean sections on women, ignoring the mother's perspective and embodied experience, where subsequently many caesarean sections have been found to be unnecessary, or in the dominant discourses around breast feeding as best (Pylypa, 1998, p31).

Contemporary medical discourses often reframe normative events as in need of treatment, for example baldness as needing medical attention, or social and personal difficulties (such as social phobias) as being medical problems (Summerfield, 2004). Within the historical and contemporary context of anorexia it becomes essential to question the dynamics of power within medical discourses that offer 'health' and reduce 'risk' and specifically in the arena of anorexia. I contend that the medical profession can become both the source of wellbeing and define hegemonic descriptions of what it is to 'be well'.

A psycho-medical description and position on anorexia, as well as some other psychotherapeutic and feminist discourses intended to aid recovery and move towards health, often ignore the complexities of the patients' lived and embodied experience and, even more worryingly, the very violence and objectification of treatment itself ignores the voice of the patient, treating dissent from treatment as attributable to the irrationality of the 'illness', and the treatment itself as "for their own good" (Saukko, 2008, p33)[25].

Bordo (1993, p67) states "In the medical model, the body of the subject is the passive tablet on which disorder is inscribed". She continues to describe how anorexia is not merely an attempt at thinness, but a search for a means by which the body can speak. This notion of embodiment is one lost to medical descriptions of anorexia, where Cartesian beliefs abound and the physical and psychological are seen as discrete. As Summerfield (2004, p242) points out, the recovery is often harder than the suffering, with medical discourses locating suffering within the psychological and psycho-medical, excluding the context of the 'sufferer's' world. Summerfield adds that from

[25] A common discourse amongst professionals can be that due to starvation the client's brain is not functioning correctly and that any position taken by the sufferer that is contrary to the professionals' perspective is due to the starvation. As Hannah said "I know I have anorexia but this is me speaking, it's not always anorexia, why won't you listen to *me*?".

1982 to 2004 the number of psychiatrists in the UK doubled; there was a 50% increase in clinical psychologists from 1999 to 2004 and a tripling of membership of the British Association for Counselling and Psychotherapy [26] in 10 years to 2003. He continues, describing the exponential rise in diagnosed psychological problems. There has been such a move from narratives of human resilience to human suffering within recent decades (ibid) that it can be argued, within a pathologising medical discourse, that normal reactions to trauma are the product of deviance. Where once the conversations might have been about normal reactions to abnormal circumstances, nowadays, within medical descriptions fuelled by psychiatry and pharmacology, these have become descriptions of deficit. In 1966, for instance, the surviving children of the Aberfan mining disaster returned to school within two weeks and, whilst there was undoubtedly trauma, a discourse of resilience prevailed.[27]

A cross-cultural perspective of 'madness' makes a significant contribution to the issue of diagnosis. A task force set up by the US National Institute of Mental Health to focus on criticism of their diagnostic manual, DSM- IV, concluded that culture can influence the expression of psychiatric disorders (Mezzich, Fabrega, & Kleinman, 1992). Bentall (2003) notes that the recommendation of the task force to include anorexia nervosa as one such culturally bound description was not taken up, reinforcing the medicalisation of anorexia.

The distribution of western health practices carries with them core elements of Eurocentric values, regarding such beliefs as explanations of human and child development, definition and constructions of the nature of self, and notions of moral authority (Summerfield, 2004, p240). With the spread of western thinking, western illnesses such as anorexia, depression and post-traumatic stress disorder, travel in unison (Watters, 2010). For example, Lester (2007) in exploring normative descriptions of mother/ daughter separation, in a context of eating disorders in Mexico, states that anorexia "exemplifies the acculturation hypothesis of eating disorders, namely, that

[26] As a psychotherapist, I have to question the growth of my profession and think of when I become a part of the problem rather than part of the solution. See, for example, (Hillman & Ventura, 1993)

[27] My own life script of overcoming emotional difficulties has contributed towards a belief that narratives of resilience are more beneficial in promoting change than descriptions of problems. This echoes, in part, the stance of solution focused brief therapy, a member of the systemic therapy family, and assists me with reflecting upon whether I am contributing to descriptions of deficit or ability in my clients with their fight against anorexia.

anorexia and bulimia are culture-bound syndromes, tied to post-industrial capitalist development and neo-liberalist values and that their appearance elsewhere is indicative of acculturation to those values." In doing so she also questions normative descriptions of family as promoted by western psychotherapies. At the same time, other culturally bound descriptions of mental illness such as koro in South East Asia and zar in the Middle-East are condescendingly described under DSM-IV as "culturally bound syndromes" (ibid), with no sense of reflection that all descriptions are culturally bound.

To conclude, at the psycho-medical polarity there is the capacity to objectify and subjugate 'sufferers' of anorexia (although the capacity to subjugate and be unaware of power practices sits within all relationships, including those that seek to avoid subjugating relationships). Through the legal authority to define psychiatric diagnoses and impose physical interventions the lack of agency, which can be perceived in 'sufferers', can be replicated and yet without occasional physical interventions 'sufferers' can die. This presents a dilemma for the therapist who wishes to contribute to the growth of agency in the patient, but does not wish to contribute to a route that so often leads to physical debilitation and potentially death. Yet, if the therapist evokes the power of the medicalised discourse in the context of risk, there is strong potential for the diminution of the therapeutic relationship, which is the primary agent of change in therapeutic encounters (Miller, Hubble, Duncan, & Wampold, 2010).

2.1.6.2 Exposing Issues of Power

The work of Foucault has been highly influential in assisting systemic therapists to consider issues of power. In considering anorexia the Foucauldian concepts of disciplinary and bio power, together with Bourdieu's notion of habitus, become central to understanding self starvation as both a response to power practices and attempt to gain agency. It is to these factors that I now turn.

Foucault states:

> Power is everywhere: not because it embraces everything, but because it comes from everywhere. . . . Power is not an institution, nor a structure, nor a possession. It is the name we give to a complex strategic situation in a particular society. (Foucault & Hurley, 1984, p93)

In Foucault's view, intention has little to do with power, for example in the case of prisons where crime is not reduced, but a lesser crime (delinquency) is substituted (Gaventa, 2003, a).

Benjamin (1980, 1988) takes a similar position towards power, in seeing it as being everywhere and further posits that we can never rid ourselves of power. In researching gendered power she suggests that culture is dominated by "universal structures of individuality and rationality" (1988, p.215). Benjamin positions these as male attributes and considers how rationality becomes a hegemony that suppresses femininity. She goes on to suggest that this is so pervasive that even feminist positions are subject to these male universals. Problematically, she develops this in recognising that this male domination often does not concern the actions of individual men (who may themselves be against male hegemony) but is embedded in cultural discourses. Thus, when working with female 'sufferers' of anorexia, exposing implicit power discourses is crucial to understanding subjugation and lack of agency. It is also critical to explore the place that women play to comply with male hegemony (Benjamin, 1988; Goldner, Penn, Sheinberg, & Walker, 1990).

Foucault's concept of disciplinary power has direct relevance to the treatment of anorexia, in which treatment has the potential to be experienced as unwanted control, exacerbating the very problem that the treatment seeks to alleviate. Discipline is "a specific technique of power that regards individuals both as objects and as instruments of its exercise" (Foucault cited in Geèienë, 2002, p120). Bio power is Foucault's description of how individuals are complicit with their own disciplining. This becomes particularly useful when looking to the body as the place of subjugation. He moves from descriptions of power as being coercive and dominating to descriptions of power as social control, where people participate in their own domination (Pylypa, 1998, p22). Drawing on Bentham's concept of the panopticon[28], Foucault describes how the 'gaze' of institutions can have a controlling effect on individuals such that they conform to expected norms. Hoy (cited in Eckermann, 2013, p6) makes the point that power can be productive when it opens up new possibilities, but can restrict when it becomes dominating. In the treatment of anorexia, the clinic or therapy room can become the

[28] A theoretical building in which the unseen 'gaze' of prison guards ensures prisoners' compliance with rules.

contemporary panopticon (Warin, 2005), potentially inhibiting collaborative relationships and subjecting patients to a replication of the gaze of society, both in defining norms in eating and weight, and in criticism of the abjected body (at the same time as practitioners within clinics are often subject to the gaze of 'evidenced based practice' and 'good' clinical outcomes as well as normative notions of health). Thus, women are in a double bind of conforming to societal valuing of 'thinness', yet criticised for excelling in their endeavours. This valuing of thinness can also be considered through Fleck's ideas of thought collectives and thought styles (Sady, 2012) in which women 'know' (from dominant discourses) that to be thinner is to be happier, which links to later social constructionist paradigms. This is part of the dilemma of being a woman in contemporary times, where women are anticipated to be the equals of men and yet criticised as not being 'feminine' if successful in that equality. Foucault, then, provides some understanding of the power domains within which anorexia sits. In studying subject and societal relationships, he was not only interested in how institutions could come to dominate subjects, but in the understandings that subjects create about themselves (Samuelsen & Steffen, 2004, p8).

Where I believe that systemic therapy in its pursuit of Foucault's thinking has failed to fully develop an understanding of power relations, is within inter-personal relationships. The work of Bourdieu has been surprisingly neglected in this regard. My search of two leading family therapy journals[29] revealed 117 papers that cited Foucault and only 9 that cited Bourdieu.

Bourdieu can be viewed as expanding on Foucault's idea of how subjectivity is formed in power dynamics, providing a complementary sociological understanding of the processes (Hoy, 1999, p11). His three primary concepts were those of 'habitus', 'field' and 'capital'.

The concept of habitus can be aligned in some ways to Bateson's notion of ethos (English-Lueck, 2010, p30). Bourdieu compares it with a train that lays its own tracks or a conductor-less orchestra (Hoy, 1999, p12). Distinct from intellectual understanding, habitus is a practical knowledge of how to proceed, how to act and

[29] The Journal of Family Therapy and Family Process were chosen as being influential to UK Family Therapy and comprehensively searchable.

respond in specific situations, our "spontaneously expressed actions in our social lives" (Shotter, 2012b, p162). Bourdieu, cited in Shotter (ibid) states:

> 'I' as an intellectual 'subject' concerned to execute a rational intention, concerned to take action on the basis of calculated profits and losses, can never be completely the subject of my own practices. As a social agent, I am endowed with habitus, it is inscribed in my body as a result of regularities encountered in my past experiences. Having acquired from this exposure a system of dispositions attuned to these regularities, it (my body) is inclined and able to anticipate them practically in behaviours which engage a corporeal knowledge that provides a practical comprehension of the world quite different from the intentional act of conscious decoding that is normally designated by the idea of comprehension.

Habitus does not require rules or explicit structures, but is bound up in historical, cultural contexts that adjust the course of action of agents within a field. Actions are not pre-determined, but exist in relation to historical events, motivation for action and regulating cultural contexts; habitus sets the tone for future habitus. In this way, habitus has links to Foucault's work on discipline (Schlosser, 2013, p35). Associations can be made with Cronen and Pearce's communications model of the Coordinated Management of Meaning (1980), regularly used in systemic therapy, in which historical contextual and implicative forces recursively influence each other. In the context of anorexia, the ways in which agents, patients, families and professionals act can be attributed to differing forms of habitus.

Habitus exists within fields and there is a recursive relationship between each; habitus can be seen to define a field's structure and the field can influence action and hence habitus. Warin (2010, p38) describes a field as "a structured system of social positions occupied by individuals and institutions. It is also a system of forces that exist between these positions." A field, then, can generate specific habitus, which becomes a 'common sense', and thus unquestioned, way of proceeding. Habitus and dispositions within the "constraints, demands and opportunities within a given field" (ibid) together combine to form cultural practices within a community. The habitus of agents, in a context of anorexia, can exist within diverse fields; those of the clinic, family, wider society and community and, indeed, anorexia itself can usefully be viewed as a field.

Bourdieu (1991) states that the concept of capital should be understood as a form of power and delineates between different types of capital; economic, cultural, social, and

symbolic. Economic capital is the accumulation of wealth, cultural capital can be understood as information and qualifications, whilst social capital is based on relationships (Samuelsen & Steffen, 2004, p5). Symbolic capital is when economic, cultural or social capital are "misrecognised in its arbitrary truth as capital and recognised as legitimate" (Bourdieu cited in Samuelsen & Steffen, 2004). An example of symbolic power, which stems from symbolic capital, can be in the health system, the power to diagnose. When an agent uses symbolic power over another who holds less power, this is viewed by Bourdieu as symbolic violence.

Bourdieu regards the body as a form of habitus, carrying with it historic meaning as also viewed by Foucault, but it can also be seen as a form of capital (Meinert 2004, p12). In the case of anorexia, the body can be viewed as carrying with it symbolic power that others cannot achieve. The ability to self-starve can imbue a power over others 'less determined'. In a context in which other forms of capital have become unavailable through life chances, events and anorexia itself, the capital of starvation might bring compensation in the form of symbolic power. In the encounter with therapist or family member other forms of capital are at play. For the family, the capital might be societal in being a good partner or parent and, in the case of the therapist, cultural capital, through knowledge and qualifications, to resolve the eating problems, whether through the psycho-medical or social constructionist polarities of positioning[30]. This has the potential to create an arena in which all agents are not only competing for capital and using differing symbolic powers and symbolic violence, but in which the participants can be seen to be inhabiting not only common fields but differing fields.

I suggest that fields can be viewed as existing within other fields in a hierarchical manner, similar to Russell's theory of logical types (1908). In the case of the therapist, who might inhabit the field of family therapy, and the patient inhabiting the field of anorexia, both embedded within the field of the clinic, potential for collaboration diminishes and misunderstanding increases. Capital earned within one field can come at the expense of capital in another or, conversely, a deficit of capital in one field might evoke a need for accumulating alternative capital in an alternative field. In the case of

[30] In my own practice I often feel the need, within a multi- disciplinary team, to evidence my worth by having a direct impact upon the psycho-medical measures of recovery, namely increase in weight. Through self and clinical supervision I remind myself of the need to remain curious rather than seek measurable outcomes, if I am to add a useful difference.

self-starvation, for example, in which women can be seen in Foucault's terms to be subjugated by, and collude with, male discourses of femininity, within the field of womanhood protest may come from gaining capital from the willpower required to self-starve (and thus the body becomes a form of capital). Gremillion (cited in Warin, 2005, p107) states that "those who use anorexia as a form of resistance are ultimately self-defeated because they participate in a field of symbolic power in which they are always disadvantaged". This leaves the patient in a Batesonian double bind (1972), with little way forward and despite the best intentions of professionals their efforts can strengthen the very double bind they are attempting to dismantle. To repeat the position of Foucault, intentionality has little to do with power, and the gaining of cultural capital for the therapist can diminish the only seemingly available capital to the patient.

To enter the field of anorexia for patient, family member and professional is to enter a field in which double binds abound. For the systemic therapist, the double bind is in attempting to navigate the polarities between the psycho-medical and social constructionist, in which at one end risk and agency decrease for the patient and at the other risk and agency increase. For the patient, the double bind is that in eating agency is lost through the act of eating and, through not eating agency is decreased with risk increasing the power practices of others, which was arguably the problem in the first place. For the family to intervene is often to increase the anorexic behaviours, and to not intervene is to do likewise.

2.1.6.3 Systemic Perspectives on Power

As previously noted, systemic therapies began around the mid-1980s to take greater account of power. Early cybernetic paradigms had not explicitly taken account of power, although descriptions of relational interactions implicitly viewed the effects of subjugation and discrimination.

Feminist critiques of gendered power (Falicov, 2003; Goldner, 1985; Hare-Mustin, 1987; Jones, 1993; McGoldrick, 1994; Weingarten, 1991) began a process, that continues to this day within family therapy, in seeking to not only take account of issues of cultural, societal and interpersonal subjugation, but to account for power within the therapy room. An anti-discriminatory lens developed within the field of

family therapy, the social graces[31] (Burnham, 1992; 1993; Roper-Hall, 1998), evidences the broad range of issues that family therapy has become concerned with. Just as feminist family therapists brought attention to issues of gender, understanding and exposing oppressive discourses such as racism (Barratt, 1999; Dutta & Singh, 2011; Dutton, El Hadi, Gray, Erskine, & Cox, 1999; Erskine, 2002; Falicov, 2003; Hardy & Laszloffy, 1995; Krause, 1998; Laszloffy & Hardy, 2000; McGoldrick, 1994; Pendry, 2011; Watts-Jones, 2004) and homophobia (Bernstein, 2000; Butler, 2009; Clark & Serovich, 1997; Geraghty & Meddings, 1999; Long, 1996; Malley & Tasker, 1999, 2004; Simon & Whitfield, 2000; Ussher, 1991) became key to being a competent systemic family therapist.

It is not, however, to be assumed that an understanding of discrimination and power practices leads to a therapy that does not, itself, involve the use of power. Whilst it can be clear in some of the early systemic therapies (such as structural, strategic, and early Milan systemic therapy) use was made of the power of the therapist to influence, there is also the potential for power practices within the systemic therapies that can form an attempt to understand underlying belief systems (such as the social constructionist orientated later Milan and post Milan, narrative and solution focused therapies). It may be that social constructionist perspectives can be less colonising, but only if awareness of the potential for obscured power practices are attended to.

The more collaborative and dialogic therapies that take a "not-knowing" (Anderson & Goolishian, 1988) position are intended to pay respect to the understanding of overt power dynamics. Without, however, a conscious attempt to expose the issues of power through dialogic conventions, power can still remain hidden. Anderson and Goolishian's (Anderson, 1997; Anderson & Gehart, 2007; Anderson & Goolishian, 1988, 1990) introduction of collaborative language oriented therapy brought a new turn to systemic therapies. The therapy of open dialogue (Seikkula, 2008; Seikkula & Arnkil, 2006; Seikkula, Arnkil, & Erikson, 2003; Seikkula & Trimble, 2005) further developed this dialogic approach at the same time as Andersen (1987) brought a more dialogic use of the one way screen (first initiated by the Milan team) and the reflecting team approach. Dialogic approaches, in

[31] An acronym for: Gender, Geography, Race, Religion, Age, Ability, Appearance, Class, Culture, Ethnicity, Education, Employment, Sexuality, Sexual Orientation, Spirituality.

contrast to a monologic approach, "invites participants to both influence and *be influenced* to shape and *be shaped* by the interaction, and to be mutually involved in meaning construction" (my italics) (Guilfoyle, 2003).

Shotter (1993a, 2008) uses the term "joint action" to show the reciprocity in dialogic conversations. The use of the not-knowing is an attempt to move from a position of hierarchy to one of collaborative enquirer with the client. In keeping, however, with Mason's critique of the not-knowing and proposal of a position of "authoritative doubt" (2005a) I suggest that consideration, in a position of *informed orienteering*, needs to take account of some 'medical knowing' that is not presented as tentative, but is still offered as an invitation to dialogic consideration.

The dialogic is not immune to power practices and the disclosure of the therapist's inner conversations are fundamental in keeping alive the exposing of power (Bertrando, 2007; Bertrando & Arcelloni, 2006; Rober, 1999, 2005b), as are protocols for conducting dialogic meetings (Seikkula & Olson, 2003). Normalised discourses, to which we are all subjected and promoters of, contain attitudes that are colonising and, therefore, in all approaches, including the dialogic, there is potential for symbolic violence. To this end, the use of a team or co-therapist and the inclusion of attention to symbolic violence is, I propose, a useful way to attempt to reveal power embedded in common discourses.

I propose that it is possible to congruently hold to a dialogic process, in which issues of power are exposed and de-stabilised through mutual enquiry, and at the same time to hold medical risks in mind.

2.2 Systemic Working

Having developed from the anti-psychiatry movement in the 1950s, systemic psychotherapy attempted to move from a view of the individual as boundaried and discrete to one of individuals being constructed in relation to context (from the Cartesian construction of "I think therefore I am" to "You are therefore I am" (Kumar, 2002)).

Dallos and Draper (2000) describe three phases in the development of systemic thinking and practice, which to a certain extent I have described earlier. In the first

phase from the 1950s to the mid-1970s structural and strategic therapies developed, in which the cybernetic paradigm described how people acted behaviourally in relation to each other. In the second phase, from the mid-1970s to mid-1980s there was a shift towards how people responded to differing belief systems. From the mid-1980s to today there has been an inclusion of cultural and societal context and power relations. A fourth phase, not described by Dallos and Draper, is the current shift towards a dialogic understanding of relationships, drawing upon the work of many including Wittgenstein (1953), Bahktin (1981) and Shotter (1993b; 2008; 2011a) . Different understandings of anorexia have developed alongside these progressions in systemic thinking.

2.2.1 Structural and Strategic Models

Minuchin's structural family therapy has been one of the most influential systemic paradigms describing anorexia. Minuchin proposed the concept of the psychosomatic family (1978), in which it was thought that the anorexia evolved within a family context. Specifically, he saw families as being enmeshed with rigid sub-systems and cross generational alliances, which subverted the parental system. Interventions focused on realigning these patterns in order that parents would take control of parenting and, particularly, eating. He regarded the family as the problem.

Eisler (2005) makes the point that there is little evidence for the existence of the psychosomatic family, but nonetheless structural perspectives pervade much thinking around eating disorders, with descriptions of enmeshed families and seeing the anorexia as a by-product of parental conflict and mother-daughter enmeshment. The Maudsley model encompasses some of this thinking in encouraging parents to take control at mealtimes.

Strategic family therapy has also contributed to the Maudsley model (Lock et al., 2001, pp 14-15) in taking an agnostic view as to the aetiology of anorexia. Both Haley and Madanes express a disinterest in the causes of anorexia, preferring to focus on limiting the effects of the anorexia upon the patient and family (ibid). They also propose the use of paradoxical interventions, which also appear in the Maudsley model, in which parents are encouraged to assist refeeding whilst acknowledging that the patient needs to resist these efforts (ibid).

Both of these approaches belong to the first order positioning of family therapy, in which the therapist takes the position of expert to interrupt family interactions. Nowadays these approaches, whilst embedded in the systemic treatment of eating disorders, are generally taken from a more tentative position.

2.2.2 Milan Systemic Approach

In 1974 Mara Selvini Palazolli, a Milan based psychoanalyst, described her struggles to cure anorexia in her patients (Selvini Palazoli, 1974). Joined by three other psychoanalysts, Cecchin, Boscolo and Prata, she initiated a group that studied the work of the Palo Alto Group of systemic thinkers and practitioners (led by Gregory Bateson, often described as the Founding Father of family therapy). Four years later the group published an account of their work with anorexia and psychosis, Paradox and Counterparadox (Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1978).

In this account, the team described how they followed the Palo Alto Group's theory that families were systems, in which behaviour was governed by rule based transactional patterns. They described the notion of homeostasis and utilised paradox to encourage change. Significantly, they moved from a pathologised description of behaviour to the idea of 'positive connotation', in which all family members were seen as attempting to preserve family cohesion. In doing this they began to move accounts of anorexia towards having legitimate purpose in the family.

In 1980 the team disbanded and whilst Selvini Palazzoli and Prata moved towards research, Cecchin and Boscolo continued to develop practice based around belief systems and moved from a social constructivist towards a social constructionist approach.

2.2.3 Narrative Therapy

A follower of the Milan approach, Michael White was an influential figure who developed, alongside David Epston, narrative approaches to therapy (White & Epston, 1990b). Influenced also by the work of Foucault, the pair took a social constructionist approach to problems. Notably they developed the technique of externalisation, that the

problem is the problem, not the person. In doing so they attempted to liberate patients from pathologised limiting descriptions towards understanding that the narrative accounts of problems and identity are socially constructed, dominated by powerful discourses and self-selective.

The concept of externalisation is common nowadays in the treatment of eating disorders, for example in the Maudsley approaches where anorexia is externalised as the "anorexic minx" (Treasure et al., 2007). Hepworth (1999), in the conclusion to her work, advocates a more social constructionist approach along the lines of narrative therapy. Likewise, the work of Maisel et al (2004) is influential and takes a narrative approach towards anorexia.

2.2.4 Contemporary Developments

Dring (2014) suggests that recent research dispels the notion of a genetic aetiology for anorexia, arguing for a return to systemic interventions that locate family factors, including "family attitudes to eating and weight, attachment difficulties, problems with the expression and resolution of conflict and parental psychological control". This return to locating the problems with the family differs from other recent systemic thinking that seeks to work with the effect of the anorexia on family dynamics, rather than seeing the origin located within these dynamics. Dring's contention has become hotly contested in the literature (Dodge & Simic, 2015), the online (restricted) forum of the Association for Family Therapy (AFT List, 2015) and indeed even resulted, in my opinion, in a uncharacteristically biased (against Dring) stance by a guest editor of the peer-reviewed Journal of Family Therapy (Lask, 2015). Whilst Dring and his critics make a useful contribution to the debate I would propose a both/ and approach. The diversity of anorexia is such that in working with families I would suggest a not-knowing position is likely to be more respectful to individual circumstances. Other significant contextual influences such as abuse also need to be taken into account when considering the function of the particular form of anorexia, with childhood sexual abuse, for example, being highly prevalent in cases of anorexia (Carter, Bewell, Blackmore, & Woodside, 2006; Dworkin et al., 2014).

2.2.5 Other Discourses

In addition to medical and systemic constructions of anorexia, family therapists are subject to other professional discourses. NICE offers guidelines for the treatment of anorexia. Alongside pharmacological interventions (“which have a very limited evidence base for the treatment of anorexia nervosa" (ibid)) NICE recommends the various psychological interventions previously discussed. As well as these recommendations, other therapeutic focuses can also contribute to descriptions of anorexia, for instance attachment theories and mentalisation-based perspectives (which incorporate psychodynamic and systemic paradigms and interventions). The guidelines also state that "Psychological interventions are the key element in the management of anorexia. The delivery of psychological interventions should be accompanied by regular monitoring of a patient’s physical state including weight and specific indicators of increased medical risk." (ibid). All of these are constructions to which family therapists dealing with anorexia are exposed.

Along with these are the cultural and societal discourses that the UK population at large is exposed to, often portrayed by the media. For example, in a study of media reports in the USA (Saguy & Gruys, 2010) the authors concluded that anorexia is associated by the media (and therefore to an extent society) with high social status and moral virtue and obesity or binge eating with poor choices and laziness. This work seeks not only to further understand the professional constructions that influence the position of family therapists, but the cultural and societal constructions.

2.2.6 Multi-Disciplinary Team Working

Different professions have different cultures and language. This can often present problems in working within a multi-disciplinary context. Eating disorders teams are, in accordance with NICE recommendations, multi-disciplinary. The systemic family therapist, sometimes the only systemic voice in a team, needs to hold to their own theoretical traditions whilst taking account of the professional system, as well as the family. In working within this multi-disciplinary team (MDT) there are recursive influences to which all professionals are prone. These differing cultures can often be barriers (Hall, 2005) but also professional identities can become more fluid in an MDT context (Reynolds, 2007), in which professional 'self' can become influenced by team

members. Reynolds (ibid) also describes how, at the same time, characterisations of other professionals can become entrenched. In my experience, the search for professional otherness and togetherness can be fraught with complexity in which professional identities can become confused. At the same, time professionals are often expected to become mobile across agency and professional lines (ibid). This contributes to the dilemma for the family therapist of holding their own paradigm whilst acknowledging the validity of, and accepting the influence of, other modalities.

2.3 Reflexivity

Throughout this thesis I am concerned with the issue of reflexivity; critical-reflexivity, especially in relation to the literature and data, relational reflexivity within the interviews and self-reflexivity throughout the process (see section 3.9 for an explanation of these forms of reflexivity).

Four main themes within this work; those of eating, women, distress and power, have followed me throughout my life.

From early childhood I was aware of the significance of food as a form of celebration and my grandparents' abundantly laden tables and continuous breaks for meals and snacks that I recall from my childhood visits. I remember from my youth the bounteous parties that my mother would prepare for friends, family and my father's clients. It was no surprise that I was drawn to train and work in the hotel and catering industry. Later, I would be a partner in a business that built bespoke kitchens and now I find myself working in an eating disorders service. I still find myself drawn to thinking of cooking for friends and family as an act of giving, not mere sustenance. The meaning of food for me is often in stark contrast (or commonalty) to my clients and continually forces me to reappraise my beliefs and consider how my bias is impacting on my positioning. Having a love of food, it can become difficult to understand extreme self-denial.

As a child, I was triangulated regularly into an alliance with my mother against my father (which, through my professional training, I later came to understand as the complexity of their mutual dynamics). What became an insecure childhood, despite my parents' best attempts, has led to a lifelong tussle with attachment issues and

feelings of insecurity. Seeing distress in women has become, in part, a habitus that invites me as (ambivalent) rescuer, a position that I have increasingly seen as being potentially patronising and colonising. My own distress through my upbringing was increased through my parents regularly moving locality (due to my Father's work) and therefore my repeatedly attempting to join groups from the position of outsider and often, through bullying, of being excluded and discounted. This has clear links to the distress of my clients who regularly experience similar feelings of otherness, to which I am drawn to soothe. Where I specifically need be cautious is that in linking my own experiences of subjugation to those of women, I do not lose account of the differences in gendered experiences and of my own male privilege. Throughout this research study I have carried gendered advantage which will have both biased my own perspective and influenced my interviews with the participants, at times in ways that I can see and at other times in ways to which I am blind.

Through my relationship to distress, and particularly women's distress, and my previous work as a Relate clinician and supervisor, I came to have a strong interest in gendered issues of power as well as other forms of subjugation. Of particular concern is considering how my (male) positioning may add to the distress of others, whilst understanding that my ability to challenge (and therefore increase distress at times) is often essential in a process of change. All four of these themes (eating, women, distress and power) have had influence upon my position in this thesis and, indeed, in my clinical work. This has implications for my position on female self-starvation as a means to reduce distress and gain control and agency.

As a white, male therapist I carry privilege (McIntosh, 1998) that will have had influence upon my thinking, both within the interviews as I discuss female forms of anorexia with both male and female colleagues, and of my own perspective of, and clinical work with, anorexia. There is a potential power dynamic in researching for a professional doctorate that has the possibility to replicate the power positions within therapy. In interviewing participants who are aware of the work involved and academic status gained in a doctorate, there is a possibility of the responses becoming more aligned to the (recursive) gaze of the researcher than a reflection of thought and practice, and for the participant to find themselves wanting. At the same time, I was aware of how interviewing colleagues might impact on my script

of being in deficit. Indeed, in my previous relationship to education, having been excluded from my final year of schooling, I carry a script of not being 'good enough' academically.

This work has led me to have huge respect for the integrity and skills of my colleagues, whatever their positioning. In delving deeply into their accounts, I discovered a complexity of practice in positioning that does not appear in the literature to any great extent. My subjectivity will, at times, have led me to misunderstand their accounts and I have striven to compensate for this in my analysis and choice of grounded theory and its process of code saturation. I have undertaken a continual process of self critique and investigation, in which I have attempted to understand my own bias.

In moving from practising research to researching practice, my own work with my clients has evolved during the process of this study. I have become acutely aware of the nuances of my positioning and how this might impact upon the client(s) and their families. Considerations of power and what I invoke have taken on a greater complexity and more comfortable relationship with uncertainty in the context of risk. My clients and I appear to have developed greater mutual understandings of the balance we need to strive between risk and agency and how these can combine to form a more collaborative struggle, as I have developed through my research.

I now turn to considering thoughts around future possible research and implications for family therapy of this study.

2.4 Conclusion of Literature Review

The literature review has discussed the history and range of perspectives within the discourse of anorexia. From early discourses of women giving themselves to God through to contemporary genetic hypotheses anorexia has been defined by others, often in pathologising ways. Whilst there are many accounts of the lived experience of the 'sufferer' these are often negated in treatment, at least at the extremes of chronicity or youth, with dominant notions of recovery taking precedence. Theories of change abound as do the implied positions of the practitioner, whilst it is generally acknowledged that a common route to 'recovery'

remains elusive. The literature, drawn from beyond systemic perspectives, has revealed a complexity of thinking around power that it is uncommon in systemic literature. Whilst the effects of subjugation and marginalisation are increasingly common in systemic literature, and family therapists are expected to have a strong attention to anti-discriminatory practice, insufficient exists in the literature regarding theories that expose power dynamics at the interpersonal level.[32]

3 My Research and Methodology

In conducting my initial literature review I found a paucity of research looking specifically at how family therapists were influenced by various cultural, professional and personal discourses in the positions they adopt towards anorexia. There is, however, a plethora of material that takes specific positions towards anorexia. At the same time, I have been aware of my own practice experience and, together with the initial literature search, how these have shaped my thinking and hypotheses to date, and furthermore how this may have influenced my data collection and analysis. This research has been inspired by my own practice dilemmas and paucity within the literature of how to position oneself in a manner that attends to both risk and the underlying complexities of agency of security in life, in service of and in collaboration with the client. This positioning is often complicated by both the clients and my own differing ambivalences.[33] It is my intention, through my research question and the data collection, that a way of positioning evolves that contributes to the practice of family therapy. In doing so I seek to address my initial research question "What do family therapists consider when positioning themselves within discourses about anorexia?" In asking this I am, to remind the reader, interested specifically in the dilemma that exists in potentially reducing risk but also reducing agency or alternatively contributing to increasing agency but also possibly increasing risk. My intent in undertaking this research is to reveal a theory embedded in the data that, together with my learning from the literature, contributes to the guidance of systemic clinicians in navigating the field of anorexia. It is to my research interviews and data analysis that I now turn.

[32] There are exceptions to this statement in specific cases, for instance of domestic violence, but less so in day to day relationships where abuse, subjugation or discrimination is not obvious.
[33] The client's ambivalence often being around wanting to escape the effects of anorexia whilst keeping the behaviours. My ambivalence in wanting to navigate between risk and agency.

3.1 Brief Theoretical Overview

Social constructionist approaches are integral to contemporary family therapy (Anderson, 1997; Barker, 1981; Carr, 2006; Dallos & Draper, 2000; McNamee & Gergen, 1992). My theoretical position as a social constructionist practitioner has a commonality with qualitative approaches to research (Dallos & Vetere, 2005; Finlay & Gough, 2008; Silverman, 1993; Willig, 2008). Qualitative approaches are commonly and fruitfully used and are applicable to family therapy research (Burck, 2005; Moon, Dillon, & Sprenkle, 1990). In contrast to quantitative approaches, that are based upon a positivist view that there is a knowable truth (Yardley, 2008), qualitative methodologies see the world as containing many multiple truths.

In defining social constructionism Burr (1995) states that there is no one model that describes social constructionism, but that there is a "family resemblance" between various approaches. She, (after Gergen), states that key components of the approach are:

1. A critical stance towards taken for granted knowledge.
2. An understanding that knowledge has historical and cultural specificity.
3. An understanding that knowledge is sustained by social processes.
4. An understanding that knowledge and social action go together.

Willig (2008) writes:

> Research from a social constructionist perspective is concerned with identifying the various ways of constructing social reality that are available in a culture, to explore the conditions of their use and to trace their implications for human experience and social practice.

This suggests a qualitative approach is appropriate, where I am seeking to understand what choices are made of cultural, professional and personal discourses, how they are used and the perceived effects of these on the anorexic 'sufferer'.

In concluding that a social constructionist qualitative approach is in keeping with my view as a therapist and, in accord with family therapy approaches, I considered several approaches to data collection and analysis. Initially discourse analysis held appeal, particularly critical discursive psychology (Edley, 2001) with its specific

focus on subject positions, interpretative repertoires and epistemological dilemmas, that seemed to closely fit with my research question. This methodology, however, would have led me to analysing hidden discourses within my participants' dialogue rather than their perceptions of processes, which are my interest. I also rejected this methodology possibly coming across as too judgemental of colleagues. Foucauldian discourse analysis similarly held appeal, with the previously described power issues involved in positioning on anorexia, but was rejected for the same reason. Interpretative phenomenological analysis (Smith, 1996) was a serious contender as, like my chosen methodology, grounded theory, it focuses on lived experiences, but was rejected as it primarily focuses on internal psychological worlds and phenomena, rather than social processes, and grounded theory is better placed to "identify and explicate contextualized social processes that account for phenomena" (Willig, 2008, p73). The recent innovation of a stance-taking methodology (Everri & Fruggeri, 2014) similarly held appeal, given that it is an attempt to construct a methodology pertinent to the relational nature of systemic psychotherapy, but whilst it would have been a prime choice if I had been researching the positioning interactions between therapist and patient, held less appeal for understanding direct individual accounts. Whilst I did originally consider thematic analysis (Braun & Clarke, 2006), I considered it to be too general for my question. Thematic analysis, as described by Braun and Clarke (ibid) has many commonalities with grounded theory in its execution but loses the line by line focus that I was keen to use. Indeed, when I found myself moving during a coding process from a line to line analysis this confirmed my belief and I revisited the data to conduct a closer analysis.

3.2 Rationale for Choice of Constructivist Grounded Theory

In choosing a methodology I was keen that it was congruent with my social constructionist beliefs and would encompass a dialogic perspective, but one that would account for my own significant relationship to the research question. Yardley (2008, p237) states that "most qualitative researchers believe that the researcher inevitably influences the production of knowledge… attempting to eliminate the influence of the researcher would make it very difficult to retain the benefits of qualitative research". The process of reflexivity allows for an

investigation of the researcher's influence and subjectivity. Grounded theory (which has been used by dialogic family therapists, see for example Rober, Elliott, Buysse, Loots, & De Corte, 2008), rather than starting from a hypothesis starts from the point of the theory that is grounded in the data (Charmaz, 2006) and, by calling for an initial coding line by line, keeps the coding close to the data rather than driven by hypotheses.

This line by line coding can assist towards a dialogic process in which there is a continual movement between the data and the research question, where the data can be seen from multiple perspectives and the research question revised in the light of the data. This is in keeping with a systemic enquiry in which "feedback is taken into account in the building of the research enquiry and in the researcher activity of making connections between categories, and moving between levels" (Burck, 2005). Line by line coding is a heuristic device which assists in the generation of fresh perspectives on the data (Charmaz, 2014). Sullivan (2011) in proposing a purely dialogical approach critiques of grounded theory that, whilst it keeps the participants' experience central to the process, it may not do justice to the complexity of the discourse and subjectivity that comprise the experience. Whilst concurring, I also believe that in interviewing family therapists, who are versed in self-reflexivity, there is ample opportunity in the interviews for exploration of the complexity. The methodology further enhances a dialogic perspective by allowing revision of the interview questions recursively with the interview data.

Charmaz chose the term 'constructivist' in order to "acknowledge subjectivity and the researcher's involvement in the construction and interpretation of data and to signal the difference between my approach and conventional social constructionism of the 1980s" (2014, p14). She criticises these social constructionist researchers as analysing the constructions of data but failing to appreciate that these analyses are also constructions. The methodology is now, however, considered to be in keeping with contemporary social constructionist stances in taking account of researcher reflexivity (ibid).

Finally, Strauss (1987, p34) states "The goal of Grounded Theory is to generate a theory that accounts for a pattern of behaviour that is relevant and problematic for

those involved". It is precisely the difficulty for the therapist and sufferer to align themselves in a manner that is useful to the gaining of capital for both, that motivates this thesis.

Burck (2005) discusses several advantages for grounded theory in data analysis from a systemic perspective, namely, offering a strong framework; having step-by-step guidelines for analysing data; a manner of bypassing researcher hypotheses; developing, through the recursive cycle of comparison of codes to data, concepts through a systemic process and a methodology that is useful in exploring family therapy practice.

3.3 Brief Overview of Grounded Theory

Grounded theory was proposed by Glaser and Strauss in 1967 as a means to move beyond quantitative hegemony in research to evidence that is was possible to bring a logical approach to qualitative methodologies, using an inductive approach (moving from bottom-up observation to emerging patterns, hypotheses and theory) (Charmaz, 2014, p7). They proposed:

- Simultaneous involvement in data collection and analysis
- Constructing analytical codes and categories from data, not from preconceived logically deducted hypotheses
- Using the constant comparison method, which involves making comparisons during each stage of analysis
- Advancing theory development during each step of data collection and analysis
- Memo-writing to elaborate categories, specify their properties, define relationships between categories and identify gaps
- Sampling aimed towards theory construction (theoretical sampling), not for population representativeness
- Conducting the literature review after developing an independent analysis.

Whilst Glaser remained true to their original thinking, Strauss, in collaboration with Corbin (1990), moved away from some of the rigidity of the original approach and in doing so opened the door to other interpretations of grounded theory. Significant in these was the development of feminist grounded theory (Merritt-

Gray & Wuest, 1995), which sought to ensure that women's voices were heard in research, and constructivist grounded theory (Bryant, 2002, 2003; Charmaz, 2000a, 2003), which sought to move from the positivist elements of both Glaser and Strauss, and Strauss and Corbin's versions of grounded theory.

Constructivist grounded theory, which I am concerned with, introduced relativity and subjectivity into the methodology (Charmaz, 2014). The term 'constructivist' was, in part, introduced in order to highlight the researchers' involvement in, and subjectivity towards, the construction and interpretation of the data. Charmaz (ibid) states that her development was in keeping with the work of both Vygotsky and Lincoln "who stress social contexts, interaction, sharing viewpoints and interpretative understands", which is congruent with a systemic approach.

The literature review is a contested area in grounded theory. As previously shown, Glaser and Strauss initially advocated delaying the literature review until after the analysis, in an attempt not to contaminate the data with previous ideas. As many have critiqued, however, (see for example Charmaz, 2014; Clarke, 2005; Dunne, 2011; Thornberg, 2012) the researcher does not come without knowledge, is often versed in the field they are studying and, in the case of academic submissions, has probably had to demonstrate a grasp of the literature to receive the necessary permissions. Charmaz (2014, p307) makes the point that the disputes over the timing of the review often do not account for the point that "any researcher should tailor the final version of the literature review to fit the specific purpose and argument of his or her research report". Consequently, I have undertaken an initial literature review in order to inform my initial thinking and questions, but the final review has been revised in the light of the data analysis to reflect perspectives of the theory grounded in the data.

3.4 Participants

All interviewees were UK qualified family therapists with at least one year's experience of working with anorexia, either in a child and adolescent mental health service, a dedicated eating disorders service, or private practice (Table 1). Eight participants were recruited through an e mail appeal to the Association of Family Therapy Eating Disorders Google Group. The eight were selected to represent

diversity of work settings (NHS and private sector/ child and adult clients), gender and ethnicity and range of original professions. The Names and identifying details of all participants have been altered to preserve anonymity

Name	**Gender**	**Ethnicity**	**Work Setting**	**Original Profession**	**Years qualified as Family Therapist**
Hannah	Female	White British	Private inpatient unit	Psychotherapist	7 years
Richard	Male	White British	Specialist Eating disorders clinic	Mental Health Nurse/Psychotherapist	14 years
Martin	Male	White English	Specialist Eating disorders service (adults)	Mental Health Nurse	16 years
Alice	Female	White British	CAMHS	Psychotherapist	20 years
Claire	Female	White British	Specialist Eating disorders service	Non clinical	9 years
Jaya	Female	Mixed race	CAMHS	Social Worker	15 years
Frank	Male	Black African	Inpatient CAMHS	Mental Health Nurse	21 years
Jess	Female	White UK British	Independent practice	Social Worker	25 years

Table 1 Participants

3.5 Interviews

In keeping with grounded theory, I started with a set of initial interview questions (see 5.5.1). These were developed through the initial literature review and reflections on my own practice. Each interview was coded prior to proceeding with the next interview, and the questions adapted in response to the categories developed in the analysis process.

In order to construct a dialogic approach to the interview and, in keeping with Charmaz's advice (2014, p63), the interview questions were designed to allow a flexible approach, whilst ensuring that my main areas of interest were discussed. The intention was to not force the data into predefined categories but, in keeping with grounded theory, to allow the data to emerge without undue influence from my discourse. The participants were aware of my research interest in advance, but not specific questions. Anderson (2014), in promoting a collaborative-dialogic approach to research, proposes that research can become a "decentralised process of learning that brings in the voices of the people". It "flips about the learning about to learning with" with intent to "call attention to the relational "engagement" and mutually beneficial aspect of the knowledge that is created in the inquiry process". To this end, whilst having some underlying structure in mind, I attempted to also incorporate a more dialogic way of recursively responding to interviewees' responses.

In taking a constructivist stance, I focused on both the content of the participants' story, the relationship between the participants and myself and the context of the interview, using reflexivity in both the data collection and the analysis. I was aware that the data were emerging from a co-constructed interview. It is the "site of the exploration, emergent understandings, legitimation of identity, and the validation of experience" (Charmaz, 2014, p91). It therefore became important for me to, as much as was possible, encourage the participants' voices and to encourage further reflections to emerge from the participants. In order to encourage a culture of reflection I chose to not take notes, but to audio record, and to treat my interview questions as a topic guide only. In listening carefully to my interviewees' responses I sought to deconstruct the emergent phenomena and for us to co-explore the properties of the phenomena.

3.5.1 Initial Interview Guide

From reflections upon my own practice and my initial literature review three main areas for enquiry have emerged; the expert position, the unsettled position and the not-knowing position[34]. Rather than have specific questions I have approached the interviews with interest in these domains, with a view to contributing towards a dialogue around these.

In the expert position I was interested to learn about the positions of expertise that the interviewees adopted around the discourses that they carry about anorexia and the knowledge that guides them.

In the unsettled position I focused on the dilemmas and insecurities that were encountered; how the interviewees dealt with the complexity of positions and how they dealt with being de-stabilised.

In the not-knowing position I was concerned with the ability to suspend desiring an outcome and how issues of power were addressed, the desirability, or not, to attempt to expose and let go of power.

I did, however, use the following initial questions as an aide memoire:

Expert Position

- What therapeutic and other professional training have you received?
- What professional experience do you have of anorexia?
- What systemic concepts influence your understanding of anorexia?
- What ideas, concepts, from other professions and or colleagues influence your understanding of anorexia?

[34] These positions, whilst not originally validated by my data, became evident through reflective conversations in supervision in considering my experience, the research question and the literature review. They also emerged within discourses around power and knowledge. The positions emerged both inductively and deductively from the data.

Unsettled Position

- What personal, societal and cultural discourses influence your understanding of anorexia?
- How do you see these various discourses contributing to your work in cases of anorexia?
- How do these discourses combine to assist your position on anorexia?
- How do these discourses combine to conflict in your position on anorexia?
- What dilemmas and contradictions arise in working with these various discourses and how do you resolve these?

Not-Knowing Position

- How do you believe the positions you take influence your clients' positions on anorexia?
- How do you see issues of power in your positioning on anorexia?

These questions are nuanced developments of my original research question "What do family therapists consider when positioning themselves within discourses about anorexia?". Whilst the research question was broad, in keeping with Charmaz's thinking (2014), my holding in mind these three position categories and aide memoires enabled me to contain my actual interview questions, as they developed. In keeping with constructivist grounded theory (ibid) my interview questions were informed by preceding interviews. Also, in keeping with the methodology codes that appeared to stand alone were not ignored as these often contain new directions of useful enquiry.

For example in my first interview, with Hannah, the theme of a genetic aetiology arose. Somewhat to my surprise when I questioned Hannah as to her views on anorexia (informed by my aide memoir of 'What systemic concepts influence your understanding of anorexia?') she answered "I get quite cross when people say it's all to do with fashion. And I get cross when people say 'they bring it on themselves', because there's an element of susceptibility or genetics". When I later asked, informed by my curiosity around her earlier answer, "how systemically would you explain the emergence of anorexia?" Hannah replied ". . . I don't think

my explanation is systemic. I think the explanation is about the biology of starvation".

I was struck by my surprise at Hannah's positioning (and her rationale that I discuss later in the category **considering anorexia**), which led to a richness of enquiry with other participants. Hannah's thinking encouraged me to look further at genetic research and hypotheses in my literature review. Prompted by this, I enquired in dialogue with Richard (my second participant interview) how he would explain anorexia from a theoretical perspective. He replied ". . . I don't think there is an anorexia gene". The dialogue developed with my referring to international studies of genetic links to anorexia (that I had learnt about from my further literature search) and Richard positioning "they'll no more find an anorexia gene than the related schizophrenia project found a schizophrenia gene".

The theme continued with, for example, my asking of Alice (interview four) "more and more we are getting some people who advocate the genetic base so I don't know what your current stance on it is – do you think it is genetic?". Alice responded: "I don't see any link genetically. I really don't. We have got a few families where the mother has also struggled with anorexia; I would say that the temperament is more genetic". In my sixth interview I asked of Jaya "So you don't like, for example, the genetic explanation?" with the response "No, I don't lean towards genetic things very easily so I knew it had to be looked at systemically".

In the above examples the participants' responses informed my questions in the following interview. By the time I had reached my final interview, I considered the codes around genetic explanations to be saturated (Charmaz (2014) states that it is the researcher who determines when she/ he considers saturation to have occurred) and my questioning had moved away from this field of enquiry.

3.6 Ethical Considerations

In considering ethical issues in my research, I drew upon the British Psychological Societies directive (2011) in considering respect for the autonomy and dignity of my interviewees and seeking to minimise harm and maximise benefit. In my initial

approach, I made participants aware of my research question and interest and ensured that I was available for discussions at all stages of the process. In taking a dialogic position I sought to be transparent and collaborative about the process at all times.

At the beginning of each interview the consent and information form was read and room given for discussion. I explained that the interview could be stopped by them at any time, that they were not required to answer any question and that they could withdraw from the research at any point of the process. Given the nature of the research question and the profession of the participants, I did not anticipate distress, but we discussed that if this were to happen we would talk over what support they felt they needed.

The audio data, written transcripts (other than those in the final thesis) and any identifying notes were securely stored and it was agreed that these would be destroyed, by me, at the end of the Doctoral degree (See Appendix 4 for a sample transcript).

3.7 Data Collection and Analysis

Having audio-recorded and transcribed the interviews I inserted them into computer assisted qualitative data analysis software (CAQDAS), MAXQDA. CAQDAS is increasingly used to contain complex data and to assist in its analysis across a range of methodologies, including both deductive and inductive. MAXQDA is particularly suited to grounded theory (Kuş Saillard, 2011). It enables the sorting and categorising, by the researcher, of large quantities of data in an easily visible manner (appendix 5).

The data was analysed by initial line by line coding. At this stage codes were in vivo or as close to the data as possible. This was the beginning stage of the theory development. Charmaz suggests the following strategy to assist with coding and to begin developing theoretical categories:

- Breaking the data into their component parts or properties
- Defining the actions on which they rest
- Looking for tacit assumptions

- Explicating implicit actions and meanings
- Crystallizing the significance of the points
- Comparing data with data
- Identifying gaps in the data

Once the initial coding was undertaken it was searched for significant or frequent codes which, in turn, were grouped into focused codes which further assisted in discovering the theory grounded in the data. Focused codes were then clustered around axial codes, which specify the properties and dimensions of higher categories. At all stages I wrote memos attached to codes or free memos, which reflected the development of my theoretical thinking and reflexivity (see appendix 6 for examples). Finally, the codes were organised into theoretical codes. This final coding was drawn from a constant comparison of data with data and memos, in order for the theory to emerge from the data, rather than the data being forced into codes.

3.8 Triangulation of Data

A full draft of this work was submitted to all participants to ensure fair representation of the data. I also submitted the work to a number of systemic and/ or eating disorders colleagues for consideration and comment, at various stages of development. As well as my academic supervisor, I consulted with the Editor of the Journal of Family Therapy for her systemic and academic perspective. Finally, I compared my findings to the literature for validation. Whilst there was no disagreement with my interpretation of data (including the participants, whose voices were being interpreted) feedback from colleagues helped inform my thinking. For example, I wrote in my initial literature review:

> If anorexia is viewed as a form of embodiment, Butler (1988) would urge us to regard it as both an expression of agency and, at the same time, an expression of gender subjugation, in which the anorexia becomes an expression of the contradiction between agency and subjugation (and goes some way to explain the ambivalence found in so many cases of anorexia).

In response to this one reader replied:

> *I think it is more complex than this; the sufferer feels she is in control of her body, as self-authoring and resistant to the forces I refer to as the "body police" who threaten her autonomy, but she also knows, paradoxically that she is out of control and in servitude to the anorexia. So even the anorexia if is a master it serves as well as a means of self expression and creativity. Talk about a double bind! It's a very complex web in which she is entangled with a multiple legged spider at its centre.*

This, in turn, led me to consider deeper the advantages of anorexia to my clients as shown in my subsequent research memo:

> It is too simplistic to focus on the debilitating effects of anorexia. My observation of both those who wish to escape but also those who clearly state to me that they do not want to lose their relationship to anorexia must lead me to consider more deeply the advantages of anorexia. I need to explore the literature further, especially around Butler's thinking.

This resulted in my adding to the original paragraph the following:

> Butler regards gender as being a performative act, in which performance creates gender, through repetitive actions; what is viewed as fixed identity is constructed through performing dominant gendered discourses. Through her thinking gender is regarded as an action (an embodiment) and, if gender is constructed through actions, there is a possible locus of change in disrupting cyclical patterns of action (2002). Anorexia can, in instances, foster a feeling of empowerment and autonomy, offering a means of self-expression and yet paradoxically, because it becomes clear over time that anorexia also demands servitude, the sufferer is in a double bind of ambivalence.

It also led to my consideration of Warin's position of anorexia as having the power to be productive.

3.9 Conclusion of Methodology

Issues of Self reflexivity, ethical issues and dilemmas

Reflexivity is not a process reserved for the therapeutic encounter alone, but is critical to all relationships. Archer (2012, p1) discusses how it is no longer sufficient to rely on habitus to navigate, but that we now need to apply a reflexive process to guide us through increasingly new situational contexts. Any research encounter needs to take heed of both the researched and the researcher. Indeed, Von Foerster (1981) stated that the act of observing influences that which is observed, and Cecchin et al. (1994) reminded us that we all carry bias that shapes what we observe. Thus, it becomes impossible to totally discriminate between what is being observed, the subjective prejudices through which we see events and our effect on what is observed. Any researched event then contains complexity that the process of reflexivity can assist us to, in part, untangle.

Reflexivity, in contrast to reflection as a process of thinking retrospectively about an event, "involves a more immediate, dynamic and continuing self- awareness" (Finlay & Gough, 2008, p ix), and, as such, involves both reflection in the moment together with an invitation to action (which may be a decision to not act).

As a researcher of the various perceptions of fellow systemic therapists within the discourse of anorexia, I brought my own strong experiences and belief, based upon several years of working within this domain (as well as personal accounts discussed later). As such, for me, constructivist grounded theory became the most likely choice to assist me to distance from my prejudices. From the construction of the research question through to the collection and analysis of the data and concluding discussion, it has been imperative to consider my reflexivity. Cunliffe (2014) draws distinction between critical-reflexivity and self-reflexivity. Critical-reflexivity she describes as:

- Exposing the situated and provisional nature of our social and organisational realities and knowledge
- Destabilising and deconstructing truths, ideologies, language, overarching narratives, single meanings, disciplinary and privileging practices.

Critical reflexivity is a deconstructionist process (after Derrida (1976)) that seeks to explore the social constructions of 'truth' and has been useful to my critical analysis of the literature and the data.

Self- reflexivity Cunliffe describes as:

- Exploring how we constitute our social and organisational experience and identities in everyday interaction
- Exploring multiple meanings and interpretations, possible responses, actions and our moral responsibility to others (which she regards as dialogism)

Self-reflexivity is a constructionist process, which seeks to explore what occurs between individuals, and has aided me in thinking about the relationship between not only myself and the topic but also between myself and the participants.

Both forms of reflexivity are an invitation to bring doubt and invoke a responsibility to act in an ethical manner.

Within this frame I was concerned about the impact of my enquiry upon the participants. In bringing my own bias I attempted to mitigate the effect through a process of dialogic interviewing, using carefully considered areas of questioning rather than specific questions, in which the participants felt as free as possible to not feel judged by me. I considered that the more dialogic the process the more open to mutual curiosity and movement we both were. This concern around potential feelings of judgement extended to my analysis and its construction. With varying perspectives, some of which were close to mine and others further afield, I held this in mind in order to attempt a both/ and position rather than aligning myself within my bias. By attempting a dialogic interview I hoped to reveal my own uncertainty as both a process of destabilising power and promoting curiosity. In preparation for the interviews I thought carefully about how to use language and what impact my questioning might have on the participants. The shared language of systemic therapy provided opportunities for mutual understanding of complex descriptions but also the constraint of assumptions, if not explored more deeply. I considered previous conversations with colleagues and what made for a dialogic

process in which I might suspend my bias and facilitate opportunity for the complexity of the participants' responses.

4 Data and Codes

4.1 Introduction

What follows is an overview of the data and the emergent codes. After doing so, I describe the codes in greater detail and locate them in examples from the interviews, beginning with summaries of the categories.

The coded data revealed five main categories from which the theoretical codes emerged; considering anorexia, considering the patient, considering the family, considering the wider system and considering the family therapist (figure 2). The relative constitution of line by line (initial) codes is given in table 2. I have also shown the percentage that each participant contributed to each category and axial code (table 3) in order to demonstrate the diversity of responses and that the codes are emergent from the data, rather than the data having been forced by the interview questions. Following, is an overview of the axial and focused codes pertaining to each category (tables 4 to 8).

These categories also represent the main actors in the relationship that the family therapist encounters within the field of anorexia. Directly, she/ he will encounter the patient, the family and possibly a co-worker from the MDT (including possibly one or more family therapists). Anorexia is also directly present in the therapy. Indirect influences upon the position taken by the therapist are (again) his/ her colleagues, the agency and wider society and culture. Finally, the therapist's own personal and professional self (and internalised others such as the supervisor) bring strong influence on the positioning of the therapist.

The dominant category was identified as considering the family therapist with the other categories influencing this core category (figure 3).

It is important to note that whilst examples are given of participants' responses these cannot do justice to the complexity of their perspectives. The act of exemplifying is reductionist and can lead to an impression that the participants'

position is their only one. In the analysis that follows all participants expressed multiple views and positions. In the words of Richard "Earlier on in the interview I was worried about not having enough of a position or not having one particular piece of theory that informs me the most." Richard expresses my concern that the examples should not imply a lack of complexity or multiplicity in the respondents' positions.

Finally, the theoretical codes that emerged from the axial coding raise three significant questions; by what process do the positions evolve, what are the positions (taken) and what actions are prompted by the positions? These become, later in the discussion, the basis for my emergent thinking around *informed orienteering*.

4.1.1 Overview of Codes

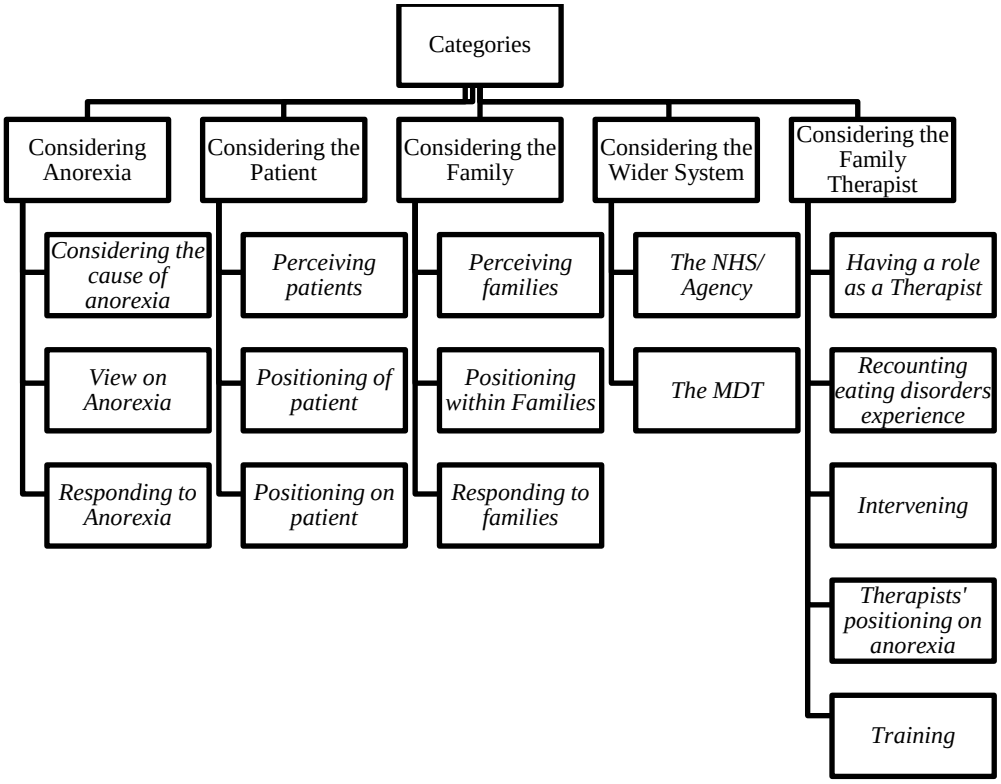


Figure 2 Categories and axial codes

Category	Number of initial (line by line) codes	% of all initial codes
Considering Anorexia	188	18
Considering the Patient	65	6
Considering the Family	61	6
Considering the Wider System	52	5
Considering the Family Therapist	692	65

Table 2 Relative size of categories

Category	Hannah	Richard	Martin	Alice	Claire	Jaya	Frank	Jess
Considering Anorexia	41	18	6	10	3	12	6	4
Considering the Patient	13	3	3	3	17	7	0	54
Considering the Family	21	0	11	7	23	10	3	25
Considering the Wider System	20	16	22	6	8	6	0	22
Considering the Family Therapist	22	19	8	10	12	10	13	6

Table 3 Participants contributions to categories as % of whole

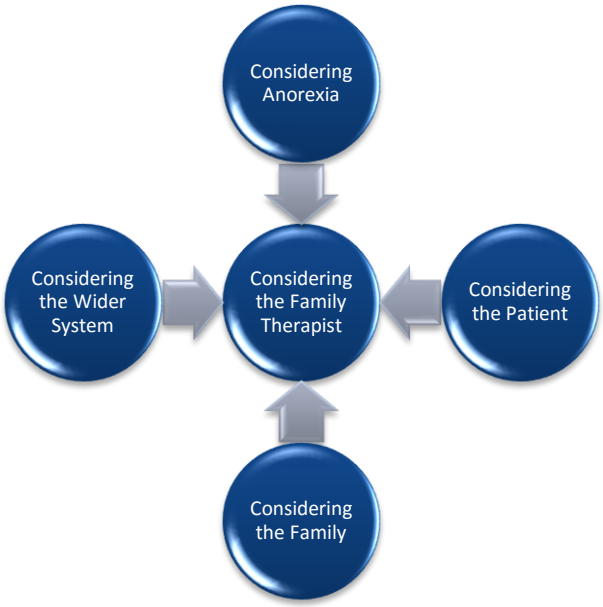


Figure 3 Relationship between categories

4.1.2 Overview of Axial and Focused codes

Category: Considering anorexia

Axial Code	Focused Code
Considering the cause of anorexia	Describing unknown causation Describing unintentional causation Describing protest causation Describing multiple causation Describing family causation Describing biological causation Describing attachment causation Describing societal causation
View on anorexia	Viewing Anorexia as bad Viewing Anorexia as not all bad Viewing Anorexia as friend and foe Seeing Anorexia as enduring
Responding to anorexia	Describing complexity Understanding nature of anorexia Naming stereotypical perspectives Confirming dominant discourses Discounting discourses Considering what it's like to have anorexia Emotionally responding to anorexia

Table 4 Considering anorexia; axial and focused codes

Category: Considering the Patient

Axial Code	Focused Code
Perceiving patients	Seeing positivity Seeing negativity Seeing people as unique
Positioning of patient	Experiencing treatment Fighting anorexia Seeing anorexia as restricting Seeing anorexia as empowering
Positioning on patient	Leading client Discounting patients Getting alongside

Table 5 Considering the patient; axial and focused codes

Category: Considering the Family

Axial Code	Focused Code
Perceiving families	Understanding parents Considering family assets Families in action Family as depleted Family as privileged Seeing originally about family crisis
Positioning within families	Supporting parents or family Aligning with parents Taking view of family
Responding to families	Seeing problems in families' preparedness Seeing problems in families' behaviour

Table 6 Considering the family; axial and focused codes

Category: Considering the Wider System

Axial Code	Focused Code
The NHS	None
The MDT	Relationship to MDT Advantages of MDT Problems of MDT

Table 7 Considering the wider system; axial and focused codes

Category: Considering the Family Therapist

Axial Code	Focused Code
Having a role as a therapist	Getting post Being self of the therapist Doing tasks of therapist Incorporating psychological and medical Needing to be as therapist Relationship to change Describing feelings of working with anorexia
Recounting eating disorders experience	Describing current post Initial experience Working on inpatient unit
Intervening	Focusing on behaviour Focusing on belief systems Focusing on contexts
Therapist's positioning on anorexia	Expert position Unsettled position Not-knowing position
Training	Original training and understanding Need for training Studying formally Studying informally

Table 8 Considering the family therapist; axial and focused codes

4.2 The Categories

4.2.1 Category: Considering Anorexia

4.2.1.1 Summary

The category considering anorexia emerged, unsurprisingly given the research question, as a central theme within the interviews.

The perceived causality of anorexia has a strong implication for the position taken by the therapist within the anorexic discourse. If the psycho-medical model is followed then causation is directly linked to treatment. Wampold and Imel (2015, p155) point out, drawing on Follette and Houts (1996), that DSM disorders "are categories that contain multiple etiological pathways and that treatments specific to the pathways are needed. . . there is little evidence that the predications of an

interactive effect of treatment and etiological pathway exists". Their argument is that if the medical model were sufficient to explain the results of psychotherapy, then their evidenced uniform efficacy of treatments for specific disorders would require further investigation. This leads to their position that "clients within disorders are heterogeneous with regard to the causal factors creating the disorder and, therefore, different specific ingredients are needed to address the specific deficits, regardless of diagnosis" (p229). There was diversity in response with the majority of participants expressing a multi-causal explanation but with strong diversity across a psycho-medical explanation, ranging from a view that anorexia is genetic and biological through to rejection of this position. Similarly, different weight was given to a social constructionist view.

The diverse range of views of anorexia expressed, from friend to foe, similarly contribute to the positions taken. It seems that the further the therapist is distanced from the notion that anorexia may be contributing, in some way, to the quality of life the further the therapist will, as Alice does, take the position that it is a bad friend. Whilst there were varying views on anorexia none, interestingly, stated sympathy with Warin (2010) that it might be transformative.

Finally, the emotional responses to anorexia, with description such as "very sad" and "heart breaking" were common to all participants. This provokes a particular dilemma for the therapist, who may be experiencing distress at their client's position and yet feeling a need to take a therapeutic position that possibly increases the immediate distress through potentially enforcing a challenging psycho-medical position.

Table 9 indicates the extent to which participants contributed to this category.

Axial code	Hannah	Richard	Martin	Alice	Claire	Jaya	Frank	Jess
Considering the cause of anorexia	63	88	42	72	0	78	92	29
Responding to anorexia	32	0	42	0	25	22	0	71
View on anorexia	5	12	17	28	75	0	8	0
Total of participants whole	**30**	**19**	**13**	**19**	**3**	**22**	**12**	**7**
Total of data whole	**41**	**18**	**6**	**10**	**3**	**12**	**6**	**4**

Table 9 Participants' contributions to considering anorexia category as %

4.2.1.2 Axial code: Considering the Cause of Anorexia

Focused Codes (denotes number of initial codes)*
Describing unknown causation (5)
Describing unintentional causation (6)
Describing protest causation (10)
Describing multiple causation (8)
Describing family causation (11)
Describing biological causation (38)
Describing attachment causation (22)
Describing societal causation (27)

*The number, in brackets, of initial codes does not account for the weight of each code (for example one participant may disproportionately constitute the code) but is given as an indication. This applies to all focused code tables that follow.

It is a dominant discourse that seeking to discover causes is unhelpful in the treatment of anorexia (Lock et al., 2001). Contemporary research attempts to find explanation and understand complexity in order to improve treatment (for example, Aquilina, Agius, & Sharma, 2014; Herpertz-Dahlmann, Seitz, & Konrad, 2011). An understanding, however, of the nature and, by implication, the cause can be of assistance to families or patients directly. Frank expresses how families are often seeking to understand causes (possibly looking for exoneration or to understand

who did what wrong) "…*because sometimes people will say things like 'if only I knew why things are the way they are'*, and, *my standard response is 'what difference do you think it would make to you if you knew?', and they say 'then, it would help me'."*

The dominant consensus amongst the participants was that anorexia is multi-factorial and complex. The many facets of explanation contribute, as developed through the later theoretical coding, to the positioning on anorexia, and subsequent therapeutic interventions.

All of the participants work either in dedicated eating disorders settings or have this work as a significant element in their caseload. The seeking of a cause can be aligned to developing an understanding of anorexia. Without a theoretical explanation of a causal discourse it can be experienced as a confusing phenomenon, which can lead to a confusion of positions. This is illustrated by Jaya in describing her earlier work with anorexia:

> *Well first of all it was very rare that I saw anybody with anorexia, in that last, beyond three or four years ago I would have one or two cases a year. So I didn't ever really get a sense of it, I didn't really have a great deal of thought about it. I always thought it was very perplexing, very strange.*

There are, however, many commonalities and differences in the participants' positions towards causation explanations. Hannah regards genesis as being largely unintended whist others take the same notion that it is unintended, but see complexity. Hannah states: "*The far, far biggest majority of my patients are ones with, it's basically a diet that's gone wrong"* and "*I think what I'm saying is there is a minority of people for whom it has been a strategy".* Richard says: "*It is tricky because there's a really complex interplay between a person's vulnerability and whether that's to do with a genetic vulnerability or a biological or physiological or some other vulnerability".*

This contrast in Hannah's and Richard's position exemplifies a dilemma in relation to the certainty of positioning. For Hannah, there appears to be more of a certainty about the nature of anorexia in relation to some of the other participants. The tension between knowing and not-knowing in a context of risk can be unsettling, as described by Mason in his position of authoritative doubt (1993), and what he describes as "the ownership

of expertise in the context of uncertainty" (2008). Hannah and Richard demonstrate a spectrum along which the other participants are aligned at differing points.

Richard is alluding to the multiplicity of causes (and therefore lack of intention) that he sees, describing:

> *One of the things that makes eating disorders a very interesting area to work in, is the mix and the range of influence is so broad that it kind of makes a mockery of anybody who would try to say I think it's primarily a biochemical, primarily a brain structure or primarily stress related or primarily… I think it really is kind of a car crash of different things.*

In looking to recovery, in the context of cause, Hannah believes: "*How you got there at this point of time because you are there, is less relevant than you are there",* with Richard adding: "*The symptoms for everybody with anorexia are really, really similar, alarmingly similar, but that their routes in are radically different and their routes out are also different".* Martin demonstrates a commonality with Hannah in saying: "*In a way I'm not that bothered to know why people have got an eating disorder but what I'm much more interested in is why they are not giving it up or what is it that the system is doing around them that is perpetuating it".*

A common view of anorexia in the data is that it can be seen as a form of protest (often against objectification or oppression) (Gremillion, 2003; Orbach, 1998). This was strongly identified by a number of the participants:

> *I think where people get more into recovery they become wanting to protest about this objectification and about what… it kind of dawns on people this is what I've been, I've been subject to… and it's wrong. But I think sometimes its origins seem different, they do feel more, more protesty. So I think those would be two big ones, protest and the kind of the way women's bodies are viewed, assessed and judged and how much stronger that seems to be becoming over time.* (Richard)

Jaya stated: "It is a real embodiment of something that has gone on and going on for these women", whilst for Jess*:* "*They might develop an idea that growing up to be an adult woman is not a bed of roses, and so they freeze their growing up processes by becoming anorexic".* On the other hand Fran stated: "*I still hold the view that a lot of people with anorexia have got a grievance. They don't necessarily know how to express that grievance".* At the same time Frank points to the greater complexity in stating: "*Not every woman who has been oppressed is going to end up with anorexia".*

This has commonality with thinking about why traumatic events have differing effects on individuals (see, for example, Furman, 1997). The notion of multiple causation, previously described by Richard as a "*car crash"*, adds to this complex interaction between events and individuals. Alice discussed: "*The kind of classic middle ground of anorexia to me tends to be a number of factors that have come along".* Jaya described this as "*multi-factorial"*.

An early structural explanation of anorexia located the problem within the family. Hannah seems particularly concerned to work in a way that rejects this position and describes how she uses biological metaphors and explanations to: ". . . *stop feeling blamed"*.

This is a position advocated, in part, by the work of Easter (2012) in studying how sufferers respond to a genetic explanation. A third of the respondents to this study, however, felt that a genetic explanation might add to feelings of guilt and shame. This leads to the most contentious of the causal explanations, the psycho-medical and genetic hypothesis.

Hannah took a firm position when asked how she would describe anorexia systemically, stating:

> *I don't think I'd explain it systemically, I think there's a lot of, I don't know if you'll find this with other people, I think there's probably quite a lot of what I do which is pure information, psycho-education and more biological, I don't think my explanation is systemic*.

Certainly Hannah was in accord with other participants in seeing delivering psycho-education to the families as an essential part of her task. The lack, however, of a systemic explanation raises an important point in positioning, which is addressed later in my development of theory; namely how can the therapist take a position that feels secure enough for she/he to maintain their own sense of agency in a context of high uncertainty and risk. Hannah tends towards a genetic explanation of anorexia, reinforcing the psycho-medical position. In discussing the recent article by Dring (2014), which as mentioned previously rejected a genetic causality explanation, Hannah stated: "*It says there's no evidence for genetics at all – we don't know because they're only starting to do the research now"*. She

adds "*I think it's not only genetic it's biological because I think there is a genetic susceptibility and we don't know"*.

Whilst seemingly being positioned differently than other participants Hannah in fact expresses a more complex explanation in stating:

> *But that's not genetic, that's more susceptibility but I do think there's more going on than, you know, well she just starves herself? There are cases, I think, when people are in such difficult situations at home that their only solution is to do something radical*.

Genetic predisposition is endorsed by others (though not necessarily a direct genetic cause to anorexia) with, for example Alice saying: "*I would say that the temperament is more genetic"*. Richard expressed: ". . *but they'll no more find an anorexia gene than the related schizophrenia project found a schizophrenia gene."* but considering "*…it might be a gene that's to do with perfectionism or tolerance of uncertainty or something like that"*.

This rejection of an anorexia gene is endorsed by others, for example with Jaya stating: "*I didn't ever like the biological – that it is just a biological thing"* and Alice discussing that: "*I don't see any link genetically. I really don't"*.

Psycho-social explanations are, in keeping with the systemic paradigm, common to all interviews. Martin explains: "*There are physical and psychological consequences of starvation, and these are restricting and all the rest of it, but the motivation, and the reason that people have them, is a way of dealing with their emotional and interpersonal lives"*. Hannah is in accord, believing that: "*Anorexia is just like any other manifestation of psychological distress"*. Frank expands on this saying:

> *So my assumption was that something else, I don't know what, but it is that something else which then triggered the way of coping, which resulted in somebody taking it out on themselves. It's a way of saying either 'I can't cope with this' or 'look at what you're doing to me, that if only you stopped, then perhaps I wouldn't suffer in this way'*.

Societal and cultural causes are viewed as having a contribution by some of the participants. Jaya, who expresses a deep interest in cultural perspectives, states:

> *It's interesting that one, the body image thing, because that does seem to be a bit of a western phenomenon from what I can tell. Other cultures like*

Chinese and South Asian, if they were presenting to a clinic like ours, they wouldn't necessarily report body image issues, which might throw us off as clinicians, oh well it's not an eating disorder, so it is not necessarily reported across all societies. I think it is becoming more a language to use, a Chinese young woman might now say, oh I look fat but earlier on in the kind of development of that condition more broadly, they wouldn't report that, they would more than likely report a tummy ache or something different. I think it is interesting, the whole body image.

In accord with the literature review in this area, Jaya and others see societal and cultural values as contributory. Richard reminds us, though, that:

Clearly the images that are in the media are available to everybody but not everybody has an eating disorder, not everybody feels compared. He also states *We've decided as a culture that it's normal to have a degree of shape concern. Then you've got lots of magazines and lots of celebrities; the Daily Mail every day will run stories judging people on their size and shape and their sweat and whatever else they decide to judge. We're quite visual as a society.*

4.2.1.3 Axial code: View on Anorexia

Focused Codes *
Viewing anorexia as bad (6)
Viewing anorexia as not all bad (8)
Viewing anorexia as friend and foe (4)
Seeing anorexia as enduring (1)

The view of anorexia is a prime mediator in determining the position that the therapist takes towards it, and subsequent interventions. Here, uncertainty creeps in with multiple views being held at the same time.

Alice, in describing how she takes, at times, positions of aligning with parents and marginalising the (child) patients' perspective says:

I will reach a connection with them, I will connect with them but I won't be really giving them much space and I will challenge their arguments to me, in are we talking to anorexia now or – but I will position myself with the parents. She goes on to state *I only take that kind of strategy with anorexia. I would not take that with other cases so I don't think that me being a parent makes that a position but I think that probably it is a very scary, very serious illness and so therefore I think if I was a parent of a child who was fading away and possibly going to die then I would want somebody to be absolutely certain that they know what they are doing and that they would be alongside me with that young person so yes, maybe that but I really – it is anorexia that I am battling.*

Alice is very clear in her thinking, that anorexia is bad and needs to be battled with, even if that means going against her normal way of encouraging a dialogue in her patient. This position is mirrored by Frank, for example, referring strongly to anorexia as *contamination.*

Claire was also clear in saying: "*It's just not going to work to be friendly with the illness".*

At the same time the participants described some of the advantages brought by anorexia. For example:

> *So, like it might be that it's brought families together. It might be that the illness has muffled feelings; it might be that it's given the child a voice; it might be that it's given them a sense of potency that it's given them a way of showing anger, what is stress. So I think the ambivalence is much more than just starvation syndrome.* (Claire)

The ambivalence to recovery that exists in clients is also mirrored in what might be seen as contradictory perspectives held by the participants, in seeking to do battle and seeing advantages in anorexia to the client. Richard demonstrates some resolution to this in saying:

> *Do I think that every last remnant has to go? No, no more so than I think every last remnant of the stuff I struggle with has to go by the end of my life. Nonsense, you have got a right to your problems as we do meet some people who feel like the world is not very stable and it's not very controllable and it's unpredictable and it's alarming because of that, so 'school work I can control that and I can do very well on my tests and I can aim for a hundred per cent', I know that I've got that right, there's a right and a wrong and I've got a right to have mine.*

Martin describes how he regards anorexia as friend and foe and therefore the source of ambivalence: "*I make that very clear and explicit to the families, your daughter has a terrible, terrible, decision to make, it can have terrible consequences and it's a comfort and reassurance, it's a friend it's a foe, it's both at the same time".*

Alice, in recognising that anorexia is viewed as a friend by the client, positions herself firmly: "*The best friend is not a good friend, it is a bad friend and I will work with the parents. I position myself very much with the parents".*

The complexity of the advantages and disadvantages, as seen from differing perspectives, makes the treatment of anorexia seemingly an arena of ambivalence. For some the work is in battling with the anorexia, attempting to successfully differentiate between client and anorexia. The task is, however, not always so clear. Richard, in turning to the possible enduring nature of anorexia, explains:

> *You know it's complicated, some people tell me that all the anorexic voice goes away, other people say well it's there but I don't respond to it anymore, and over the years I've come to accept that some people will have a chronic relapsing condition that they have to manage.*

4.2.1.4 Axial code: Responding to Anorexia

Focused Codes*
Describing complexity (3)
Understanding nature of anorexia (5)
Confirming dominant discourses (3)
Discounting discourses (17)
Emotional responding to anorexia (11)

Responses to anorexia were all strong, with the participants expressing both cognitive and emotional responses. Jaya expresses the confusion that can exist in being with anorexia:

> *I have wondered about what to call it as well, do we even call it anorexia, what do you call it, two doctors, male doctors discovered it and fought over who got it first, please! And then the saints and it goes back to twelfth century stuff. It is kind of wow isn't it? And then, how not to get too seduced by it as well. Because it is such a powerful phenomenon and we grapple with it every day and its, bloody hell, what is going on here?*

Claire, on the other hand, responded stating:

> *How would I make sense of it? I mean obviously there's the sort of cognitive distortion that can come with the illness and I think also the illness brings with it sometimes unintended consequences, sometimes the illness has been a solution to, not necessarily a consciously invited by the solution to the dynamics or experiences in the child's life, a young person's life.*

Hannah was keen to reject some dominant discourses around anorexia, particularly those of body image issues:

> *Because there's an element of susceptibility or genetics there are a lot of people who can be quite thin and can be constantly quite thin and not*

succumb to anorexia, in lots of cases it's luck and I think the popular discourse is oh well they just want to be like models, and they did this on purpose and they want to attract attention, I think that doesn't help people.

The more cognitive grappling with the notion of self-starvation was mixed with more emotional responses. Jess, for example, said: *"It's enormously rewarding when people get better"* but also described how she experiences the work as *"very hard work, it's very sad work, because their near ones and dear ones do feel very worried about them all the time, it's very painful work"* adding other descriptions such as "*stressful"* and "*very draining"*.

Martin recounted how:*"It's more heart-breaking for me, that they chose anorexia, they don't, they, it's upsetting, it's left them thinking they've got no other choices"*.

4.2.2 Category: Considering the Patient

4.2.2.1 Summary

The data revealed that the relationship to the patient is complex. The patients were often seen to be in deficit, through the anorexia, through age and through chronicity. The patients' relationship to anorexia, often at best one of ambivalence, appears to contribute to a difficulty in forming collaborative relationships, which often appear to become adversarial. The necessity to engage the family alongside the patient also contributes to a difficult terrain, in which multiple relationships need to be negotiated. Whether to be alongside, leading or following the patient is discussed later in more depth.

Table 10 indicates the extent to which participants contributed to this category.

Axial code	Hannah	Richard	Martin	Alice	Claire	Jaya	Frank	Jess
Perceiving patients	38	0	0	0	18	75	0	26
Positioning of patient	13	0	100	67	64	0	0	49
Positioning on patient	50	100	0	33	18	25	0	26
Total of participants whole	**3**	**1**	**2**	**2**	**9**	**4**	**0**	**32**
Total of data whole	**13**	**3**	**3**	**3**	**17**	**7**	**0**	**54**

Table 10 Participants contributions to considering the patient category as %

4.2.2.2 Axial code: Perceiving Patients

Focused Codes*
Seeing positivity (5)
Seeing negativity (6)
Seeing people as unique (6)

A common theme expressed was of differentiating between anorexia and the 'identified patients'. Just as there were mixed responses, both between participants and within their individual responses, on their considerations of anorexia the same applied to that of considering the patient. As with the view of anorexia, the perceptions of the patient who is presented for 'treatment' in the clinic, strongly inform the positions taken by the therapist within the field of anorexia. A theme that emerged was of the differentiation between different patient groups. There was a difference highlighted in chronicity between inpatients and out-patients and also between age groups. Jess, discussing the statistics that propose that a third of sufferers recover, said: *"When I look back over my life's case load of anorexics, I don't think a third of mine have got totally better, but that's probably because I've seen the in-patient group".*

In discussing age, Jaya offered: "*The fact that she is 17 and a half I have to take an awful lot more cognisance of what she is saying than I would at a 13 year old".*

These comments reflected other participant's views and add a dimension to the positioning. Judgements are made of capacity based on age and chronicity that may

be potentially limiting in the availability of dialogue. Jaya, though, sees no such dilemma and takes a dialogic stance towards the patient:

> *It is a style I like to take with everyone across the age range and with a younger person I know I say things like 'I am really sorry, this must sound horrendous, what I am asking your mum and dad to do', so I have to engage with that person's kind of misery because I have asked their mum and dad to ensure they have cheese next week – so I am having to say, 'I know this is really hard for you but I am trusting your mum and dad to know what is best for you to eat', that sort of thing.*

Such is the complexity of presentation and factors, that perceptions of the patients were difficult to generalise about and is, maybe, best left to Jess who said:

> *It's so hard to generalise, because I do think, despite the knowledge base and the importance of having that knowledge based on what eating disorders do to people and how they impact families, I do still think that every patient is unique and every family is unique, so my practice will be different with each and every one, I think it needs to be.*

4.2.2.3 Axial code: Positioning of the Patient

Focused Codes*
Experiencing treatment (9)
Fighting anorexia (2)
Seeing anorexia as restricting (9)
Seeing anorexia as empowering (9)

The ambivalence of the patient towards treatment was also a common theme. Jess recounts that: ". . . *unless it's that very rare group of patients who say 'I'm in the grip of this monster, please help me', but they are very small, that group who actually want you to kind of come in and really do something, because they know it's not helping their life".*

In doing so she is expressing the difficulties experienced in working with clients who are often at odds with their ambitions for therapy. Indeed, they are often attending only reluctantly under pressure for loved ones or through the legal enforcement of the Mental Health Act.

In this context, treatment is often experienced as frightening, particularly regarding any move towards encouraging weight increase. As Claire observes: *"They're very scared so they're on hyper alert"*.

At times, previous experiences of treatment have been negatively experienced. Alice sees previous experiences of treatment as often hindering engagement:

> *Some of them have gone private and had just such a shoddy deal privately with all sorts of sending them off in all sorts of directions, they have been dismissed by GPs, they've been sat on waiting lists when they shouldn't be, they have been often through a path that has not been helpful and they haven't felt reassured or listened to*.

Although the ambivalence may be a barrier to engagement, Claire believes that: *"I found it to be that people sometimes are too scared to say and actually voice that they want to recover but they might be able to indicate or show in some way"*.

Some patients are perceived as seeing anorexia as restricting and, for others, empowering. Even if they want assistance, Claire believes that anorexia will often not allow their voice: "*. . . they're not allowed to say certain things out loud…The illness won't let them"*.

Martin states the following regarding the patients' relationship to assistance:

> *They've got alternatives. Whatever it is that has happened to them that's made them turn to that, that they think, this is the only option they've got. Whether its anorexia or I don't know, self-harming, or drug and alcohol addiction, in a way, I don't give a monkeys, to be honest, it's that they feel they haven't got options. Or they won't be entitled to them, or that they warrant them, and I think that's, it's more heart breaking for me, that they chose anorexia, they don't, they, it's upsetting, it's left them thinking they've got no other choices. They often, they often put a schema together where they understand that they feel that the family are failing to offer them options. Not in a withholding, cruel way, but in a, in a way that they don't know.*

Anorexia is also encountered as empowering to patients. Hannah describes it as a solution, but "*radical"*, and Jess explains of the patient voice: "*That's what I rely on, I rely on my anorexia, my anorexia tells me what to do, if somebody takes my anorexia away, I don't know what's going to happen"*.

4.2.2.4 Axial code: Positioning on the Patient

Focused Codes*
Leading client (2)
Discounting patients (5)
Getting alongside (12)

The perceptions of the patient and the patient's own position towards anorexia has influence upon the position taken by the therapist towards the patient, in the nature of recursive circular relationships. In the context of risk positions, particularly with younger children, participants could become strident. For example, Alice explains: *"If it is very powerful I will virtually ignore and I will position myself very, very strongly with the parents and take charge, because I don't have a belief that the young person has the capacity to do that, because they have been taken over".*

Jaya, in a context of providing information about consequences to anorexia, says: "*…perhaps they would rather it wasn't said because it taps into them having to face up to some recovering themselves and having to face up to what they are doing and they might not want to hear it, they might not be ready to hear it".* Hannah remarks that: "*Some of our patients move from adolescence to adulthood with us and most of the so called adults are not very adult at all".*

So, in some instances, the positions can be challenging to the patient (or parents) whilst in other examples there was effort to get alongside them. Jess describes how she aligns with parents, who may be adversarial to their child: *"I think I've learned a lot more about getting alongside the parents at an early stage and maybe that has changed my practice…but I do feel it's really important to recognise that parents feel incredibly disempowered by an eating disorder".*

Claire describes how she weaves between taking the lead and getting alongside thus:

> *It's bread and butter motivational interviewing territory, whereas instead of presuming that somebody doesn't want to change, which is the classic view that somebody really is that anorexia is, it's egosyntonic, they don't want to change. I mean, it would be daft to extrapolate a universal truth from one practitioner's experience but that's not how I found it to be. I found it to be that people sometimes are too scared to say and actually voice that they want to recover but they might be able to indicate or show in some way.*

> *They might be able to say that it's not that they don't want to recover, it's just that they're terrified of the recovery journey or, that they don't have the confidence in their own ability to be able to do it. But if they could fast-forward to maybe five years from now, this will be behind them, a memory. That's what they'd like to be. And so within that kind of frame of being very, very candid that my job is not to hang around and to – and that my job is to be alongside them in recovery. There will be times when they hate me and they feel really, really angry and, however they experience the claws of anorexia and live with that, being a voice whether that be thoughts, whether that be emotional, overwhelmed, they will experience some of that towards me because I can't, I come as part of the team to help their parents*.

Richard sums it up as: "*You don't just hit everybody with the same thing"*.

4.2.3 Category: Considering the Family

4.2.3.1 Summary

The concept of the family as being part of the cause of anorexia is a contentious one, and yet the debate still continues as exemplified by the recent aforementioned article by Dring (2014). All of the participants regarded the family as being part of the solution, rather than part of the problem. How much this is determined by powerful discourses such as the Maudsley approach (which promotes this position) is unclear. Whether Dring's proposal, received with great opposition, represents a subjugated and hidden discourse is equally unclear. Within the positions taken towards the family there was a range, from total alignment in familial disputes, to considering the families to being lacking in skills and: ". . . *just not getting it"*.

What was common was an understanding that families are key to recovery from anorexia (unsurprisingly, given that the participants are family therapists) and that this conforms to the dominant literature. Where alignment is closer to families (who generally regard anorexia as a problem) or to the client (who often at best has an ambivalent relationship to anorexia) this may be a prime indicator of the positioning of the therapist to anorexia.

Table 11 indicates the extent to which participants contributed to this category.

Axial code	Hannah	Richard	Martin	Alice	Claire	Jaya	Frank	Jess
Perceiving families	8	0	0	0	21	50	100	67
Positioning within families	15	0	100	100	50	33	0	33
Responding to families	77	0	0	0	14	17	0	0
Total of participants whole	**5**	**0**	**8**	**4**	**12**	**6**	**2**	**14**
Total of data whole	**21**	**0**	**11**	**7**	**23**	**10**	**3**	**25**

Table 11 Participants' contributions to considering the family category as %

4.2.3.2 Axial code: Perceiving Families

Focused Codes*
Understanding parents (4)
Considering family assets (4)
Families in action (3)
Family as depleted (10)
Family as privileged (1)
Seeing originally about family crisis (3)

Perceptions of the family, as with perceptions of the patient, inform in part the position taken by the therapist. Early systemic views of the parents (often the mother) as being part of anorexia's genesis still influence contemporary systemic thought, often through a desire to demonstrate distance from early hypothesises. This is in keeping with the beginnings of systemic family therapy in Bateson's notion of the schizophrenogenic mother (Bateson, Jackson, Haley, & Weakland, 1963). As discussed earlier, Dring (2014) caused dissension in the systemic community, both in publication and online forums, through encouraging a return, in part, to locating genesis in familial relationships. Minuchin's (1978) original description of psychosomatic families has been rejected in current systemic treatment options (Eisler, Lock, & le Grange, 2010; Lock & Le Grange, 2012). In keeping with this stance, there were no criticisms in the data of the families as being critical in the formation of anorexia. There were, however, many empathic responses to parental actions in the context of anorexia, especially regarding attempts to combat anorexia. Claire, for example, stated: "*Parents are doing this*

as an act of love and care, not as an attack and *they're not doing it to cause distress; they're doing it to pull their child out of this hell".*

Jess regarded families as being *in crisis* and regarded much of the work as crisis intervention and: ". . . *helping families regain a sense of parenting agency when their life has been turned upside down by the impact of the illness".*

All of the participants expressed compassion for the families, often regarding them as having become depleted. Claire talked of the: " . . . *level of fear or shame or sheer exhaustion that they're experiencing".* Frank notes that therapy can add to these feelings: ". . . *because a lot of parents will often see that it's me blaming the.* Following this, Jess states that: "*I do feel it's really important to recognise that parents feel incredibly disempowered by an eating disorder. By the eating disorder, one, and by the multidisciplinary team, two. And so, that's a double disempowerment".*

Jess also explains how therapy can add to familial disempowerment, with the parents feeling:

> *. . . like their parenting authority has been taken away, their confidence has been taken away and although they are on the one hand extraordinarily grateful that their child's life is being saved and their child is being treated, they also feel incredibly wrong- footed that they're not in the forefront of parenting their child.*

Thus the participants expressed a view of families as depleted and how they and the professional network can exacerbate this. At the same time, familial contributions were also perceived as key to therapy. Jaya considers that: *"It is not just a person with anorexia, it has got an impact on this whole family and I didn't get why you would work on it individually, I just thought it had to be family, a family approach".*

Jess also added to the theme of therapy as disempowering, pointing out that the professional team can be regarded as: ". . . *more supportive than two parents at home with you don't know how many children and two jobs to keep and some grandparents that might be failing and the mortgage to pay or the rent to pay".*

4.2.3.3 Axial code: Positioning within Families

Focused Codes*
Supporting parents or family (7)
Aligning with parents (8)
Taking view of family (7)

The positioning within families might also be regarded as a position within anorexia. Significantly, the participants that worked primarily with adolescents and children were more expressive of their alignment with parents, Alice, for example, stating:

> *I position myself very much with the parents because actually – and that will depend on how powerful anorexia is in the room. If it is very powerful I will virtually ignore* (the patient) *and I will position myself very, very strongly with the parents and take charge, because I don't have a belief that the young person has the capacity to do that, because they have been taken over.*

At the same time, Alice highlighted how this goes against how she would:

> *. . . normally operate which is to engage the young people. . . I think if I was a parent of a child who was fading away and possibly going to die then I would want somebody to be absolutely certain that they know what they are doing and that they would be alongside me with that young person so yes, maybe that but I really – it is anorexia that I am battling*.

This clear and strong alignment with the parental sub-system against anorexia was echoed by Claire who was prepared to risk the possible benefits of a therapeutic alliance with the patient:

> *There will be times when they hate me and they feel really, really angry and, however they experience the claws of anorexia and live with that, being a voice whether that be thoughts, whether that be emotional, overwhelmed, they will experience some of that towards me because I can't, I come as part of the team to help their parents*.

Part of the therapist's task can be sitting with potential fury that becomes part of the process of developing a therapeutic relationship. Careful navigation is required to avoid the dilemmas in positioning within anorexia with, as Claire later recounts, the: ". . . *importance of engagement and the importance of engagement with everybody in the family and the engagement with the young person in their*

ambivalence". Jess extended this thinking in discussing the patient's age as influencing her position:

> *I am more influenced by parental authority, parental responsibility, you know, parents in charge of the child's eating, whereas once you get into the 14 to 24s, you've really got a person that's going to validly claim they should have much more right to say what they're going to eat within certain bounds.*

4.2.3.4 Axial code: Responding to Families

Focused Codes*
Seeing problems in families' preparedness (10)
Seeing problems in families' behaviour (2)

As well as aligning with parents to fight anorexia, participants also often take a psycho-educational approach. For example, Jaya reported:

> *I don't necessarily know for the young person themselves but I think for the parents, I think it is quite containing because they are not having to wait for their psychiatric appointment somewhere down the line, they have got that kind of information – psycho-education if you like – kind of on a regular weekly basis so they can ask questions.*

For Hannah, families are sometimes lacking in information both generally about anorexia and specifically about treatment from the team:

> *A lot of parents who feel things are being taken out of their hands they don't know how to get information* and *Quite often I find parents saying 'we've had no communication from the ward at all, it's really nice to hear this; no one's told us this'.*

As well as a psycho-educational element to treatment being required in information about both anorexia and the treatment pathways, it was also regarded in relation to a perceived lack of family preparedness for the tussles within anorexia. Jaya, clarifying how parents struggle to understand what is needed of them, quoted a parental position as:

> *. . . 'this is ridiculous, she just needs to eat'* stating *they don't conceptualise the gravity of the situation* and *I am trying to get the families to grasp the seriousness of it and they are just not getting it and week in, week out they are just not getting it and I find that really difficult.*

Following a theme of parents struggling to grasp their role in recovery, Claire saw part of her role as getting: *". . . adults (to take) responsibility for the organisation and the preparation and the expectation of their eating, not anything else. And that can be quite a hard one for parents to get their heads around".*

4.2.4 Category: Considering the Wider System

4.2.4.1 Summary

The multi-disciplinary team is seen, varyingly, as a source of support or opposition. This will depend very much on individual experiences and relationships but a common factor is differing perceptions of anorexia and treatment options. The need for medical support will bring potential for the position of the family therapist to be influenced strongly by this, and away from more traditional systemic descriptions. At the same time as mutually influential collegiate relationships, this can bring opportunity to create a both/ and position that encompasses many possibilities. Martin's description of being *more receptive and accommodating to the other* appears to be useful in both holding a systemic perspective and encompassing the possibility of others, in the spirit of dialogism.

Table 12 indicates the extent to which participants contributed to this category.

Axial code	**Hannah**	**Richard**	**Martin**	**Alice**	**Claire**	**Jaya**	**Frank**	**Jess**
The NHS	0	0	18	0	0	0	0	0
The MDT	100	100	82	100	100	100	0	100
Total of participants whole	**4**	**5**	**13**	**3**	**4**	**3**	**0**	**10**
Total of data whole	**20**	**16**	**22**	**6**	**8**	**6**	**0**	**22**

Table 12 Participants' contribution to considering the wider system category as %

4.2.4.2 Axial code: The NHS/ Agency

Focused Codes*
None (2)

Little was discussed regarding the agency context directly, although Hannah alluded to the power of the NHS in awarding contracts to the private sector and Martin described how some: *". . . people's experience of the NHS and eating disorders generally is that they feel judged".*

The power of the NHS through NICE guidelines was, however, described by several participants as having authority over treatment pathways.

Bourdieu's notion of capital and habitus (1991) is useful in considering the positioning of participants within the field of anorexia, in an NHS context. Hannah stated of anorexia "I don't think of it systemically", going on to describe how she worked in a manner contrary to her training. This typifies the difficulty in adhering to systemic principles when, within a multi-disciplinary team, capital is gained through expert knowledge and adherence to the authority of NICE guidelines and 'evidence based practice'. Over time, within this context, habitus can be developed by the therapist that no longer questions the 'knowing how to proceed' of the dominant discourse, and systemic positions such as curiosity are applied to families but not the treatment itself.

4.2.4.3 Axial code: The MDT

Focused Codes*
Relationship to MDT (15)
Advantages of MDT (20)
Problems of MDT (13)

The participants expressed varied views about their relationship to the MDT and the advantages and disadvantages of team working generally. Claire, for example, said: *"I think if I were a lone practitioner or an isolated practitioner or a practitioner working within an organisational structure that didn't support real rich multi-disciplinary working I wouldn't have that sense"* (of being able to assist patients). Jaya sees the team as a resource to support her practice: "*I want my nursing colleagues to support me with some of the practical and physical stuff"*.

At the same time, others experience a difficult relationship with their team. Hannah discussed how she worked very differently from another family therapist and experienced this as disapproval and a cause of dispute. Martin described how he sees his colleagues as having: *". . . a completely different philosophical position than me"*.Richard takes this further, in discussing mental health practitioners outside of eating disorders services, as having: *". . . a hatred of people with eating*

disorders that's akin to hatred of people with alcohol problems or self-harm or that kind of thing, believing that these are seen as *wasting our time"*.

Whilst relationships can be fraught, there are seen to be distinct advantages to MDT working. Hannah sees that: ". . . *it makes a big difference that I'm very much part of the ward"*. Richard sees the team as supportive in surviving the complexities of anorexia in reminding: ". . . *ourselves regularly that we are good enough, we do know what we're doing and that this is a tough, nasty illness"*. He focuses on these complexities, pointing out that it is: ". . . *really tricky when you're on your own rather than versus being part of a team who understand the complexity of the problem"*. Martin takes this further in co-working with a family therapist in keeping a check on his personal biases, saying: ". . . *my own personal experience might be skewing and its useful to ask a colleague to keep an eye on me"*. Alice, in looking to the medical risks, sees that: ". . . *the good thing about working as a team is a lot of the actual risk of anorexia is taken over by the medic which is kind of nice"*. Jess echoes this position strongly with:

> *If I'm working on my own in private practice, it's very different from working in a multi-disciplinary team where the consultant's kind of just responsible for keeping that child alive, whereas I am responsible for family therapy. I'm not responsible for keeping that child alive*.

Claire sums these perspectives up as: "*I passionately believe that people are better taken care of in multi-disciplinary teams"*.

The possibility of 'splitting' within the team is, however, strongly expressed. Alice recounts how:

> *. . . there is a lot of splitting that happens which is quite interesting ... so we get psychiatrists emailing us saying 'even though you have told the parents to be in charge actually we didn't think that was working so we are telling the young person to be in charge of their own food'.*

Claire also adds how, as a family therapist, the focus can be on the family dynamics and there is a possibility to ignore the eating imperative and how: *". . . the illness has a field day"*.

Martin offers resolution for fracture within the team, recounting his own past experience:

It was almost as if I had to be the champion, the advocate of the (patient), to justify a systemic position … I don't know if that was always the most effective, that people didn't feel listened to, that they didn't feel respected and I think I tried to maintain my integrity and I now try to do it in a way that is more accommodating and receptive to the other.

4.2.5 Category: Considering the Family Therapist

4.2.5.1 Summary

The data highlights that, working within the field of anorexia, family therapists have several facets that contribute to their habitus. The role itself brings both assumptions that the therapist carries of the role and contextual influences that shape the role. Professional and personal self were also identified as influential in the relationship to anorexia. Gaining knowledge of eating disorders was predominantly achieved through self-education and through experience on the job, rather than formal teaching. The range of positions was varied as was the spectrum of interventions delivered by the therapist, and the implicit assumptions about the nature of anorexia, through the epistemological assumptions behind the theories of change, were diverse. The three positions revealed were, those of expert (holding expert knowledge and expertise), unsettled (dealing with dilemmas and insecurities in positioning) and not-knowing (suspending desire of outcome and giving a high focus to issues of power), in varying proportions used by all participants, with fluidity being demonstrated between the positions. The axial code **'therapists' positioning on anorexia'** was identified as the central code, which the other codes influenced (Figure 4).

Figure 4 Relationship between axial codes in therapists' positioning on anorexia

Table 13 indicates the extent to which participants contributed to this category.

Axial code	Hannah	Richard	Martin	Alice	Claire	Jaya	Frank	Jess
Having a role as a therapist	35	34	28	41	6	31	35	42
Training	24	27	32	20	27	24	14	5
Recounting eating disorders experience	10	13	4	0	6	2	5	16
Intervening	15	19	32	13	49	32	36	21
Therapist's positioning on anorexia	17	7	5	26	11	12	12	16
Total of participants whole	**58**	**75**	**64**	**72**	**72**	**65**	**87**	**39**
Total of data whole	**22**	**19**	**8**	**10**	**12**	**10**	**13**	**6**

Table 13 Participants' contribution to considering the family therapist category as %

4.2.5.2 Axial code: Having the Role as a Therapist

Focused Codes*
Gaining post as family therapist (17)
Being self of the therapist (56)
Doing tasks of therapist (84)
Incorporating psychological and medical (14)
Needing to be as therapist (31)
Relationship to change (8)
Describing feelings of working with anorexia (6)

The role of the therapist, from initially gaining a post through to perceptions of how a family therapist should act is influential in the positioning upon anorexia. Self-perception can be thought of in terms of Bourdieu's concepts. As the therapist enters the field of anorexia, the habitus developed through the personal self and the professional training and experience will mediate how the therapist considers how she/ he should act in order to gain their perceived capital. The perceptions of self that develop will have a strong inter-relational influence upon the positioning taken towards anorexia.

Interestingly, all of the participants recounted how they had not specifically planned to work with eating disorders, but how it developed through other roles. Richard stated:"*I didn't come into this line of work specifically because I had a special interest in anorexia nervosa".* Alice said: "*It is not an area that I ever really wanted to go into or had any interest whatsoever – I have to say that".*

Having, however, come to work with anorexia, throughout the data are descriptions of the self of the therapist. Rober (1999) describes how *"*The therapist's inner conversation is described as a negotiation between the self of the therapist and his role". The relationship between awareness of self and perceptions of the role will also, through the internal dialogue, inform the positions taken.

Hannah described how she acted differently in regard to anorexia, attributing the difference to the field of the inpatient unit: "*So I became aware in this job that I was acting very differently from what I had been with previous family therapy, but*

having said that it seems to work. So it's a very, very different animal from what you and I were trained to do".

This illustrates how both the self of the therapist and the habitus can be altered through the field.

Bourdieu would propose that other factors of the self inform the habitus.

Richard illustrates how his multiple factors of the self, within the field of his service, facilitate his positioning: "*I think age and stage of career and where I am in the organisation helps that, you know. I've been doing my job a long time, I've met a lot of people, I've worked with a lot of people, I'm at a point where I can say, 'I've got a lot of experience'".* This allows him to "*manage it and deal with the situation with compassion and not with power".*

Martin was particularly concerned with noting the influence of his family of origin in his positioning as an "*activist"*:

> *I can draw a line from the session I had yesterday right through to my grandmother. . . I can see a line throughout that runs through that. That feels very strong to me. I could almost be blinded by it, just, because it's so obvious. So how that has made me who I am today, given my experience, my history, the things that I'd be, you know my values and beliefs.*

Gender was a feature in consideration of self, with what is predominantly a female oriented difficulty.

Richard considers that he had a differing relationship with the client, influenced by his gender and age:

> *I know from talking to the patients that they will say that their relationship with me is different and is devoid of the comparison stuff that they do with their female therapists. So the shape of my body is less relevant than it is of the female colleague, age is also helpful, I'm a middle-aged man, girls say to me why would I, on what dimension do I compare myself to you? Whereas you know, I think, younger women have a much harder time in terms of managing that dimension of their relationship.*

Alice echoes this position when she considers her relationship with her client: "*I sometimes think about my weight, my own weight and whether a young person sitting with anorexia is sitting with me thinking 'who the hell are you to tell me about women and weight'".*

Consideration was also expressed as to how the participants needed to be in their role, ranging from using humour to 'being with': Hannah said: "*There's no point in coming to a therapist who sits there and says 'Oh what do we do', not when this is a life or death illness"* and *I use humour".* Ricahrd reported: "*I do use humour a lot… and self-deprecating humour quite a lot, that's a method of adopting a one down position".* Jaya noted that she was: "*. . . being a bit playful" Claire added that: ". . . (using) what John Shotter would call withness even if all it can be is a very sincere acknowledgement. To do it lip service doesn't work because these kids have bullshit radars".*

4.2.5.3 Axial code: Training

Focused Codes*
Original training and understanding (23)
Need for training (24)
Studying formally (4)
Studying informally (39)

The professional self of the therapist, in the context of anorexia, is heavily influenced by training. The participants had a diverse range of original professions, drawn from social work, psychotherapy, mental health nursing and, in one case, from no direct prior client context. These professions gave a range of comfort with the psycho-medical and psycho-social polarities with, for example, greater experience of the psycho-medical sitting with those with nursing training and the psycho-social within social work or therapy training.

A strong common theme was the need for training specifically in eating disorders, and a perceived lack of formal training provision.

Hannah had no input on eating disorders in either her integrative or systemic therapy training which she "*thought was appalling"*, commenting that "*it's only in the last couple of years that there's been a lot of training around it".*

The lack of training opportunities was echoed by others. Richard commented that: "*There was no training at all about family therapy interventions for eating disorders, not at all".* Alice added: "*There was hardly anybody who was, really,*

had the knowledge on how to work with anorexia because the more that I began to train and seek ideas, … no one really had any model to work with".

At the same time, participants expressed how specialist knowledge is needed to work with eating disorders:

> *It's very important that clinicians provided for families in crises are not only qualified clinicians but have a knowledge of eating disorders, that you are rowing through treacle in the dark if you don't know about eating disorders themselves as well as your craft, your trade, your core profession. So I think you do need that knowledge, and if you come into a post not knowing it, then you need to have a good induction and you need to be linking up with other like-minded clinicians who are going to be able to say 'yes, that's really common'.* (Jess)

Learning was gained through two main areas; learning from others and learning from literature.

Hannah describes how she needed to learn from both ways:

> *I kind of taught myself, I went off and learnt my own eating disorders stuff and added to it by continuing to work on the unit and, from what I've heard, I think certainly at that time other people did much the same thing. I've heard that other people have basically had to self-teach themselves.*

Richard said how he had grown up with feminist eating disorders literature which added to his leaning 'on the job': ". . . *trying to surround myself by people who I felt were confident to support my skills or my knowledge, or my creativity… there (was) other wider reading, I'm thinking of growing up with 'fat is a feminist issue'".*

Learning from others was commonly expressed: "*I learned by soaking up – by being with people, watching them"*(Alice), "*I think the game changer for me was having the opportunity to be alongside different colleagues in different settings… most of my initial fast learning in the family home"* (Claire) and "*Because I self-educated myself".* (Frank)

4.2.5.4 Axial code: Recounting Eating Disorders Experience

Focused Codes*
Describing current post(4)
Initial experience(41)
Working on inpatient unit (7)

The experience of the participants expressed within this coding is very similar to the axial code training of the therapist. The participants recounted varying experiences of anorexia through their work history. This category does not sufficiently add to the data from the previous category, to the research question, and has, therefore, not been expanded.

4.2.5.5 Axial code: Intervening

Focused Codes*
Focusing on behaviour (62)
Focusing on belief systems (73)
Focusing on contexts (18)

Whilst these codes originally emerged inductively, the diversity of interventions led me to categorise these in a more deductive manner. I used Carr's (2006) division of systemic theories into focusing on behaviours, beliefs and contexts to orientate myself.

The relationship of positioning between expert and not-knowing, as highlighted in the literature review can be tracked through the development of family therapy, from early structural thinking through to postmodern and social constructionist perspectives. Central to qualifying training in family therapy (AFT, 2011) is the knowledge of the history of family therapy. As theories are revised, and at times become unfashionable, they are often developed by incorporation into evolving theories, or become distinctly part of the theoretical lexicon of the family therapist. It is, therefore, common to find therapists using historically developed theories in both their original form, or developed and merged into more contemporary theories. From the perspective of positioning, this leads to what may have originally been an expert position being used in the spirit of authoritative doubt (Mason, 1993). For example, structural family therapy, whilst originally proposing

a normative and instructional view of family, is often contemporarily used in a spirit of collaboration and enquiry (Vetere, 2001).

From this perspective, it is insufficient to identify an intervention to describe a position, but the action needs to be understood in context. It becomes possible to introduce a traditionally expert position in a non-expert manner and to use a non-expert intervention in an expert manner. Once this is applied to the analysis the category 'interventions' reveals a wealth of positions. Using the three positions from the axial code **'therapists' positioning on anorexia'** (expert, unsettled and not-knowing, discussed later) I extracted data from the focused codes. Interestingly, all the participants seemed to take both the expert position and the not-knowing at times, in differing proportions. The unsettled position was voiced more by those participants who displayed greater use of the not-knowing position.

The expert position can be thought of as a knowing position, aligned often, though not exclusively, with the psycho-medical perspective. Some were very clear and structured in their positions. Hannah describes how she takes the expert position regarding anorexia but becomes more curious about the family, and how she is rejecting of the not-knowing position:

> *You have got to be an expert in eating disorders, so I do present myself as, 'I can tell you about eating disorders, I can tell you about the illness. I can't tell you about your family, I want you to tell me about your family'. . . For me, because I think I first started this particular job I learnt a lot very quickly and I realised that, if you take the non-expert position for example, I think that's somewhere where there could have been a conflict but I think it's, I've thought a lot of this, through a lot, and I think it's very, very important that you can't sit with an inpatient family who are absolutely terrified that their child is going to die and say 'what do you think we should talk about today, what would be helpful for you?'*

Alice takes a similar position, moving from that of expert to a potentially more collaborative stance:

> *Initially we see the family in a clinic setting with a psychiatrist and a psychologist and the three of us would work the family together …initially our focus is on refeeding so we would put all our energy into refeeding and anything – and that means empowering the parents and whatever – and then we would – time would evolve as the anorexia was diminishing we would start to have – I would be able to have more conversations with the family about some of the ideas and some of the strategies that they could use to support each other.*

The expert position was, again, acknowledged by Claire, who was clear about its boundaries: "*What is needed to get them through is, is, adults taking responsibility for the organisation and the preparation and the expectation of their eating, not anything else".*

Frank described how his position of certainty had moved over time:

> *At the time, used to see myself as feminist, and my brand of feminism was very much based on this idea that women's problems are caused by men. It was a very simple way in which I looked at-. If I saw a woman suffering, as far as I was concerned, it's because the boyfriend or the husband or the brothers or the dad had let her down. So I would always go for the men and I would do this kind of lecturing them, so I would be very much looking for what it is that they were doing that I believed was contributing to their problems? As simple as that. It was like cause and effect, so there was nothing systemic about it. Relational, yes, systemic, I don't think so.*

The position of certainty is one that brings a tension, though useful in the medical domain where a greater certainty can also reduce risk. Certainty can also exist in the psycho-social domain and just as a tension can exist between the psycho-medical and psycho-social it can exist within the latter:

> *You don't want to get back to the old school of pathologising the family and saying that this child is like this because his parents are like that, but I do have a bit of a hypothesis about girls falling prey to an anorexic illness coming into them in adolescence when they observe their mothers having some kind of undesirable lifestyle or life story*. (Jess)

This tension, which is exemplified in the unsettled position, is demonstrated by others:

> *I am not very good in my own life at uncertainty and I don't suspect I am that brilliant at it as a therapist. I try and I know I have got to kind of hold uncertainty and manage it and keep curious and keep kind of a dialogue going but if I looked at some video recording, I would probably not see that as perhaps as much as I had wished*. (Jaya)

> *I think keeping the dialogue open about that all of the time and keeping people aware of the complexity of trying to help somebody who might not feel like what you're doing is help, or who doesn't want that kind of help is really complicated.* (Richard)

> *I guess what was helpful for me in that dilemma, and it was a real dilemma, where to place my ethics of practice and my practice understandings and sort of skill sets within the frame of such high medical risk and, what some would describe as an egosyntonic focus. I guess I've got a different view on that but some of them would describe it as egosyntonic. It took a while for*

me to find how to marry my beliefs in dialogism and that sort of probably more social constructionist style with the complexities of multi-disciplinary working and high medical risk. (Claire)

The not-knowing position, which entails holding truths lightly, was demonstrated strongly amongst the participants, often incorporating a both/ and approach in relation to the psycho-medical and psycho-social:

It's my belief that you have to attend to both, you attend to the physical, and the physical consequences of starving, but you've got to find out why they still want to starve in the first place. You've got to be working around, not just why they starve themselves, but offering alternatives to starving themselves, and why they are dealing with their feelings and anxieties the way that they are. and what options there are to do things differently . How are you going to learn to live without the eating disorder. And where are you going to develop those, where are they going to practice those? I think the treatment should encompass of all those things. (Martin)

I don't come with the presumption that that's how things should be. I do come with a kind of working assumption that that's generally what's necessary for now. (Claire)

I do that once I have analysed with them, in a dialogical kind of way, what other options there might be. I might say to them 'so you chose to do A or B, were you aware that you could also use C and D, did you know about these things?'. I do that by getting interested in saying to people 'when you chose what you chose, from what list did you choose those things? What options did you have?'. Because what I'm interested in is to know what options they have in their tool kit. So I get interested in saying 'so you chose to do that and you chose to do that, what else could you have chosen?'. And they say 'nothing, I'd run out'. That is an invitation to me to then share. So rather than do it from the Rogerian perspective where you are saying well, my job is to paraphrase and to just think with the person around their thinking, my job, as you said earlier, is to introduce more options. 'I know you have chosen that and that, but did you know that you also have other options?' And 'these are some of the options'. (Frank)

4.2.5.6 Axial code: Therapist's Positioning on Anorexia

Focused Codes*
Expert position (66)
Unsettled position (37)
Not-knowing position (75)

The three positions that emerged from the data were, to some extent, identified through the literature review (and therefore influenced the interview questioning);

they also strongly emerged, inductively, through the data analysis, the data and literature reciprocally validating each other.

All positions were identified within all participants, in differing proportions.

Jess stated the dilemma in the expert position, in that issues of power (discussed previously and later) need to be accounted for and yet, at times, the family and the severity call for adoption of this position:

> *The smaller the differential between myself as a professional and them being the person coming for a service, the better the way the work is going to flow. But there's a paradox in there with eating disorders, because the other downside is that when people come to you and they know you do know a lot about eating disorders and they know nothing except that their world has been turned upside down, they are hugely relieved. So it's the double-think about expertise and reduced hierarchy*.

Frank adds to this in describing how, in the context of the trust within a strong therapeutic alliance, a mandate can be given to take the expert position. At the same time he is very clear that the position is taken in order to stimulate autonomy within the client, rather than to dominate:

> *I've got these examples of what happens when we give people too much choice, because I think it's unethical to set people up to fail by expecting them to do things that they don't have capacity to do. Which is why sometimes we have to negotiate that thing equivalent to the power of attorney, where due to the therapeutic relationship, the person will say to me 'I trust you to act in my best interest'. So we have that, so I go for that*.
>
> *There are times when clients want me to be in the domain of production, where they are saying to me 'we want you to ring the GP on our behalf'. We negotiate that, and I say to them 'if I do that, what are you going to be learning from that process? How do I do that in such a way that I empower you? Because I don't want you to become dependent on me, but I'm quite happy for us to negotiate how my doing this is going to contribute to the widening of your own competencies. But I can demonstrate to you how to do it, I'm happy to do that, as long as you are going to learn from that'. So I don't have any problems with taking that position as long as it's been negotiated.*

The adoption of the expert position was echoed in considerable data such as: "*You do take quite an expert position which is really different from all the other therapy that I do so I am coming in as someone who knows about the physical consequences of not eating"*. (Jaya) . Hannah said: "*You have got to be an expert in eating disorders". Other positions were:*

> *But what I perform with the parents at that time is that I have knowledge and I have expertise through experience and I have so that they can trust enough, then as the risk fades or reduces, we can start getting into the more exploratory answer to the territory.* (Claire)

> *The medical certainty can inform me about whether I can carry on where I think I am going with the family around looking at the uncertainty and relationships and being kind of exploring that, or do I really need to go back to the medical and that allows me to make those judgements.* (Alice)

Doubt about the position taken, or a sense of how to proceed, exemplifies the unsettled position. Whilst there may be an attraction to the certainty of being an expert, or the certainty that it is appropriate within the not-knowing position, the unsettled position indicates a degree of healthy uncertainty and self-questioning, what Mason describes as a position of safe uncertainty (1993):

> *For the time being, I am going to take that benevolent dictatorship position and I'm going to step in, I'm going to rescue you. When I've rescued you, we're then going to talk about it, once I am convinced that you're well enough…I want to be inviting other people to help me think about my thinking.* (Frank)

Meanwhile Jaya described that: "I think it just means you are more curious if you keep that position of safe uncertainty… I sometimes am quite quick to move into safe certainty".

The not-knowing position has a relationship to attempts to disempower the therapist. In the expert position there is an increase of authority through claimed knowledge, which may or may not be in the awareness of the therapist. In the not-knowing position there is a more conscious attempt to hold power in mind:

> *When it comes then to thinking about the psycho-educational stuff how certain are you in the way, how do you present yourself in the certainty of the information that you are giving…deal with the situation with compassion and not with power over, not with, you're at that weight so that's not going to happen so we're going to do this and we're going to do that.* (Richard)

This position encompasses an ability, as described by Anderson (1995a) to take a both/ and position in holding systemic curiosity (Cecchin, 1987) whilst also owning expertise about eating disorders: Martin noted that "*I know eating disorders; I don't know your family. I don't know you, I don't know why your family is as it is. But I know the consequences of starving yourself*." Alice stated:

> *I am always uncertain because first of all I think it is good to be uncertain and it sounds like I am quite certain about it but I am always uncertain because I think that there is a – apart from the biological stuff I am not uncertain about – but as far as the, what's the relationships that have gone on and have happened, I am never certain because that would stop me, my curiosity and understanding of what has gone on.*

Jess said that *"I think it's really important to kind of remain curious and interested in the unique presentation of each anorexic feature as it comes to each child or family".* (J

Frank describes the fluidity that other participants expressed in moving between positions: "*So part of what they've began to do is to become experts. Now our work is very much around saying 'so what is it that you would like me to do?', so it becomes more and more and more dialogic".*

4.3 Theoretical Coding

4.3.1 Summary

The theoretical codes, which developed inductively from constant comparison between the categories and axial codes, address three key questions; by what process do the positions evolve, what are the positions (taken) and what actions are prompted by the positions? The principal axial and focused codes that informed the emergence of the theoretical codes are shown in appendix 6, although indications of the theoretical codes were dispersed through all the axial and focused codes. The three theoretical codes are recursively related (Figure 5), with the therapeutic encounters becoming part of the history and reflexivity of the therapist in developing future positions. The theoretical codes are addressed in greater depth in the discussion.

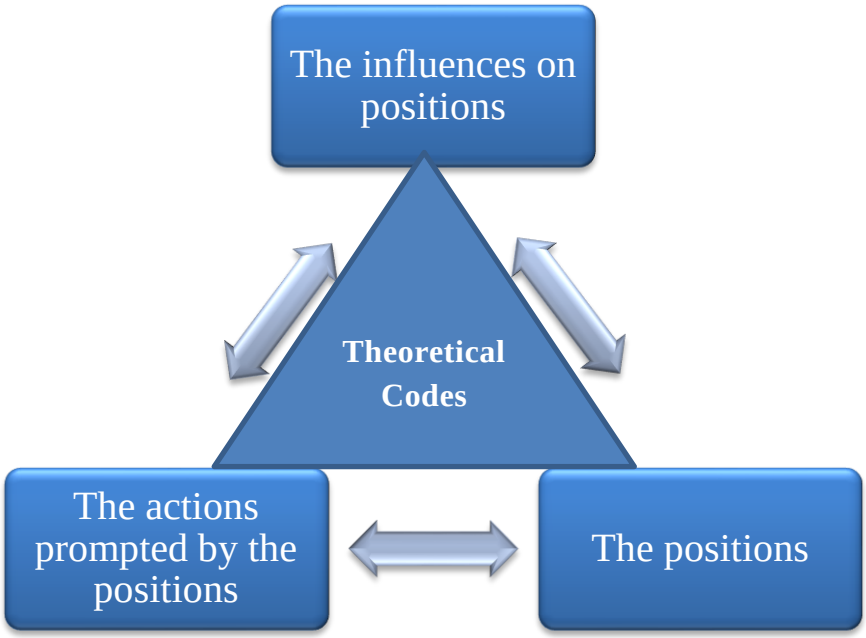


Figure 5 The relationship between the theoretical codes

The positions are seen to be part of a hermeneutic circle (Figure 6) in which the positions are both influenced and influential. A circular process can be punctuated with the history of the professional and personal self of the therapist which, in turn, combines with the professional and personal context of the therapist to inform the view of anorexia. This view will, in turn, influence the position taken which will result in an action (or intervention), which will invoke a response in the patient/ family system. Through a process of reflexivity this may add to the history and either invites confirmation or adjustment of the therapist's available positions. This process can contribute to a constant re-evaluation of the position(s), depending on the therapist's willingness to engage reflexively and, in the case of anorexia, potentially embrace a possibility of uncertainty in a context of risk.

The positions identified (Figure 7) are those of the expert position (which has a relationship with certainty), the unsettled position in which dilemmas exist and may be embraced without a need for resolution and the not-knowing position in which uncertainty is embraced in an attempt to be collaborative and adopt a preparedness to accept doubt over the nature of, and relationship to, anorexia. The positions precede three identified actions, those of comfort, support or challenge (Figure 8). These three actions can be beneficial to either the client or the anorexia, dependant on context, and can move from occasion to occasion.

Figure 6 Positioning hermeneutic circle

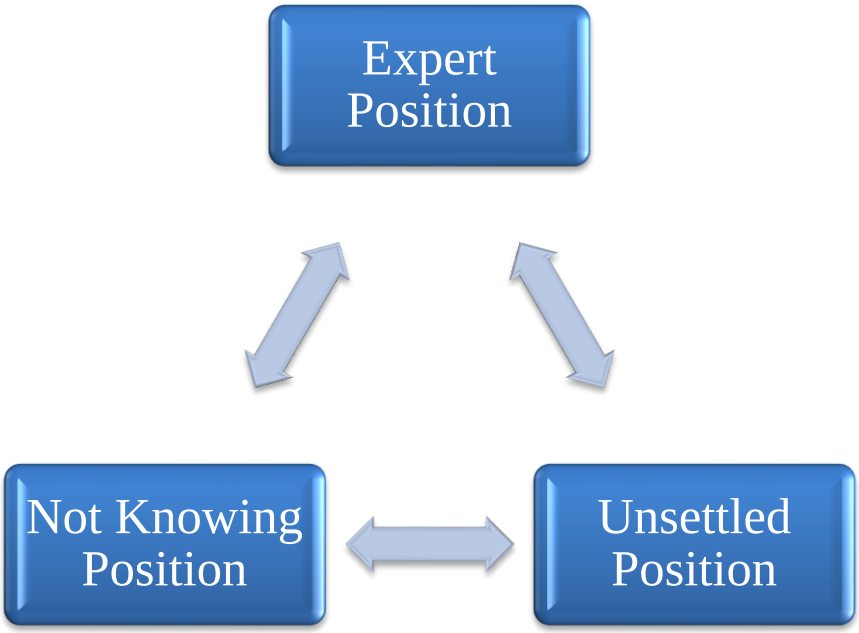
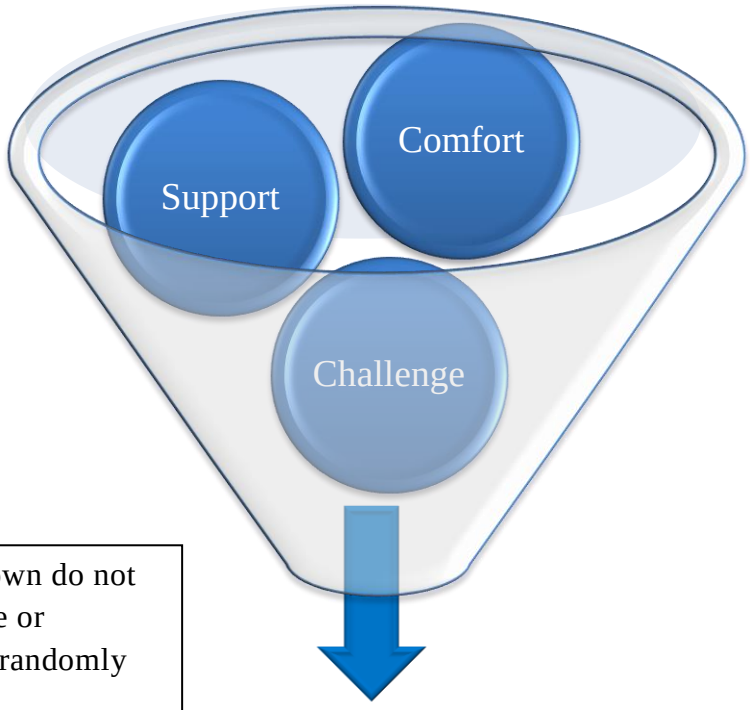


Figure 7 The positions



The positions shown do not imply a preference or hierarchy and are randomly placed.

Figure 8 Positioning actions

4.3.2 Theoretical Code: Influences on Positions

4.3.2.1 History

The history of the participants was evident, predominantly, throughout the axial coding 'Considering the family therapist'. Martin, for example, was very clear of his activist heritage:

> *I am also aware that I can get caught up with my own pathology, about the activist, about being, be the champion of the oppressed, I might be, you know, people's saviour, being the one who's got a monopoly on care, and I think that needs to be always thought about. My, my [sic] family do missionary work.*

Claire, meanwhile, makes strong links with her previous professional identity in shaping her positioning:

> *My therapeutic background is influenced by my first career which was as a* (anonymised) *which was rather an odd way to begin. I guess what that primed me to do was to be passionately interested in the stories that I'm told*

and the voices of the narrative terms of subjugated, narratives of discourses and about the influences of power and the effects of agency and not agency.

The history of the therapist, professional and personal, brings influence to the context of the therapeutic encounter.

4.3.2.2 Context

The context of both the internal experience of the therapist and the wider agency, society and culture combine to inform the view of anorexia. For some, the MDT has been influential in contributing to the view of anorexia and for others their team has been a barrier.

For example, some participants describe how colleagues contribute to sophistication of thought and hope:

> *. . . an individual practitioner in a non-specialist team trying to deliver family therapy for eating disorders, is really tricky when you're on your own rather than versus being part of a team who understand the complexity of the problem.* (Richard)

Claire stated: *"If I were a lone practitioner or an isolated practitioner or a practitioner working within an organisational structure that didn't support real rich multi-disciplinary working I wouldn't have that sense"* (of recovery being possible). For others the team can, at times, be a barrier to understanding: *"I think that (the team) have a completely different philosophical position than me"* (Martin), and *"There is a lot of splitting that happens"*. (Alice)

Societal and cultural contexts similarly contributed to the participants thinking, for example, with dominant discourses of illness: ". . . *and the whole thing about you've been ill"* (Hannah) and "*I think that probably it is a very scary, very serious illness"* (Alice).

But all participants also expressed complexity around discourses, for example:

> *So, like it might be that it's brought families together. It might be that the illness has muffled feelings; it might be that it's given the child a voice; it might be that it's given them a sense of potency that it's given them a way of showing anger, what is stress.* (Claire)

4.3.2.3 View

The view on anorexia emerged strongly in all categories. Within the axial code '**view on anorexia'** there were perspectives ranging from 'anorexia as an illness' and 'bad', through to understandings that remarked on the advantages of anorexia

in communicating distress and offering control, for example with Jess stating: "*I would understand it all as a presentation, a communication of distress"* and "*I do have a bit of a hypothesis about girls falling prey to an anorexic illness coming into them in adolescence… If they see their mothers as unhappy or oppressed"*. Frank described "*…in other words one is feeling out of control so one reaches for anorexia as a form of gaining control, which then colonises"*. (Frank)

The above examples illustrate the ambivalence that is endemic within the field of anorexia, as expressed by the participants. Whilst the client often has ambivalence about leaving anorexia, torn between discomfort and familiarity, the participants see the destruction of the presentation alongside the advantages to the sufferer. This complexity of view undoubtedly contributes to the multiplicity of positions.

4.3.2.4 Position

The three positions have been previously illustrated through the analysis of the category **'Considering the family therapist'** and therefore will not be re-discussed here, but are addressed further as a separate theoretical code (4.3.3) and in the discussion.

4.3.2.5 Action

The three identified actions of the participants are discussed in section 5.4

4.3.2.6 Response

The response of the client to the actions of the participants was not a feature of the interviews, but would complete the hermeneutic circle. If further work was to research the responses to the therapists' actions, this would add to the knowledge base.

4.3.3 Theoretical Code: The Positions

The three identified positions (Figure 7) are recursively related to each other and were revealed both explicitly through the codes that focused on positions and implicitly through those that did not, as previously seen.

The expert position (of knowing or suspending doubt over knowledge) is best understood in contrast to the not-knowing position, which is inspired by, but not

identical to (as it incorporates the possibility of a both/ and position), Anderson's definition of not-knowing:

> *Not-knowing refers to the attitude and belief that the therapist does not have access to privileged information, can never fully understand another person; and always needs to learn more about what has been said or not said . . . not-knowing means the therapist is humble about what she or he knows. Not-knowing involves respectful listening- listening in an active and responsive way. The therapist listens in a way that shows the client to have something worth hearing. Having an authentic commitment to being open to the other person's story is critical to dialogue.* (1995a pp.27-44)

This position has been critiqued (for example, Mason, 2002; 2005; Rober, 2005b) but was clarified and expanded upon by Anderson (2005) and is concordant with the definition of this category.

The expert position, in contrast, can be thought of both where the therapist holds certainty over their knowledge or, critically, suspends doubt over their knowledge in a context of risk. This is not, therefore, as simple as expert as 'bad' and not-knowing as 'good', but involves at times a purposeful suspension or reduction of enquiry, in order to ensure perceived imminent risk.

The unsettled position represents where there is tension between these positions and is indicative of the initial dilemma expressed by me of the polarities between the psycho-medical and social constructionist polarities.

Examples of these positions are given in 4.2.5.6 Therapists' positioning on anorexia.

4.3.4 Theoretical Code: Actions from Positions

Emerging from the data were three possible actions taken by the participants, those of comfort, support or challenge (Figure 8).

In part, these themes arose from positioning dilemmas, exemplified as follows:

> *One of the dilemmas that I have in my work is that I need to hold both that risk in mind with which that ability to hold risk in mind also gives me some authority, gives me some power, gives me the ability to move into an action mode, which can range from you know, 'we've got to regularly monitor you' through to 'we've got to call for a mental health act assessment'. And at the same time, that position means that that potential for that to exist is ever present and therefore will have some impact on my relationship with my client, and the sufferer and the parents or partners may view that in*

> *different ways, and at the same time I'm trying to work in the domain of aesthetics and to be creative and to recognise this as an individual form of distress.* (Richard)

Jess stated meanwhile: "*. . . you just really want them to have a full, healthy life".*

The question arises as to how to achieve this, what actions will contribute to moving towards a full, healthy life (and who defines what this is and how it should be achieved). The actions of comfort, support and challenge appear thematically to encompass differing, potentially beneficial actions

4.3.4.1 Comfort

To soothe, console, or reassure; bring cheer to. (Dictionary.com, 2015b)

The direct action of offering comfort was only slightly in evidence in the data, although it was implicit in several statements, for example: "*One* (task) *is weight restoration and the other is supporting emotions while this is going on".* (Hannah)

Claire was more explicit in acknowledging the need for reassurance and acknowledgement of pain:

> *But once that conversation begins with the young person, then the compassion of the acknowledgement of the agony of that experience can be spoken. 'So I'm really sorry what you're experiencing, it's hell, and I know because lots of other young people have told me'.*

4.3.4.2 Support

To sustain (a person, the mind, spirits, courage, etc.) under trial or affliction. (Dictionary.com, 2015c)

The action of support was prevalent across the categories, both towards the patient and the family, with Hannah being explicit in this action: "*What my position was within the family is to support the patient through recovery . . . 'it isn't something anybody has done, you have got there, this is unfortunate and we really need to support you to get you out of it'".*

Other participants indicated a position of support thus: "*If you unpack what people are already doing, it helps them ... about expanding their options and their choices"* **(**Frank), "*Well, we don't want you to recover from anorexia and then have social anxiety to fill its place, so you have got to tackle that as well"* (Jaya),

and "*That's what they'd like to be. And so within that kind of frame of being very, very candid that my job is not to hang around and to – and that my job is to be alongside them in recovery"* (Claire).

4.3.4.3 Challenge

A call or summons to engage in any contest, as of skill, strength, etc. (Dictionary.com, 2015a)

Finally the action of challenge was, again, disclosed in relation to both the patient and family alike: " *'So I'm going to take some action to prevent that happening, and it would be better if we could agree that you'll go to hospital but if you don't then we'll just make sure that happens' "*. (Richard). Other participants discussed: "'This (inpatient unit) *is a place where your eating disorder is going to be addressed'"*. (Jess), and "*You've got to say 'okay, so did you know that this was an issue, that your drinking behaviour or your husband's drinking behaviour is really impacting on your daughter's life? We need to talk about that, that's got to be talked about"*. Frank said "*'I know you have chosen that and that, but did you know that you also have other options?2", also sating:*

> *'You have lost an awful lot of weight, I'm very concerned about you losing weight, also, we had agreed that once you get to this certain weight, we would be moving into a different domain, we're no longer in the domain of explorational explanation, we're now in the domain of production. I can not collude with you'.*

4.4 Conclusion of Data Analysis

The breadth and complexity of the participants' responses cannot be given justice within the limits of this piece. I have attempted to bring together the main categories and codes that will be of benefit to the systemic community, in practice as well as theory. There were many contradictions within the participants' accounts, which I regard as a sign of healthy doubt, flexibility and the taking of a both/ and position. I have not given significant space to these contradictions, partly because I am in accord with Anderson and Goolishian (1988), who propose that contradictions do not necessarily require resolution and partly because the existence of these contradictions and dilemmas of orientation are assumed within my research interest. A lack of dilemmas and contradictions I would regard as a position of unsafe certainty (Mason, 1993). It is the navigation of these dilemmas, identified both within the literature and interviews, to which I now turn.

5 Discussion

5.1 Introduction

The data have focused on therapists' accounts of their work. Whilst it was not within the scope of this work to interview families it would be incomplete without at least a nod in the direction of a family's perspective of treatment. A recent article in The Guardian newspaper (Moorhead, 2015) focused on an account from a mother (Jessica) and daughter (Nancy) of their experience of treatment, writing "she and her mother talk about why turning to the medical profession was a disaster." Clearly any account is subjective and there will be many differing experiences from others, none the less the article brings an interesting narrative. Moorhead writes:

> Then there was the fact that, once Nancy was diagnosed and referred to the Child and Adolescent Mental Health Services (CAMHS), Jessica felt undermined and unsupported. "I felt blamed, disapproved of, traumatised. One therapist in particular was very suspicious of our relationship – she felt we were unhealthily close, and that I was colluding in Nancy's illness." Looking back, Jessica feels she was simply struggling with an incredibly difficult situation, with her daughter wasting away in front of her and a younger child to look after as well. The attitude of the therapists became one more burden.

Whatever the intent of the therapist, the mother's experience was far from a dialogic one in which the relationship is felt as being mutually (though not necessarily equally) influencing.

Nancy's account, written within her own book (Tucker, 2015), gives an insight into the complexity that the family therapist is attempting to position themselves within. Moorhead, again, (2015) writes:

> At one point she provides the kind of description of how anorexia feels that could only have come from the vortex of the condition itself. "I am too big and too small and too much and not enough and too frightened to change and too sad to stay the same," she writes. "I am an addict and a slave to the beauty myth and I diet and regress and reject and control and cry for help and I still can't stop the ring-ring-ringing in my ears telling me that something bad is coming, something bad is coming RIGHT NOW. I want to shine and I want to be invisible and I want to be myself and I want to be anyone else in the world and in the end I think the only solution is to get smaller and smaller and smaller and then one day to disappear".

Within the field of anorexia the positioning of the therapist is key to new possibilities if the therapist's position is not to become part of the problem, that of increase in risk or diminishment of agency.

I now turn to a discussion of the theoretical codes in relation to the literature and my proposition of the act of *informed orienteering* as one way in which to navigate the dilemmas stated. These codes have disclosed a gap in the literature in addressing the positions taken by family therapists as well as informing my suggestion of a way forward.

5.2 Influences on the Positions

The data indicates a range of views of and positions within discourses about anorexia from the participants. This reflects the diversity within the literature. What is clear from outcomes is that there is no definitive understanding of anorexia, its causes or treatment for recovery. Indeed, there can be differing views on what constitutes recovery. The data also indicates that the positions taken are dependent on the views of anorexia which, in turn, are influenced by the personal and professional history of the participants. Thus, the notion of anorexia may become extremes of subjectivity. The literature and data also raise questions of power relationships.

I have previously described the lenses that Foucault and Bourdieu can bring to considering both power considerations from cultural and social perspective, alongside power within interpersonal dynamics. The hermeneutic circle that encompasses the contributory factors of positioning (the discourses and how they become constructed) is subject to the impact of both power and power practices (Figure 9). I have also previously considered contributions from feminist perspectives, essential in my view in considering anorexia as it affects women[35]. The effect of the 'gaze' (in Foucauldian terms) of male gendered discourses has been discussed in my literature review. Nonetheless, it needs emphasising that no discussion about a female form of anorexia can exclude understanding and reflection of the powerful gendered position that men take within the majority of

[35] Whilst there are differing forms of feminist perspective, including those that more recently include a multi- cultural view, I refer here to all that seek to expose injustice and power structures and promote equality in all aspects of society and relationships.

cultures, nor the potential for these discourses to subjugate and entrap both women and men.

Figure 9 Power influences on positions

The shift in systemic psychotherapy from systems observed to observing systems was inspired by the work of von Foerster (1981) and the move from a first to second order cybernetic paradigm. With the understanding that the act of observing a system influences a system (and therefore that the observer is part of an observer/ observed system) came a shift to consider the therapist as part of a therapist/ family system. This began new considerations of the influence of power and control within the therapeutic relationship (Hoffman, 1993) and the genesis of collaborative therapy. At times, however, the therapist is drawn still to taking a first order position in the context of risk. Several participants described a point at which the power of the clinic or law may need to be invoked in order to assure patient safety. This move from the domain of explanation to that of production (Lang, Little, & Cronen, 1990) can be seen, in some respects, as the same as that of working with domestic violence (see for example, Cooper & Vetere, 2005; Paymar, 2000), in which a move to considering risk needs to be precedented over collaborative enquiry. I am in accord with Larner (2009) who describes how an "ethics of hospitality", which embraces other language and theoretical dimensions

to reduce risk, needs to be taken. He describes this as an ethical position in which the therapist can embrace a "systemic capacity to think and converse in many therapeutic languages at once" (emphasis in original). Likewise Bickerton, Hense, Benstock, Ward & Wallace (2007) describe a model for working with risk which prioritises both emotional and physical safety. The therapist needs to become skilled in balancing each of these safeties and to do so in a manner that minimises fracture of the therapeutic relationship. In the context of ever-present risk in the field of anorexia this requires constant dialogic, collaborative and democratic consideration.

McNamee (2015) points out that whilst a social constructionist position is a relativist one "it is not rampant relativism". It does not allow a person to construct the world as they want and anything goes. Rather, in seeing beliefs and values as being locally constructed, she posits that one must not impose constructs from one community upon another. She proposes that a task of a social constructionist therapy is to open a conversation that promotes curiosity about local differences and coherence. A first order position that is concerned with risk and the promotion of safety will depend on local notions of ethical action. Within this domain, McNamee (2009) makes the point that "One insidious expectation is the idea of a deficiency or weakness within the person. Put bluntly, people go to therapy because they "have" some internal flaw."

Within the discourse of anorexia the position of the therapist can, at times, be one of promoting anorexia as deficit or flaw promoting a need to empower through recovery that in fact, through the act of diagnosis, disempowers (ibid). McNamee goes on to propose that, whilst diagnosis itself is neither right nor wrong, a collaborative (and therefore democratically relational) stance can allow the therapist to contribute to a relationship within which the therapist is an expert with authority and also, at the same time, construct a discursive relationship where the therapist departs from cultural expectations of psychotherapy; authority is decentred to enter into conversation in which there are no preconceived notions of who therapist or client should be. Within this collaborative relationship, while it is necessary to attend to ethical and legal frameworks, explorations can be made of the dominant discourses that command ethical actions and begin to question, from a relationally responsible stance, the "taken-for-granted truths" (ibid), described by

Bourdieu as doxa (1977). McNamee suggests a move in "focus from the "rightness" or "health" of a client's actions- temporarily – to a "consideration of the conditions and resources that grant coherence to those actions such that alternative understandings might emerge" (emphasis in original) (2009). Within this morality of relational responsibility, what is therapeutic (and therefore ethical) becomes open and in movement, as is dialogue. Relational reflexivity (Burnham, 2005), the ability to coordinate appropriately within a relationship, allows one to have power with, not power over (McNamee, 2009). Freire (1996) describes, from a pedagogical perspective, a banking form of education in which knowledge is deposited within recipients, in a subjugating manner. He advocates a dialogic form of relationship, in which the division between teacher and student emerges into a relationship between teacher-student and student-teacher. The teacher learns from the student and the student learns from the teacher in a symbiotic relationship, "a process in which all grow" (ibid, p61). He goes on to state:

> The leaders do bear responsibility for coordination and at times direction, - but leaders who deny praxis to the oppressed thereby invalidate their own praxis…If they are truly committed to the liberation, their action and reflection cannot proceed without the action and reflection of the others. (ibid. p 107)

This notion of a therapeutic relationship with one who is oppressed has clear links to the therapeutic stance taken within anorexia. At the same time, as McNamee has stated, it is not therapeutic to accept that anything goes.

It would seem from the participants' responses that, on occasions, a first order position is more readily taken in the case of children and adolescents. Wilson (personal communication), a significant thinker and clinician in systemic child focused practice, suggests that we need to enter into dialogue without colluding (with anorexia). The stance of McNamee signposts a direction, in which the therapist can be both the expert and collaborative, through moving to a decentred position in which, I would suggest, Cecchin's concept of curiosity (1987) is maintained. At times, it may be that the therapist becomes imbued with the language (and therefore truths) of the clinic, language which is diagnostic in nature and which can construct unintentional disempowering relationships, which lead to a lack of agency and, in Honneth's terms, a lack of recognition. McNamee offers that a good clinician understands the relationship between behaviours and

diagnosis and yet does not position his/herself as a "knowing professional", but as one who is "curious to know how the client's life-world unfolds" (2009). I would propose that the same applies to increased chronicity where the maintenance of curiosity, whilst not colluding with risk, needs to be maintained. It is a task for the systemic therapist to continually ask themselves how they are positioning themselves within a system that potentially takes power over the other. It is their responsibility within a power structure to connect with the dilemmas of agency and risk, whilst not being seduced by local clinical language and practices.

The positions of the therapist (participants), interviewed in my study, indicate several polarities; from monologic to dialogic, the psycho-medical to psycho-social and from a systemic to individual perspective (Figure 10). These are not, however, constant and the relative positioning along the spectrums will vary from moment to moment, displaying either fixed variable points or both/ and positioning (Figure 11). Power forces, cultural, societal, organisational and interpersonal bring influence on the relative movement and strength of the positions (Figure 12). In the same way, the family members and the identified patient are also subjected to these positions and forces (Figures 13 & 14). The actors in the therapeutic encounter co-construct a relationship in which the positions are recursively influenced within the relationship (Figure 15).

Akamatsu's (1998) description of multiplexity is useful here, the understanding that we are privileged in some contexts and disadvantaged in others. In moving within the positions feelings of power and powerlessness amongst the participants may move around, as capital is gained or relinquished. This makes for a complex flow of currents in which attention needs to be paid by the therapist to the complex layers of meaning (which may move through a dialogic process) that can contribute to all participants' feelings of privilege or disadvantage.

Figure 10 Positioning influences

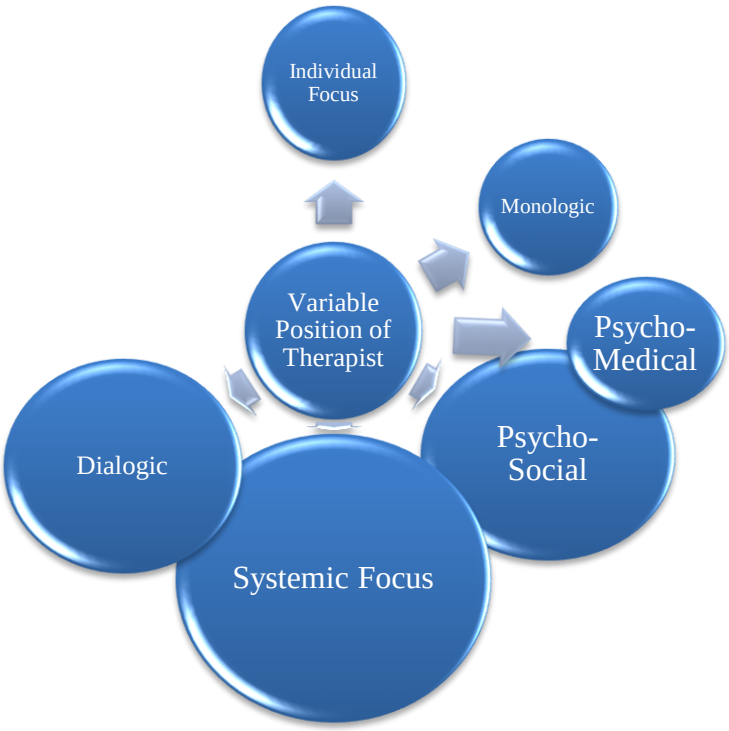


Figure 11 Variable positioning influences (1)

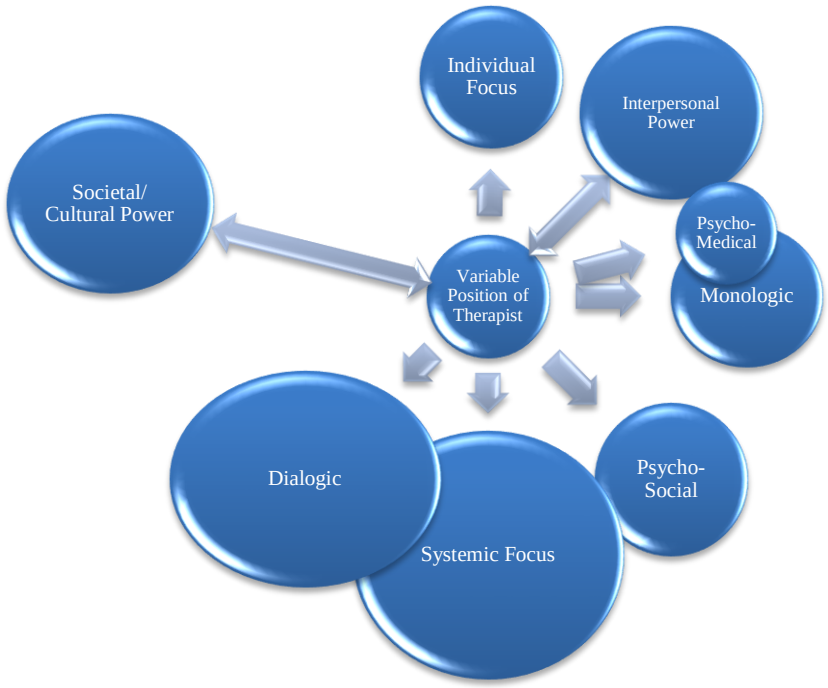


Figure 12 Variable positioning influences (2)

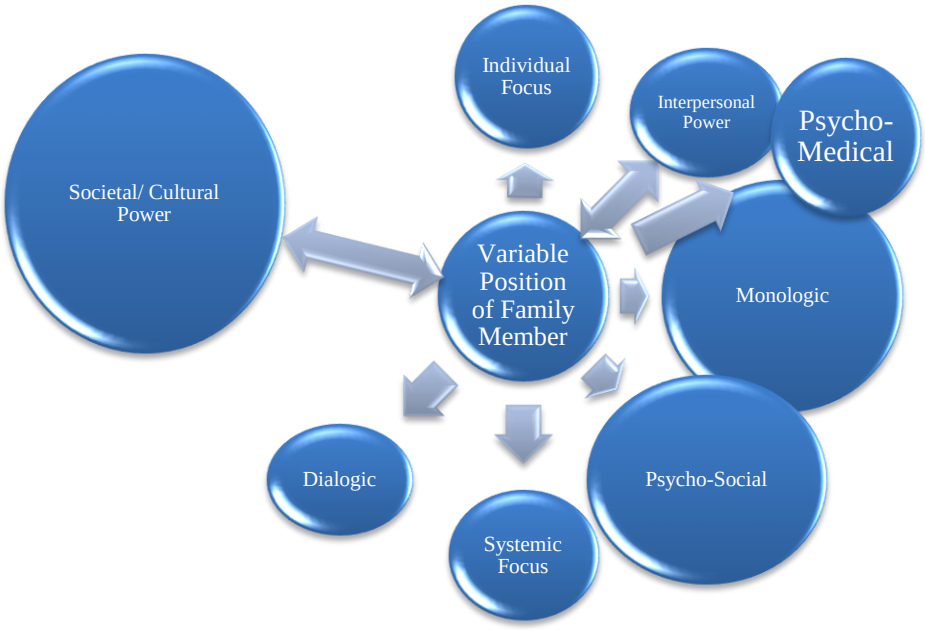


Figure 13 Family member positioning influences

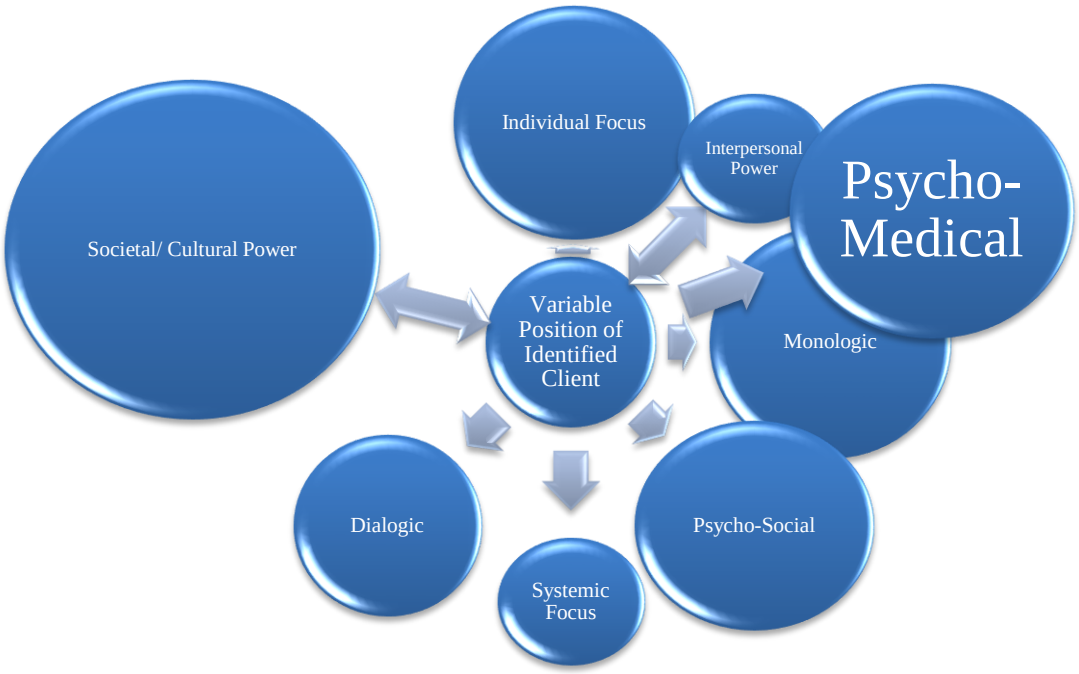


Figure 14 Identified client positioning influences

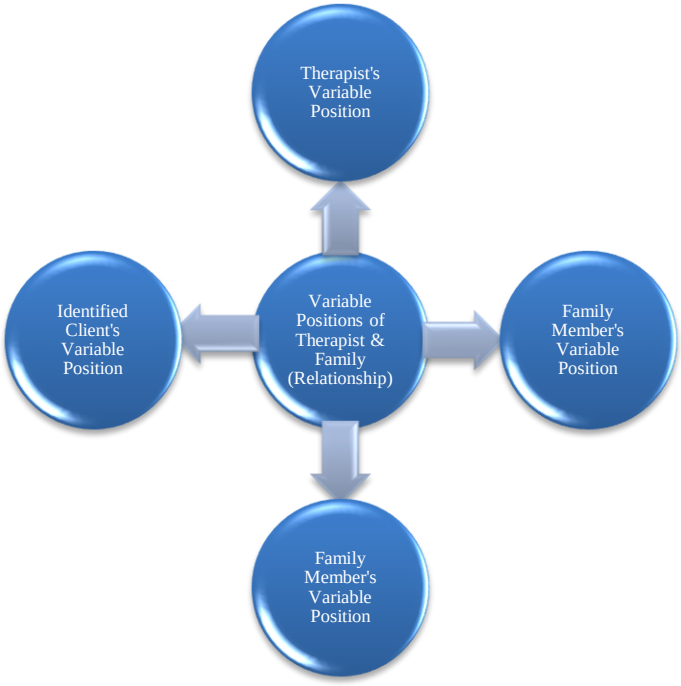


Figure 15 Interaction of positioning influences

5.3 The Positions

Perfectionism and a fear of not being good enough are endemic in the field of anorexia. These traits, often strongly identified within the patient, are also commonly evident within the family system, as loved ones struggle to have influence. The therapist, from a second order perspective, is not immune to these traits. The pressure to contribute to, if not effect, change can be strong within the context of the gaze of peers and the desire of the therapist her/himself to gain capital. I propose that the fear of loss or lack of social capital can become a driver to take a position rather than risk becoming seemingly inert within the therapeutic field. This fear, which I describe as the impotent position (Figure 16) becomes a hidden potential around which the three identified positions revolve, and gives the imperative to take a position.

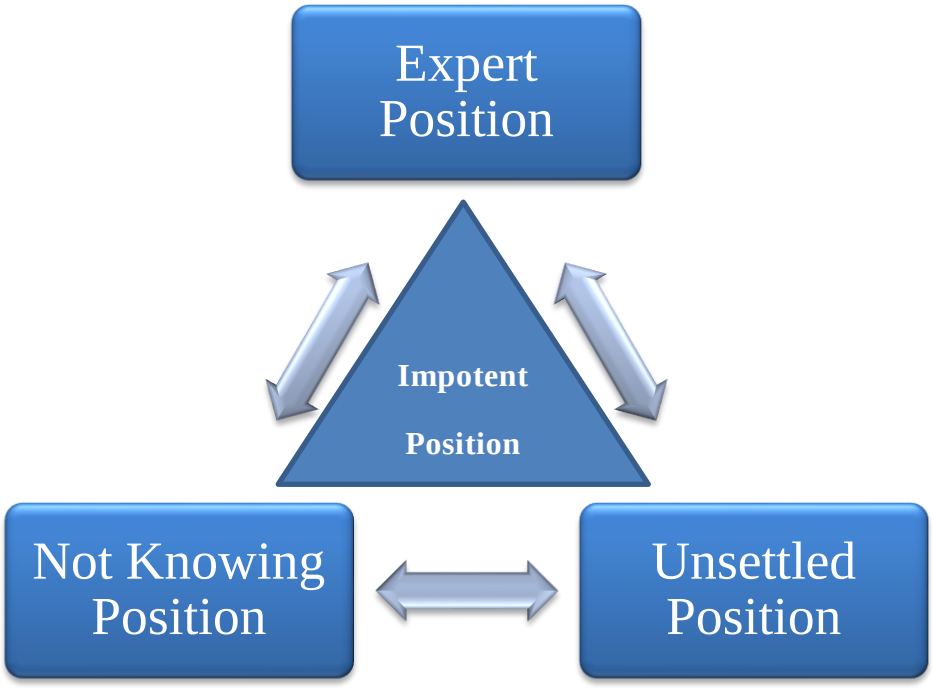


Figure 16 The impotent position

The drive to have efficacy, for the therapist, can be seen through Honneth's thinking of recognition in which a lack of recognition leads to a disempowerment of therapeutic agency. Similarly, for Bourdieu, the necessity to build capital is about gaining interpersonal power. The potential loss of capital through not taking

a position within the field of the clinic can be strongly influenced through the gaze of the professional and agency system and the need for recognition of therapeutic worth. Just as the patient is attempting to gain agency through starvation, the therapist, as previously discussed, can be seeking to gain agency through promoting 'recovery'. This powerful energy has the potential to steer the therapist towards the certainty of the expert position and/ or the not-knowing position (for one can become an 'expert' in not-knowing, creating less of a differentiation between the positions than there may seem at first sight). The unsettled position is one of courage to remain within, for it has the most direct route to impotence, having less certainty than the other positions. I propose that the dialogic stance of *informed orienteering* can encompass and allow movement within all positions, in a manner that allows for contradictions and holds dilemmas to be tolerated.

Mason's concept of safe uncertainty (1993) is a useful lens for considering the positions. The expert position can be considered as being about having knowledge and cognitive reflexivity; it sits with the domain of certainty and at times might be indicative of medically safe certainty or unsafe certainty. When the expert position, applied to anorexia, is applied from a psycho-medical or social constructionist paradigm, to the total exclusion of the other, then the therapist is increasing the risk of diminution of agency and emotional growth or physical health. The unsettled position can be considered as emotionally reflexive, but within the domain of unsafe certainty. The not–knowing position can be seen to be within the domain of cognitive and emotional reflexivity and safe uncertainty, so long as the psycho-medical is held in mind.

5.4 The Positioning Actions

The positioning actions identified (section 4.3.4) of comfort, support and challenge evolved both through the data and my own practice. I regularly share my thinking of these positions with families, to seemingly useful effect. In a context of externalising, in which anorexia is regarded as separate from the client, I continually consider whether the action is useful to my client or anorexia (Figure 17). The gap between intent and effect can often add to, rather than diminish, the power of anorexia.

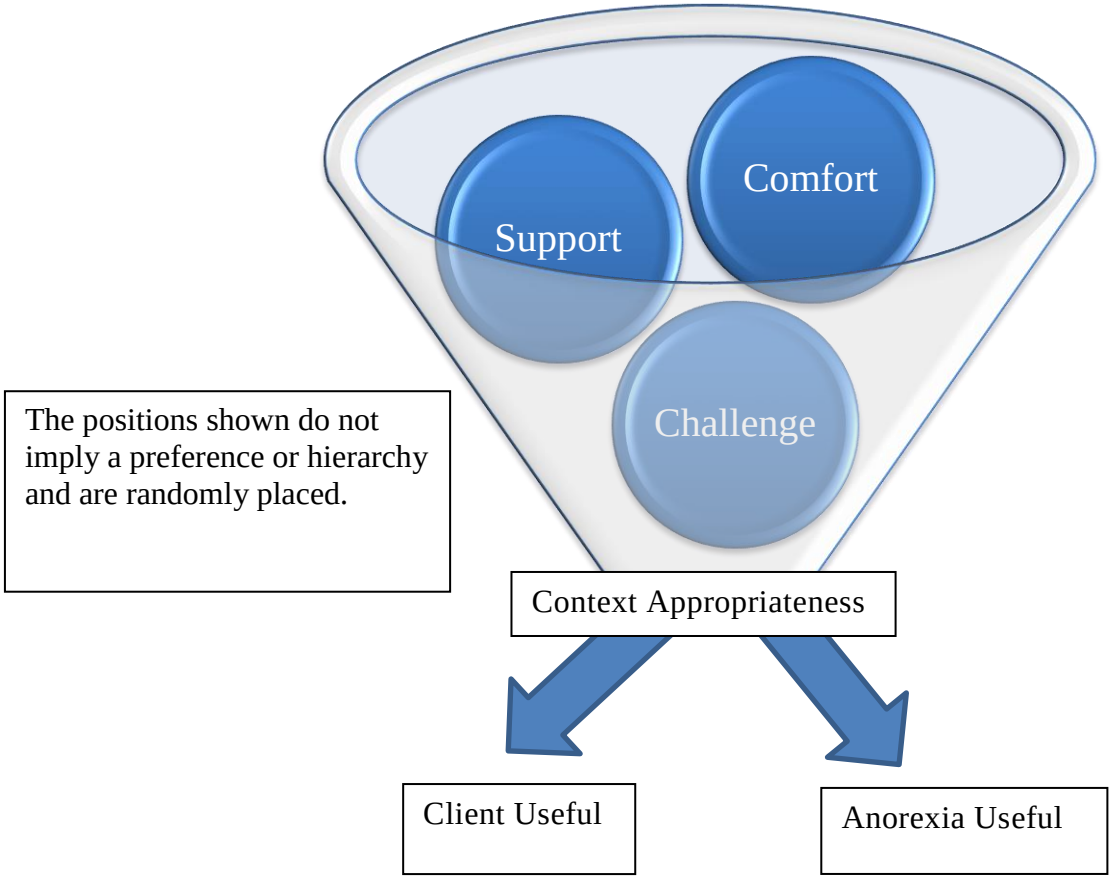


Figure 17 Comforting, supporting and challenging

Whilst comforting is appropriate as both a human response and within the therapeutic relationship it can often become counter to intent in two ways. Firstly, the comfort of distress can evolve into a position in which change is seen as too distressing to be attempted, enhancing anorexia. Secondly, Michael White (personal communication) distinguishes between affirmation and attribution. In a process of comforting care needs to be taken to not give the same attribution to distress, marginalising subjugated accounts, whilst affirmation can sit alongside enquiry.

Support and challenge, similarly, need to be considered in a context of who the action is useful to. Parents will often challenge eating behaviour in a manner that evolves into confrontation, assisting an anorexic coup. Likewise the therapist seemingly, from the data, can take a first order instructive positon more easily with clients of younger age or greater chronicity, than a second order collaborative

stance. Support needs to be co-constructed with agreed outcomes or, again, anorexia can prevail. Through constant consideration of who an action is useful to an aide is given to the concept of *informed orienteering*.

I now offer my notion of *informed orienteering* as a way of steering through these complexities.

5.5 Informed Orienteering

To re-state the dilemma, the systemic therapist has a range of discourses available that, at their polarities, comprise a psycho-medical perspective which potentially involves reduction in risk and agency and, at the opposite polarity, a social constructionist perspective that potentially increases agency and risk. The task of the therapist, I propose, is to navigate between these points in order to contribute to an increase of agency, whilst risk progresses towards acceptable medical norms. The focus of a systemic therapist is the space between individuals and, as such, does not collude with a world view of individuals as boundaried beings[36] (Gergen, 2009), but as self always being formed dynamically in relationships. In treating all views as subjective, and there being many truths, it follows that the psycho-medical, for all of its potential individualised pathologies, needs to be taken into account when managing physical risk by systemic family therapists, who are arguably more comfortable operating within a social constructionist paradigm. To paraphrase Foucault, it is not the clinic that is the problem but when the power of the clinic becomes subjugating that *is* the problem.

The systemic therapies comprise a 'broad church', ranging from normative approaches, such as structural family therapy, through to those that seek to understand meaning in context and take account that self is socially constructed and subject to power dynamics. This broad range gives accessibility to many approaches at any one time and, much as treatment of anorexia generally requires a multi-disciplinary approach, it can be argued that no single approach is currently regarded as having sufficient efficacy (Price Waterhouse Coopers, 2015). For some therapists a single paradigm is their chosen modality but, I would argue, it is the task of the therapist to co-construct with the family or individual an approach appropriate to the individual specifics of the

[36] A term coined by Gergen to denote the misconception that individuals (and mind) are discrete from each other, rather than formed through relationships.

encounter, privileging the family and not the theory, in keeping with a dialogic position.

The adoption of a collaborative and dialogic approach, I would contend, has great potential in the treatment of anorexia. Whilst these can be regarded as sitting within a social constructionist frame they do not fall into the dilemma that can arise when working in a single modality. Ali Borden (a narrative therapist and author working in eating disorders (see Maisel et al., 2004)) describes how she will tell a patient the physical point at which she will have to hospitalise the patient, then work within her modality without a requirement for dialogue about physicality (personal communication). Whilst this gives much scope for collaborative dialogues, it also gives potential for starkly arriving at a non-collaborative and possibly subjugating point in therapy, and the possible fracture of the therapeutic relationship.

My proposition for navigation is to adopt a dialogic position, that of *informed orienteering*, in which all points between the polarities of anorexia are 'listened' for, both within the mind and body of the therapist and within the therapeutic conversations. When Anderson and Goolishian published their 1988 paper, promoting a move towards therapy as a linguistic encounter, they began a movement from a structural to a dialogic phase in family therapy that continues as a process today. The concept of 'not-knowing' that they introduced was an invitation to use curiosity to suspend the therapist's assumptions with an invocation to listen in order to hear, rather than to give space for the next therapeutic intervention. In placing, as they did, the client as expert they did not deny the expertise of the therapist. Rather, they acknowledged the knowing of the therapist and invited the therapist into a position of expert of the process, rather than the content. This process was a move towards the dialogic, in which a polyphony of internal voices, both of the client and therapist, are brought into the encounter.

The work of Bahktin is influential in informing the dialogic. He states:

> Life by its very nature is dialogic. To live means to participate in dialogue: to ask questions, to heed, to respond, to agree, and so forth. In this dialogue a person participates wholly and throughout his whole life: with his eyes, lips, hands, soul, spirit, with his whole body and deeds. He invests his entire self in discourse, and this discourse enters into the dialogic fabric of human life, into the world symposium. (cited in Rober, 2005a).

Bahktin regards language not as descriptive, but as giving meaning through dialogic encounters that shape the context in which the language is used. In this way, a dialogic experience becomes one in which new realities can occur, through a dynamic process. By moving from a monologic encounter, in which the words of the client are received and interpreted, to a dialogic one, in which the internal polyphony of inner voices of both client and therapist are revealed and their combined accumulated lived experience can be brought forth, new and morphogenic meanings can emerge from previously constructed narratives. Shotter states "Don't ask what goes on inside people's heads?' instead, ask 'What do people's heads go on inside of?" (personal communication). A dialogic process is one in which the 'going on inside of' can be linguistically changed to move from external monologues to external dialogues and, potentially, then moving from internal monologues to internal dialogues.

The work of Bourdieu becomes useful in this regard. If, as previously suggested, patient, therapist and family can be gaining capital in differing competing fields, little space exists for dialogic collaboration. If, however, a field can be found, in which there is enough commonality and diminished need for competitive capital accumulation, potential for transformative dialogic encounters develops. I propose that one such field is that of human suffering and the search for security. Attachment Theory, and specifically the Dynamic Maturational Model of Crittenden (2011), posits that we are all attempting to survive and that, in doing so, we develop attachment strategies designed to facilitate security. At times, however, through relational experiences, these strategies, which are designed to be a solution can become exaggerated and contextually inappropriate over time, and thereby become a problem. Habitus can develop, in which the more capital that is gained the more insecure the subject becomes, both in emotions and physicality, as can be understood in the case of anorexia. If the therapist can hold a position of recognition that what ails the 'sufferer', which is the insecurity of life, is what ails humanity and that we merely have differing solutions to this life experience through diverse searches for happiness, then a more dialogic position might be found[37].

[37] Self-disclosure is a risky strategy in therapy but can contribute to a relationship based on commonality, if used with caution. For instance in working with Kathy (who had returned prematurely from university due to her anorexia, developed in a context of the stress of her studies) and her parents, I disclosed my own son's need to do the same, due to illness. Through a

Shotter (2012b, p136) states that we cannot plan for innovative change but we can prepare for it, and occasion it by setting the scene, by using first-hand experience. By getting in touch with the self of the therapist, and specifically having an understanding of one's own suffering and security-seeking strategies, it is possible to prepare for a dialogic relationship in a context of polarising distress. In knowing how to go on, Shotter (2011a) suggests that by listening not only to our cognitive thoughts, but to our embodied in-the-moment experiences, we can gain a sense of where we are and how to go on, a process he describes as orientation. He suggests having a 'withness thinking' (2011b) in which one has a:

> knowing to do with one's participation within a situation, with one's place within it, and with how one might 'go on' playing one's part within it- a knowing in which one is affected by one's surroundings perhaps more than one even affects them. (2012a, p2)

In this knowing how to go on there is a dialogic process in which one responds, not only to one's inner cognitive processes, but to one's inner felt experience and, significantly, to one's surroundings and others. It is a process in which the spirit of Anderson and Goolishian's not-knowing becomes embodied. In this manner, new habitus can develop for the participants of the dialogue, which, in turn, may alter the nature of the field of the therapy room in the treatment of anorexia. In the words of Gergen and Gergen (2015) "we cannot control the winds but we can adjust the sails." By moving with dialogical responsiveness, the therapist can adjust their sails to navigate safely the polarities.

This work began with my research question concerning the positioning of family therapists within the domain of anorexia. This was informed by my dilemma of how to navigate between reducing risk whilst contributing to agency. It soon became evident to me, through both the literature review, interviews and data analysis, that the notion of agency is complex and riddled with dominant discourses and power positions and practices. Through this evolves the question of whose agenda determines the shape of therapy when so often the client is, as best, ambivalent to change. Therapy can so easily become, inadvertently, part of the problem.

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dialogue of commonality of suffering and attempts to recover, Kathy began to diminish the shame she felt, that was allowing the anorexia to thrive.

In my own practice I have moved, over time, from an agenda to eliminate anorexia to one of considering with my clients the question of where the relative influence sits within the relationship between client and anorexia, and whether there are alternative possibilities to this balance of influence. I declared at the beginning of this work that I regard the practice of *informed orienteering* to be one way in which to navigate my dilemma in a manner that has possibilities for both growth in agency and reduction of risk. The notion of *informed orienteering* is not a new theory of change or way of working, but a manner in which all dimensions can be considered whilst navigating through the thorns of the undergrowth on the path to new options.

The participants in my research expressed many differences in their approaches but all had in common a regard and concern for their clients and a desire to keep them safe, whilst contributing to change. Different emphasis was given to the balance between agency and risk, which is core to my dilemma.

Informed orienteering is an application of dialogic, democratic and collaborative thinking, within the context of risk. It has its roots in the stances of Shotter's withness thinking and orienteering, combined with influences such as collaborative therapy and open dialogue and in Mason's thinking around the positions of safe uncertainty and authoritative doubt.

The principal points of *informed orienteering* (within the field of anorexia), as contained within this thesis, can be summarised as:

- The taking of a systemic, dialogic and collaborative stance.
- Attending to the dilemma of decreasing risk whilst increasing agency.
- Having knowledge of, and accounting for, both the psycho-medical and social constructionist polarities.
- Taking both/ and positions in a stance of authoritative doubt.
- Giving ongoing consideration to issues of both interpersonal and societal/ cultural power positions and practices.

The notion of orienteering, how to proceed moment-by-moment rather than in a pre-determined, un-negotiated manner, does not mean not carrying knowledge. Being able to point things out along the way, without commanding how things are viewed, is essential to a democratic, collaborative relationship in which all participants can learn

and grow. Wilson (2015) discusses family therapy as "a process of humanisation." He goes on to state:

> The therapist/ practitioner places open responsiveness to others' contributions as a central tenet of practice. This means resisting the drive to categorise, to place oneself as expert above the other (though neither should eschew knowledge and experience that might be useful), or to respond to the other as object…(the therapist) openly engages as a human being who is a professional helper. The focus of a democratically shaped dialogic orientation is on the other's responses and resources as a guide to the direction of the family therapy session.

Wilson's statement embodies the spirit of *informed orienteering*, in which the therapist also carries specific knowledge and experience (both medical and emotional) of anorexia. It also encompasses Shotter's notion of withness, in which the therapist appreciates that otherness is part of the issue in anorexia's development (Figure 18).

Figure 18 Withness and otherness

In order to effectively orienteer the therapist will often move between leading, following and walking alongside (Figure 19), responding to the needs of the family and client in moment-by-moment patterns of relational responses. Rober (2005a) writes:

> The therapist is not primarily concerned with knowing, or with not-knowing. Instead the focus is on the idea that first and foremost therapy is a

meeting of living persons, searching to find ways to share life together for a while.

In a context of risk, especially where the client is younger or health is chronic, it will be hard for the therapist to adhere to a position that seems to be so far from that of perceived safety and certainty. I propose that, as demonstrated through some of the participants' positions, it is possible to discuss risk and implications for decreasing health whilst holding the central systemic positions of maintaining curiosity and dialogue. This gives potential to navigate more effectively through the domains of risk and agency

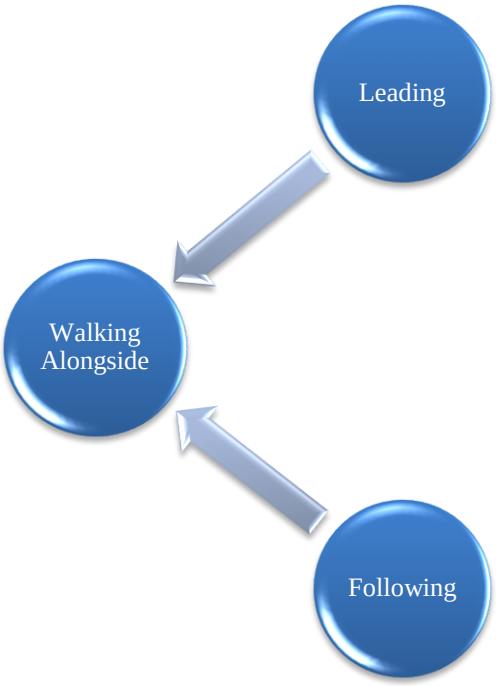

Figure 19 Alongside, following and leading positions

I now turn to considering the impact of myself upon this study and this study upon me.

5.6 Recommendations for Future Research

This research has, by necessity and as is normal, focused on a specific locus, disregarding tempting by-roads that have emerged. These form part of the potential

for future research. This study has, given its sample size, been an abbreviated grounded theory research. The concept of theoretical sampling demands that analysis of the data informs further sampling and analysis and this in turn informs my suggestions for further expansion of my research.

The variables in responses of the participants regarding both chronicity and age present areas of interest, which require further exploration. It was clear from the responses that the ability to move away from the psycho-medical polarity was influenced by how youth or risk (in the form of chronicity of medical measures) was perceived. There has not been space to explore this in greater detail and specific research around how these two variables influence positioning of the therapist would appear to be potentially beneficial.

Risk within the discourse of anorexia has been key to this work but the arguments put forward here would be interestingly located in other areas of risk, for instance those of drug and alcohol abuse, risk-taking behaviours (such as sexually dangerous practices) or extremes of self-harm. All of these examples, and others, can be viewed through a similar lens of security-seeking strategies and would give useful comparisons, once researched.

The voice of the clients and their perceptions has been missing in this study. Whilst there is a plethora of accounts of patient and family experience in the treatment of eating 'disorders', and in family therapy generally, there appears to be none that specifically seek to understand the clients' experiences of the variation in positioning and the power dynamics within this domain.

Finally, the results of this research would be usefully expanded to consider more participants. A greater explicit focus in the questioning on power and some of the conclusions regarding the use of a more dialogic stance within treatment, given the difficulties in locating this to any extent in the literature, would contribute to this study.

5.7 Implications for Systemic Psychotherapy

This work has been influential in changing my own practice and as such, I propose, has elements of use to family therapists.

The work of Bourdieu has been useful in allowing an interpersonal lens for considering power dynamics, both within families and between the therapist and client. In introducing the notion of gaining capital through habitus it becomes possible to add to the common practice of thinking of power in discriminatory terms (often through the social graces (Burnham, 1992; 1993; Roper-Hall, 1998)) or through Foucauldian perspectives. Likewise, some of the power perspectives brought by those in the psycho-social and feminist (especially contemporary third wave feminism[38]) thinking fields (for example Butler and Benjamin) offer a richness that the field of systemic psychotherapy still waits to take advantage of, within its dominant discourses.

My addition of "informed" to Shotter's concept of orienteering, my placing emphasis on the need for specialist knowledge of anorexia within a dialogic frame, has possibilities to add to the reflexivity of the therapist in considering their positioning in-the-moment, alternative positions, and why they are choosing a particular stance. Within the dialogic relationship, my experience has been that it facilitates greater consideration of the nuances of power in-the-moment and, as such, adds to both the therapeutic relationship and the emergence of new possibilities. The understanding of the double hermeneutic influences on positioning, as well as the power forces within this field bring additional subtlety to the therapeutic lens for considering the variable effect of actions within the field of anorexia. Within my own practice, I have found that consideration of my actions in relation to my intent give a sense of process rather than a set of rules, in which to flow through the complexities of variations in clients' and anorexia's responses to me. Sharing of this thinking, in diagrammatic form, has proven useful to parents struggling to exit the double binds.

5.8 Conclusion

This thesis has explored the field of anorexia and how family therapists do, and might, orientate themselves within it. It has considered both previous and current thinking and brought some new considerations, especially around power issues and my introduction of *informed orienteering* as a possible tool for navigation.

[38] Whilst areas that emerge from this thinking, such as queer theory, sit within the margins of current family therapy it appears from this research journey that there is much still to be introduced into the mainstream, rather than being restricted to dialogues around discrimination.

In addition to the contribution that I hope my research will make to the extensive literature and research in the field of eating disorders, it has aided my own practice and left me with a desire to extend my own learning further, both within the field of anorexia and applications outside of this. It is my hope that it will be of some interest to colleagues and assist their own practice.

Finally, it became clear from the research interviews that the participants came to the field of eating disorders more by chance than desire to work in this area. They commonly expressed a lack of specific training and the need to educate themselves. In some ways, this may account for the attraction, at times, of the expert position. Being within a multi-disciplinary team (often as the sole family therapist) in which a medical model dominates it can often be difficult to hold a systemic perspective and there can be a temptation to absorb the dominant discourse in a context of potentially life threatening risk. In such contexts, adoption of at least parts of the medical model can assist the building of capital within the team.

In my early working within the field of anorexia I suffered from a lack of knowledge of the implications of my positioning. In working with Magda, for example, I was keen to distance myself from conversations with her and her family about her worryingly low weight, preferring to leave this to colleagues and thus, in my mind, not threatening the therapeutic relationship. By not seeing that I could do both/ and, attend to the relationship and take responsibility alongside my colleagues for risk, I starkly arrived at a point where Magda was sectioned under the mental health act, the family felt I had ignored risk and Magda felt betrayed by all. If, at that time, I had adopted a stance of *informed orienteering* there may well have been potential for continuing a collaborative generative relationship, whilst attending to medical safety and systemic change.

I propose that specific training in working with risk in eating disorders and, *at the same time,* holding to systemic training is essential if family therapists are to adopt their remit (and mandate) of taking a systemic perspective whilst also taking responsibility for risk. There continues to be a need for specific training workshops in this area if systemic thinking and practice is not to be subsumed under the banner of ‘family interventions’ as specified by NICE guidelines.

It matters little
That something is true
Or not
till someone says you must live
A certain way
Because they believe
Something is true
Or not

(Siffre, 2015)

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7 Appendices

7.1 Appendix 1. Participant Information Sheet

Department of Psychosocial Studies

30 Russell Square

London
WC1B 5DT

Tel: 020 3073 8045

Identification Number for this trial:

PARTICIPANT INFORMATION SHEET

Title of Project: **What discourses influence the positioning of Family Therapists on Anorexia.**

Name of Researcher: **Nigel Jacobs**

You are being invited to take part in this research study that is being done as part of the Professional Doctorate in Family and Systemic Psychotherapy in the Department of Psychosocial Studies, Birkbeck, University of London. And has a strong educational element in furthering the research abilities of the researcher himself, as well as learning that evolves from the study. It will provide investigator with the specific experience in undertaking research analysis. There has been little previous research into the professional discourses towards Anorexia Nervosa, despite considerable literature being in place, however, none address how varying and often conflicting discourses are addressed by family therapists.

The study has received ethical approval.

Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information sheet carefully. Talk to others about the study if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

This study wants to explore an understanding of the professional, personal, and societal discourses that influence where Family Therapists are positioned on anorexia.

Why have I been chosen?

We are aiming to involve 8 Therapists within Eating Disorders Services, or CAMHS or similar from all over the UK. We are asking you if you would be willing to help as we thought you might be suitable for the study and interested in taking part.

Do I have to take part?

No, it is up to you to decide. If you interested in taking part in the study, we will describe the study, go through this information sheet with you and then give you a copy.

If you decide to take part, we will ask you to sign a consent form to show that you agreed to participate in the study.

If you agree to take part, but then decide that you do not want to carry on with it, you can leave it at any time. Again, this will have no effect on the care that you receive.

What will happen if I agree to take part?

We will ask you to take part in an interview with the researcher that will involve asking you a series of questions about your perceptions of the influences that you encounter in thinking about your work with Anorexia. This interview will take no more than an hour and a half to complete.

What are the possible benefits of taking part?

The process of reflection through the interviews potentially gives direct benefit to the participants, in reflecting on their own practice. The outcomes of the research, which will be shared with all participants, may bring benefit to their own practice.

What are the possible disadvantages of taking part?

In order to help with the study you will need to be willing to take part in an interview and sign the consent form. This will take no longer than an hour and a half during your meeting with the researcher.

If you agree to participate you will agree a convenient time and place for me to interview you. You are free to stop the interview and withdraw at any time.

Will my taking part in the study be kept confidential?

Yes, we will follow ethical and legal practice and all information about you will be handled in confidence and stored in an anonymous fashion. That is, if you take part in the research, you will be given a unique research number and only this number will appear in the information stored. Stored information will be controlled by Mr Nigel Jacobs the only researcher who will have access to this information. The information will be kept in locked cabinet and encrypted Computer. The information you provide will be destroyed after three years.

What if there is a problem and something goes wrong?

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been treated during the course of this study then you should immediately inform the Study Supervisor on the address and number above. Any complaint you have about the way you have been dealt with in the study will be addressed. The normal National Health Service complaints mechanisms are also available to you.

There are no significant risks in this study, which interviews Family Therapists regarding their clinical practice.

Family Therapists are used to reflections upon their practice. As such, this research will be an extension of the familiar process to the participants. It is possible that the interviews may rise self-questioning by the participants of their own practice. Any undue distress from this would normally be mitigated by clinical supervision, but the researcher will clarify any distress during and at the end of the interview.

The process of reflection through the interviews potentially gives direct benefit to the participants, in reflecting on their own practice. The outcomes of the research, which will be shared with all participants, may bring benefit to their own practice.

What will happen to the results of the research study?

Once the study is completed, we will produce reports that will describe the findings of the study. We will produce a summary of our findings which we will send to all those people who take part in the study and would like a copy. You will not be identified in any report or publication. The reports we write will not include personal details of the people who take part. A code will be attached to your data so it remains totally anonymous.

The analysis of our interview will be written up in a report of the study for my degree. You will not be identifiable in the write up or any publication which might ensue.

Contact for Further Information

If you have any further questions about the study, please contact Dr. Margarita Palacios at the above address and telephone number. Otherwise, I will contact you in the next week to see if you would like to arrange an appointment to meet.

THANK YOU FOR YOUR TIME

Information Sheet date of issue: ***14 January 2014***
Information Sheet version number: ***Version 1.0***

7.2 Appendix 2. Participant Consent Form

Department of Psychosocial Studies

30 Russell Square

London WC1B 5DT

Tel: 020 3073 8045

Identification Number for this trial:

CONSENT FORM

Title of Project: **What discourses influence the positioning of Family Therapists on Anorexia.**

Name of Researcher: **Mr. Nigel Jacobs**

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated **14 January 2014** **(version 1.0)** for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I have been informed about the nature of this study and understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐

3. I understand that the content of the interview will be kept confidential and data collected during the study, may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records. ☐

4. I am over 16 years of age. ☐

5. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person	Date	Signature

Consent form date of issue: ***14 January 2014***
Consent form version number: ***Version 1.0***

There should be two signed copies, one for participant, one for researcher.

7.3 Appendix 3. Full Coding Set

Category: Considering anorexia

Axial Code	Focused Code	Line by Line Coding (bold= sub-code) (number = occurrences of code)
Considering cause of anorexia		
		knowing aetiology helps [1]
	Describing unknown causation	describing desires and triggers process [1] thinking of aetiology as confusing [1] considering aetiology [1] not discovering cause [1] unknowing aetiology [1]
	Describing unintentional causation	seeing anorexia as chance [1] believing anorexia is diet gone wrong [2] regarding minority as using anorexia as strategy [1] seeing anorexia as coincidence [1] describing anorexia genesis as not related to actions [1]
	Describing protest causation	emerging anorexia as gender response [1] describing grievance aetiology [1] seeing anorexia as embodiment [1] not seeing it all about oppression [1] seeing ed as protest in family politics [1] regarding protest and image as of prime contribution [1] considering origins not about protest [1] seeing protest in recovery process [1] regarding ed as protest [1] differentiating predisposing and perpetuating factors [1]
	Describing multiple causation	regarding ed as multi factoral [1] seeing cause as less relevant [1] seeing anorexia as having different aetiology [1] regarding anorexia as car crash of influences [3]

		anorexia as multifactorial [1] describing bio-psycho-social aetiology [1]
	Describing family causation	explanation of AN as to do with marriage partners [1] **not blaming home [0]** equating high aspiring families with "fine" [1] rejecting horrible event aetiology [1] discounting abuse aetiology [1] avoiding mother blaming [1] **blaming home [0]** considering home to be awful [1] thinking that family will play into biological illness [1] describing home causes [1] considering context as aetiology [1] considering horrible events [1] blaming mothers [1]
	Describing biological causation	Understanding biology of anorexia [1] **rejecting biological cause [0]** seeing genetics as not part of ed [3] rejecting genetic explanation [1] rejecting genetic position [1] rejecting biological aetiology [1] describing thinness as not leading to anorexia [1] **attributing biological cause [0]** tipping into starvation [2] tipping into anorexia [1] considering biological baggage of psychological distress [1] promoting medical discourse [2] describing susceptibility to anorexia [0] differentiating genetics and susceptibility [1] defending genetic discourse [2] taking genetic and susceptibility position [2] seeing explanation as biology of starvation [1] thinking that illness is MAINLY biological [1] thinking as illness that is biological [4] seeing temperament as genetic [2]

		seeing some small link with genetic aetiology [1] describing as biological [0] attracted to certain temperaments [1] being sensitive [2] being driven [2] describing biological cause [1] **using biological to take away blame [1]** thinking biological description useful [1] **promoting Minnesota experiment [1]** putting Minnesota results on women [1]
	Describing attachment causation	considering attachment strategies [1] **considering causation of vulnerability [1]** considering genetic and life vulnerabilities [1] putting sway on predisposing vulnerability [1] describing vulnerability [1] **not seeing attachment as prime [1]** not seeing as attachment trauma strategy [1] **Considering insecurity [0]** linking ed to panic and insecurity [1] not coping [1] holding that ED is about emotional and interpersonal life [2] viewing anorexia as manifestation of psychological distress. [1] communicating distress [1] regarding anorexia as symptom of distress [1] considering control as factor [2] seeing controlling eating as bringing order and safety [1] not only seeing control in cases of bad things happening [1] controlling chaos with ed [1] connecting control with perfectionism [1] regarding anorexia about control [1] working with control in family [1]
	Describing societal causation	applying gendered statistics to ed [1] **theorising about anorexia as adaptation [1]** explaining anorexia as adaptation [1] **developing social constructionist view of ed [1]**

		seeing anorexia as social construction [2] losing social constructionist view [1] **theorising how women should be [0]** thinking women care about their bodies more [1] thinking of western men as needing thin attractive virgins [1] thinking of female need to be healthy and slightly plump [1] theorising that girls should not look buxom [1] theorising that girls should look virginal [1] theorising that girls should be androgynous and virginal [1] **considering cultural contexts [0]** regarding culture as part of aetiology [2] Being a visual society [1] socially constructing body image in couple relationship [1] explaining AN as to do with famine [1] **Thinking of body image [0]** considering media as part of the aetiology [3] stating to do with media as insufficient [1] becoming aware of body image when someone else is aware [1] having susceptibility to media images as comparison [1] not understanding body image, as a man [1] considering body image to be culturally bound [2]
View on Anorexia		
	Viewing Anorexia as bad	regarding anorexia as contamination [1] Not befriending illness [1] Seeing anorexia as bad [1] pointing out restrictions of illness [1] Battling with anorexia [2]
	Viewing Anorexia as not all bad [3]	not needing all anorexia to go [1] using perfectionism to bring stability [1] using ed to make insecurity more tolerable [1] Considering advantages of anorexia [1] Considering advantages leading to ambivalence [1]
	Viewing Anorexia as friend and foe [3]	Viewing Anorexia as friend and foe [3] seeing ambivalence to treatment [1]

	Seeing Anorexia as enduring	accepting some may not fully recover [1]
Responding to Anorexia		
	describing complexity [1]	viewing anorexia as perplexing [1] rejecting simplicity [1]
	Understanding nature of Anorexia	understanding why anorexia is so tenacious [1] Suffering unintended consequences [1] describing self-harm [1] seeing anorexia as close to self-injury [1] understanding anorexia's rationale [1]
	Naming stereotypical perspectives	describing classic situation [1]
	Confirming dominant discourses	thinking it's luck [1] being interested that all women have dieted [1] normalising thinness desire [1]
	discounting discourses [1]	treating ed as generic FT [1] thinking it's not systemic but socially influenced [1] rejecting structural descriptions [1] not explaining ED systemically [3] getting cross about own fault discourse [1] getting cross about fashion discourse [1] rejecting model discourse [2] rejecting on purpose discourse [1] thinking of discourses that don't help [1] describing inpatients as beyond popular discourses [1] rejecting diet discourse [1] looking at legal perspectives [1] rejecting CBT approach [1]
	Considering what it's like to have anorexia	thinking it's horrible to have anorexia [1]
	Emotionally responding to anorexia	feeling the power of anorexia [1] Feeling sad about not seeing other options [1] Balancing heartbreak [1] Feeling heartbroken [3] feeling rewarded [1]

		feeling stressed [1] feeling drained [2]

Category: Considering the Patient

Axial Code	Focused Code	Line by Line Coding (bold= sub-code) (number = occurrences of code)
Perceiving patients		
	Seeing positivity	wanting to change some behaviour [1] seeking possibilities [1] recognizing changes as child [1] Seeing patients recognising anorexia
	Seeing negativity	manipulating body [1] losing sexual self [1] learning thinness from mother [1] considering co morbidity [1] not accessing self [1] being conflict avoidant and causing [1]
	Seeing people as unique[1]	**Seeing diversity in patients [0]** seeing range of ages [1] seeing mainly teenagers [1] treating ages differently [1] being dialogic across age range [1] Depending on age [1]
Positioning of patient		
	Experiencing treatment	being fearfully alert [1] becoming less compliant [1] not wanting FT as sign of getting better [1] feeling safe to talk [1] wanting support [1] being scared by authority [1] being relieved by authority [1] Experiencing poor treatment [2]
	Fighting anorexia	fearing voicing desire to recover [1]

		getting control over anorexia [1]
	Seeing anorexia as restricting	Being silenced by anorexia [1] seeing patients controlled [1] losing choice [1] Being trapped in anorexia [1] Screaming within anorexia [1] seeing patients disempowered by ED system [2] Anorexia as choice [1] Shutting down options [1]
	Seeing anorexia as empowering	wanting to manage thinness [1] acknowledging need for radical patient strategies [1] relying on anorexia [1] thinking anorexia is fine [1] MAXQDA 21/03/2015 5 identifying as thin not anorexic [2] wanting to be thin [2] patients feeling agency [1]
Positioning on patient		
	Leading client	seeing struggling as ineffectual [1] Ignoring if anorexia strong [1]
	Discounting patients[1]	thinking of adults as not adults [2] adult patients presenting as teenagers [1] not asking patient [1]
	Getting alongside[2]	wanting clients to have full life [1] having valid voice [1] Needing support [1] seeing similarities and differences [1] rejecting ego syntonic argument [1] not hitting everyone with the same thing [1] accepting anorexic decision [1] reducing hierarchy [1] feeling threatened barrier to getting alongside [1] getting alongside age problem [1]

Category: Considering the Family

Axial Code	**Focused Code**	**Line by Line Coding** **(bold= sub-code) (number = occurrences of code)**
Perceiving families		
	Understanding parents	Experiencing love as an attack [1] Not expecting parental consent to dying [1] Understanding parental love [1] Finding a collaborative understanding [1]
	Considering family assets	considering family structure [1] seeing parents as reflexive [1] seeing families as important [1] being restricted by context [1]
	Families in action	Empowering support through love [1] Intending by parents [1] Not standing by [1]
	Family as depleted	experiencing fear and exhaustion [1] seeing despair and distress [1] seeing anorexia impacting on whole family [1] freezing communication by anorexia [1] seeing parents as diminished [1] **Being disempowered [0]** losing authority [1] feeling blamed [1] disempowering from ED [1] disempowering by adolescent [1] disempowering by MDT [1]
	Family as privileged	seeing private cases having more resources [1]
	Seeing originally about family crisis	supporting families in crisis [1] considering entrenchment [1]
Positioning within Families		
	Supporting parents or family[1]	collaborating with family [1] collaboratively working on eating [1] prioritising parents [1]

		supporting parents through knowledge [1] helping parents to get close [1] understanding working in territory of fear [1]
	Aligning with parents[5]	being biased towards parents [1] Promoting fathers voices [1] Being empathic with parents [0] taking parents perspective of daughter [1]
	Taking view of family	
Responding to families		
	Seeing problems in families preparedness	struggling with parents position [1] Struggling to understand [1] seeing families lacking information [2] seeing that families lack preparation [1] seeing family as more complicated than they realised [2] believing families can have information overload [1] seeing families as lacking information [1] seeing families as not being given communication [1]
	Seeing problems in families behaviour	considering parental protectiveness [1] thinking family anger gets things off on wrong foot [1]

Category: Considering the Wider System

Axial Code	**Focused Code**	
The NHS/ Agency		
		feeling judged [1] resisting need to cure [1]
The MDT		
	Relationship to MDT	working collaboratively with colleagues [1] believing psychiatrists can see ed as non-complex [1] believing some professionals think ed work is waste of time [1]

		regarding some colleagues as having hatred of working with ed [1] Needing colleagues [1] compensating for colleagues [1] comparing with other FTs [2] being disapproved of by other FT [1] showing interest in colleagues disapproval [1] disputing with colleagues [1] being unlike colleagues [2] taking different view than colleagues [1] working with MDT [1]
	Advantages of MDT	needing support systems [1] being advantaged as MDT [1] influencing greater than parents [1] being an alternative family [1] being more supportive than parents [1] being powerful as MDT [2] holding risk by MDT [1] wanting to be in MDT [1] better in MDT [1] building MDT confidence in systemic [1] feeling supported by colleagues [1] Risk holding by consultant [1] needing mdt approach [1] **keeping check on power [1]** using power benevolently [1] **Being in a team [0]** using other perspectives [1] being part of MDT [1] working on an inpatient unit [1] being a big difference as part of ward staff [1]
	Problems of MDT	needing certainty in treatment [1] looking for certainty in treatment resolution [2] being vocal in team [1] being different from colleagues [2]

		building dependence [1] seeing colleagues as taking mother position [1] being distrusted by colleagues [1] being judgemental [1] subverting family therapy [1] **Splitting [0]** rejecting splitting work [1] working creating splitting [1]

Category: Considering the Family Therapist

Axial Code	**Focused Code**	
Having a role as a Therapist		
	Gaining Post as Family Therapist	unmotivated by working with anorexia specifically [1] Emerging of interest [1] not being obsessed with ed [1] being a sessional family therapist [1] being concerned with suffering [1] being dissatisfied working in adult ward [1] being interviewed for post [1] being only interviewee [1] being scared of being interviewed [1] being wanted for post [1] caring about service delivery [2] coming and going as sessional post [2] expectations on permanent post [1] fighting to get funding for permanent post [1] preparing hard for interview [1]
	Being Self of the Therapist	**Negatively connoting self [0]** worrying about male colleagues [1] rescuing women by men [1] seeing professionals as gender imbalanced [1]

		self-informing motivation [1] being unhappy as child [1] **needing to be strong and informed [0]** background informing need for strength [1] needing to be strong to make difference [1] being knowledgeable for strength [1] **Considering self of therapist [0]** describing self thinly [1] being an activist [1] being real [2] being reflexive [1] using self of therapist [1] working differently than training [1] Using experience to see possibilities [1] feeling experience and age useful [1] seeing self as contributing to practice [1] describing spirituality of therapist [1] saying therapists attachment is therapeutic vehicle [1] using therapists family of origin [2] being influenced by therapists family of origin [1] self-influencing professional position [1] Describing life experience as a qualification [1] considering own gender [2] having difficulty as female therapist [1] being a man as difference [1] comparing devoid with male therapists [1] ED FT dominated by men [1] being censored [1] needing balance [2] having a long view [1] **Considering body of therapist [0]** Considering own weight [1] being comfortable with own body [1] not using male body to compare [1]

		changing self [2] Changing body posture [1] changing self to be with [1] **self-disclosure [0]** disclosing position or bias [1] disclosing self-experiences [1] disclosing when useful [2] disclosing self at process level [2] disclosing processes, not details [1] exposing inner dialogue more than others or in past [1] Using stories [1] **doing a performance [1]** being different from social self [1] being seen as a different person [1] **thinking systemically implicit [1]** describing cultural relationship to systems [1]
	Doing Tasks of Therapist	**Attending to process [0]** Motivating with information [2] Having more certainty at beginning [1] using psychoeducation with adults [1] **offering support for recovery [1]** supporting recovery [1] supporting refeeding [0] defining recovery [1] supporting medical safety [1] understanding of the biology of it [1] seeing medication as nonsensical [1] intervening medically [1] prioritising safety [2] acting within a risk contract [1] being expected by society [1] having no problem with medical interventions [1] being assisted by nursing background [1] not colluding with anorexic risk [1]

		drawing the line [1] working with pyramid of risk [1] accepting therapists postion to risk [1] taking authority for death prevention [1] using the relationship to contain risk [1] being dialogic with risk [1] working dangerously [1] stopping death [1] using mdt to assess risk [1] giving psycho education [3] seeing need for information [1] seeing deficit of information [1] helping to stop shame and blame [1] opening up family conversations [1] opening conversations about what is possible [1] understanding what family have not experienced before [1] unwinding by doing things differently [1] dispelling families tales of deficit [1] having normal and non-anorexia conversations [1] discussing young person's social desires [1] discussing parental protective role [1] discussing freedom [0] looking at loss of normal development [1] opening up family information [1] discussing emotion further down the line [1] dealing with conflict [1] needing to address other issues [1] not needing to focus on emotions [1] not using food as voice [1] encouraging dialogue around difference in family [1] encouraging conflict not through food [1] conflict not through food [1] **Building relationships [0]**

		Being collaborative [0] not being collaborative when risk too high [1] needing skill to be collaborative in risk [1] considering complexity of collaborative relationships [1] Engaging [3] not engaging anorexia [1] families not engaging in Psychological [1] working hard at engagement [4] engaging families [2] Using knowledge to build faith [2] Engagement in medical work [1] Seeing therapy as a relationship [1] developing therapeutic relationship [1] having meaningful contact [1] seeing relationship as human to human encounter [1] incorporating genuineness with multi selves [1] wanting genuineness in relationships [1] needing real contact [1] developing the therapeutic relationship [1] being direct as opposed to directive [1] establishing relationship boundaries [1] taking relational risks [1] double thinking hierarchy and expertise [2] fining it easier to take authority to risk earlier in relations [1] predicting struggles in relationship [1] being an advocate [1] believing experience needed to work in heterogeneous way [1]
	Incorporating psychological and medical [2]	guarding against being too medical [1] being comfortable with medical and FT rubbing along [2]

		being fluid between positions [1] combining medical and psychological [1] multitasking weight emotions and scripts [1] balancing emotions and weight restoration [1] prioritising medical over psychological [1] Losing systemic focus [1] losing people through systemic focus [1] being collaborative in the expert position [1] bolting on collaborative to expert [1]
	Needing to be as Therapist	doing inpatient role style [1] displaying confidence and competence [1] needing to be interested in ED [1] needing to be proactive with life and death situations [1] having sincerity [1] Working successfully [1] declaring expertise [1] taking uncriticising stance [1] using energy in work [1] being dedicated [1] being relational [1] getting to know to engage [1] displaying sympathy for families' positions [1] **using charm [1]** using humour [2] using self-deprecating humour [1] Being a bit playful [1] **not needing to use power [2]** taking one down position [1] Rejecting power talk [1] Avoiding power talk [1] **needing to contain [1]** holding both clients and parents [1] *need to be specialist [4]*

		working differently with ed [2]
	Relationship to change	wanting change [1] changing in the moment [1] giving chance for joining in change direction [1] holding to need for change [1] seeing need for change in self for change in client [1] seeing need for change [1] **seeing for some change can happen [1]** seeing recovery in behavioural change [1]
	Describing feelings of working with Anorexia[1]	Experiencing healing as therapist [1] Feeling appreciated [2] Finding ED work rounded [1] Making a difference [1]
Recounting ED Experience		
	Describing current post	not working with adult men [1] working across age range [1] having a gap in ED work [1]
	Initial experience	getting aetiology wrong [1] **Seeing first ed case in general caseload [0]** working with ed as a social worker [1] working in CAMHS [3] gaining experience on placement [2] seeing ed as part of generally caseload in CAMHS [1] **being new to ED [1]** working one shift a week on unit [1] not purposely working with ED [1] first seeing anorexia in specialist clinic [1] seeing first ed case [1] **Working non systemically [0]** working with age 16> on placement [1] working as an ED nursing assistant [1]

		working with ed without specific model [1] seeing ed as part of general work [1] Focusing on food [3] Treating ed in individual ways [1] Treating ED as medical [1] medicating and locking up [1] Starting to work with ED [1] having a ED placement in a psychiatric setting [1] being on a non-systemic ED placement [1] having ED experience before systemic training [1] being on a brief ED placement [1] being relational instead of systemic [1] beginning to work with ED [1] **Becoming systemic [0]** Discovering family therapy [1] originally being non systemic [1] Thinking systemically at beginning [1] **Differentiating between in and out patients [2]** working mainly with outpatients [1] originally working in ed inpatient [1] **recalling past as less organised around ed treatment [1]** Being unpathologising [1] Having less concern with risk [1] seeing need for specialism in ed treatment [1]
	Working on inpatient unit	having a fine line between being staff or entertaining patient [1] needing to entertain patients [1] doing variety of tasks on unit [2] trying to stop boredom for patients [1] working with extreme cases [1] working with chronicity [1]
*Intervening**		
* Focused codes were reorganised into:	Working narratively (beliefs)*	Writing letters [1] **externalising [2]**

Focusing on behaviour Focusing on belief systems Focusing on contexts The original coding has been retained here and the new coding noted after each focused code		separating patient from problem [1] believing in externalising [1] **Looking to the future [0]** Feed forward letter writing [1] Working with need for certainty [1]
	Working constructionally (beliefs)*	Using metaphor [1] using curiosity [1] using irreverance [2] using humour with discretion [2] not being neutral [1] struggling with neutrality [1] **bringing in new perspectives [1]** challenging anorexia [1] **valuing mentalisation [1]** looking for epistemological errors [1] **Taking anothers' perspective [0]** seeing how it is to be a teenager [1] understanding what it's like for the patient to be in that situation [1]
	Working with eating (behaviour)*	Considering food [0] doing family therapy seperate from food [1] Considering starvation [0] Considering alternatives to starvation [1] Considering need for starvation [1] Working with eating [0] Supporting to eat [1] Discussing plans for eating [1] Controlling eating [1]
	Being caught out (behaviour)*	being caught out by family secrets [1] being caught out by lack of information [1] not being caught out by family secrets [1]
	Being collaborative (beliefs)*	creating reflective space [1] using transparency [1]

		being collaborative with dilemmas [1] being tentative [1] valuing mindfulness [1] resolving expert and non-expert [1] **Taking a not -knowing position [0]** using authoritative doubt? [1] taking a social constructionist stance [2] learning through dialogue [2] not knowing about the family [1]
	Delivering traditional family therapy (behaviour)*	being into attachment theory [1] Working across models [2] working with behaviour [1] doing couples therapy to treat anorexia [1] exploring options [1] unpacking what people are doing [1] Communicating with scaling [1] **Thinking trans- generationally [0]** locating in family perspective [1] thin king it is fundamental to see 3 generational model from be [1] working with parenting scripts [1] starting always with genogram [2] working with parents experience of being parented [1] considering life stages [1] working with family life cycles [1] Seeing age as developmental age [1] Being age appropriate [1] working with life scripts [1] considering life stage transitions [1] **revealing things in family [1]** touching on other things [1] **Revealing dynamics [0]** doing family therapy to understand family [1] working in the guise of [1]

		revealing dynamics through supporting family [1] working with family dynamics [1] **Delivering structural interventions [0]** intervening structurally [2] facilitating role play [1] Not preconceiving family structures [1] Inviting structural positions [1] Accepting different styles [1] Reclaiming family life [1] balancing family needs [1] working structurally [1] **discussing risk [0]** having dilemma in ethics with medical risk [1] engaging with anorexia being dangerous [1] Taking hard stance because of risk [1] exposing issues [1] using semantic polarities in risk conversations [1] considering usefulness of semantic polarities [2] being collaborative in context of risk [1] describing how to talk about risk [1]
	Developing understanding (beliefs)*	needing to increase awareness [1] helping parents understand [1]
	Diminishing negativity (beliefs)*	reducing guilt [1] holding hope [2] Thinking of life without illness [1] finding reason to live [1]
	Discussing risk (behaviour)*	having dilemma in ethics with medical risk [1] engaging with anorexia being dangerous [1] Taking hard stance because of risk [1] exposing issues [1] being collaborative in context of risk [1] describing how to talk about risk [1]

		being dialogic about risk [1] **using semantic polarities in risk conversations [1]** considering usefulness of semantic polarities [2]
	Exposing power (beliefs)*	Considering oppression and rescuing [1] Considering gender as power [2] Exposing power of therapist [1] talking about control by therapist v anorexia [1] exposing polarities and power [1] thinking of power as status or entitlement [1] exposing power in dialogue [1] exposing how power can feel nasty [1] talking about power [1] considering how men define women [1] **exposing gender differences [1]** beginning to see ed as gendered issue [1] seeing ED as gender subjugation only [1] **Considering power [0]** Regarding power issues differently in children [1] introducing feminist position into therapy [1] thinking of weight as a female issue [1] considering patriarchy [1] rejecting patriarchy at home [1]
	Finding intervention difficult (behaviour)*	struggling with older children [1]
	Having flexibility (beliefs)*	seeing anorexia as having different routes out [1] working with customising [1] working in both domains of production and aesthetics [1]
	Modelling (context)*	modelling OK to be wrong [1] showing trust in family response [1]
	Rejecting systemic position (behaviour)*	rejecting externalising [1]

	Supporting (context)*	using family therapy to help people [1] supporting the patient [1] supporting refeeding [1] **Motivating [0]** using motivational interviewing [1]
	Taking non pathologising stance (beliefs)*	emphasising that not pathology [1] not conducting session focused on why patient has upset family [1] not conducting session on why patient has done this [1] not wanting to pathologise [1] **considering homogenous and heterogeneous in treatment [1]** thinking of biomedical as homogenous [1] contrasting homogeneity and heterogenic [1]
	Taking positions (beliefs)*	rolling with resistance [1]
	Thinking context (context)*	Being wider than systemic [1] being interested in whole family [1] working with social context [1] **Bringing in other perspectives [0]** seeing difference learning from other families makes [1] learning from multi family therapy [1]
	Using self (beliefs)*	using multiple selves [1] **being real, not fraudulent [1]** spotting fraud [1]
	Working at process level [1] (behaviour)*	Moving in and out of FT [1] Focusing on refeeding [1]
	Working with context (context)*	organising context for change [2] believing context needs to be evidenced based [1]
	Working with emotions [1] (context)*	Attending to emotional and psychological needs [3]
Therapists positioning on anorexia		

	Expert Position	Championing subjugated discourses [1] Seeing all as systems [1] working repetitively in early stages [1] **Fighting anorexia [0]** positioning alongside to understand and fight [1] being combatative against anorexia [1] Taking responsibility for fighting [1] **being recovery focused [1]** supporting the family through recovery [1] **Rejecting psycho social [0]** rejecting the non-expert position [1] not focusing on psycho social [1] constraining social constructionism [1] not having social constructionist stance [1] **seeing anorexia as biological [3]** using biological to explain power issues [1] using a scientific explanation [1] Rejecting psychological cause [1] diminishing ed through bio position [1] rejecting causal descriptions [1] **Needing a model [0]** needing to be an expert in ED [4] considering importance of having a model [1] Using a model [1] Learning a manualised approach [1] Using a manualised approach [2] creating a care pathway [1] gaining more work through care pathway [1] working with best evidence [1] following a manual [1] converting to model [1] **Promoting agency [1]** fostering autonomy [1] Linking agency to narrative therapy [1] Building agency [1]

		Wanting agency [1] Encouraging agency [1] **Demonstrating expertise [1]** trusting the family therapist [1] expecting expertise [1] **Empowering [1]** Disempowering through institutionalising [1] enabling through medical knowledge [1] empowering parents [1] **taking expert position [1]** seeing only positive aspects of therapists power [1] thinking expert position may not be wanted by patient [1] using expert position as containment [1] creating stability through expert position [1] **considering medical risk [1]** Using medical safety to allow creativity [2] acting in best interest [1] **Knowing [0]** demonstrating knowledge [1] seeing most families as uninformed [1] Being prescriptive of process [1] showing the way [1] **Working with Medical interventions [0]** feeling constrained by risk [2] weighing and monitoring patients [1] **working with ambivalence [1]** experiencing patients ambivalence [1] Describing cognitive distortion [1]
	Unsettled Position	**feeling criticism of family as therapist not being good enough [1]** potential for criticism of practitioner in ed [1] **Being moveable [0]** intervening as moral duty [1]

		understanding rather than controlling [1] positioning influenced by capacity [2] Spotting opportunities [1] Using whatever springs to mind [1] resolving certainty and uncertainty in treatment [1] negotiating with clients [1] moving between domains [1] **being comfortable with contradiction [2]** avoiding colonisation [1] benevolently dictating [1] holding conflicting explanations [2] **Feeling uncertain [0]** describing lacking capacity [1] retaining dialogic opportunity with ambivalence [1] disclosing dilemmas [1] engaging families with dialogue around contradiction of therapy [1] be careful of when to adopt directive position [1] being eclectic [1] thinking of eclectism as not knowing what to do [1] being safely uncertain [1] Contributing to safe uncertainty [1] struggling with certainty [2] moving into safe certainty [1] unsure about power dynamics [1] worrying about not having a strong enough position [1] being uncertain of model [1] seeing limitations in model [1] **exploring agency [1]** emancipating from colonisation [1] accounting for Stockholm syndrome [1] seeing everyone as having right to problems [1]
	Not Knowing Position	joining with family as team [1] using a script [1]

		listening attentively [1] **Not needing to know [0]** Feeling uncertainty desirable [1] not knowing how people should live [1] not knowing specific form of anorexia [2] not needing to find blame [1] not needing to understand [1] not predicting [1] **not using power [1]** avoiding trap of power practices [1] not needing to use power practices [1] treating with compassion not power [1] using power practices when necessary [1] not imposing [1] avoiding colonising [1] **using withness [2]** being neutral in rogerian way [1] Seeing therapist as also suffering [1] Communicating without speaking [1] using compassion to position [1] Attunement [0] Attuning children and parents [1] Reframing to attune [1] being attuned [1] **relaxing with complexity [1]** differentiating respect and collusion [1] easier to be relaxed with age [1] **using dialogic [1]** Having expertise [2] having curiosity [1] Resisting being formulaic [1] seeing client as expert [1] sharing difficult decisions [1] Rejecting outcomes [1] disclosing values [1]

		Holding models lightly [2] Regarding therapy as a human interaction [2] using compassionate talk to open dialogue [1] being dialogic [1] working dialogically with ambivalence [1] working dialogically with risk [1] marrying dialogic with risk ideas [1] doing dialogic differently [1] advantaging not knowing [2] being collaborative [2] Mixing dialogic with outcome [1] Orienteering [1] pointing out [1] having rough map [1] moving slowly towards [1] Working instinctively [1] dialogic being helpful [1] being dialogic as way of being [1] theorising about dialogic [1] dialogism influencing self-knowledge [1] empowering dialogically [1] contributing to dialogic context [1] developing dialogue [1] creating with language [1] **being constructivist [1]** not assuming about family [1] **being a possibilist [3]** need to not give up hope [1] taking a both/ and position, as a possibilist [1]
Training		
	Original training and understanding	early understandings of ED [5] thinking original learning still relevant [1] training originally in non-systemic [4] Training to work with families [3] Understanding ED at beginning of working [1]

		Moving from social work to FT [1] considering ed in early days [1] discovering FT [1] being uncomfortable with structural ideas [1] falling in love with strategic therapy [1] questioning strategic thinking [1] starting FT training [1] describing early FT training [1] becoming interested in FT [1]
	Need for training	becoming interested in FT [1] training developing confidence [1] being agnostic about knowledge [1] not having specialist knowledge [1] needing ED knowledge [1] learning about effects of anorexia [1] **Lacking formal training [0]** Having first profession [1] seeing lack of ed in systemic training [1] Training in ED only recently being available [2] not having ED training was appalling [1] **Lacking model of work [1]** Lacking risk knowledge [1] feeling wobbly [1] Building model base [1] learning biological [2] being uncertain about biological [1] getting better at risk management [1] building confidence [1] learning the Maudsley model [1] Following the Maudsley model [1] struggling with lack of progress [1] Developing pathway [1]
	Studying formally	training whilst on the job [1] training formally [1]

		Studying MFT [1] Practicing MFT [1]
	Studying informally	training in social work [1] training whilst social worker [1] learning from conferences [2] **Learning from others [0]** learning with families [1] learning from patient [1] learning from own parent [1] **learning from colleagues [1]** not learning from colleagues [2] **Teaching self [0]** learning from literature [4] learning theoretically [1] studying about ED and FT [1] studying generic ED [2] studying history of ED and FT [1] studying NICE guidelines [1] learning from feminist writing [1] reading non systemic ED literature [1] reading when not family therapist [1] learning from reading [1] **using work to train in ED [1]** learning on the job [2] learning from colleagues [1] running a weekly group on placement [1] having responsibility on placement [1] being on placement 15 years ago [1] being on placement for 3 years [1] teaching oneself through work [2] **teaching oneself through study [1]** hearing that others self-teach [1] thinking that others self-teach [1]

		gaining experience on wards [

7.4 Appendix 4. Sample Interview with Coding: Richard

..Understanding ED at

9 **Participant B:** Interesting, I think my formulation then was very very simple, um it was this is a problem that this young person has, that's similar and different to the problems that the other young people who come here have got. So some people are wanting to kill themselves and other people are wanting to starve themselves and other people are wanting to count to five before they walk through a doorway every time. Um, I think at that time we also had somebody on the ward who had a basic refusal syndrome and the ethos on the unit was very, looking back now, very non judgemental and very accepting of the situation as it is, change needs to happen but it will happen in a supported and supportive way with, you know, manageable amounts of challenge.

..Being unpathologising
..Having less concern with

10 **NJ** So it sounds as if you're describing a very non-pathologising stance towards the presentation?

11 **Participant B:** Yeah, yeah, I don't, it's interesting because I don't remember there being huge anxieties about the medical risks, um, and so on, that might apply more so now actually, so no, but to be honest I think service is in nineteen ninety one where the adolescents were much less, much much less pathologising than they are now, but incalculably

12 **NJ** Any idea's as to what changed that? What shifted it?

..early understandings of ED

13 **Participant B:** I think the shift from, the kind of ideology that's behind health in adolescence so historically a much greater connection with education, with child guidance movement and within inpatient units with therapeutic communities, so most of the adolescent units that we're aware of in the nineties were run along therapeutic community lines,

14 **NJ** Yes

..Treating ED as medical
..Treating ed in individual

15 **Participant B:** there was an emphasis on the group and lots of emergency meetings when thing's weren't going as they were meant to go and the group would resolve the difficulty together, I think as the medical model has become more prevalent in, in the way child and adolescent service are constructed and organised, I think that's had quite a huge influence on… I remember a time when there was a shift from the group program to individualised care planning, which was seen as a positive thing. Um, I think we've gone a long way down that road in an unhelpful way certainly with for inpatient settings I don't think that that's been useful, um, in lots of ways. Um, a good example I guess would be having people who were horribly psychotic in group… group therapy sessions where the

group was invited to help manage that versus um probably five years later, the psychotics don't go to groups because it makes them worse, so they're exempt and that marked a shift , I think the same things also about meal times with people with eating disorders, the culture, again we are in the nineties was, I remember much more talking about the food and more talking about if you're not going to eat that, the other patients.., if you're not going to have your toast can I have your toast, it was a much more open conversation, now it seems as though conversations like that would be described as triggering and shouldn't be happening on an inpatient unit. People are on their individual plans, It just feels different to me.

..Focusing on food

16 **NJ** Okay, I think I'm hearing in that description that different equals not as good?

17 **Participant B:** I don't, see that's tricky because I think I would say that about in patient units but I don't say that about outpatient treatment,

..Differentiating between in and

18 **NJ**: Okay

19 **Participant B:** I think there is a difference I think um, we have much better developed ways of thinking about eating disorders and young people and the treatment is, uh, has had some time to kind of get more established in outpatient clinics. I go back to the nineties, even though some of the work at the Maudsley had been done and published and what have you, I don't recall the take up as being as kind of rigorous and as organised and CAMHS eating disorders teams, specialist eating disorder teams, I don't remember any of them being around then.

..Differentiating between in and

..recalling past as less

20 **NJ:** Right

21 **Participant B:** Whereas now there are many, many more of those, um and you know, Ivan Eisler is recently talking about never mind evidence based treatments, we need to think about evidence based contexts for delivering the treatment in and that a specialist team is significantly different in that sense, in that an individual practitioner in a non specialist team trying to deliver family therapy for eating disorders, is really tricky when you're on your own rather than versus being part of a team who understand the complexity of the problem.

..believing context needs to be

..seeing need for specialism

..needing mdt approach

22 **NJ** Which is your current context?

23 **Participant B:** Yeah.

24 **NJ:** And between the nineties and here what was your, an overview of your development in relation to eating disorders generally?

25 **Participant B:** I've been shifting from, I did a couple of years in an inpatient setting, so most of the subsequent work from then has been a, for outpatient and b, part of a generic CAMHS caseload so I'd have a whole mix of things as well as eating disorders. Generally not having more than, I don't know, half a dozen kids with an eating disorder on the case load, and used to managing those in a multi disciplinary team , um, and not always following a specified model actually, um you know more often just doing a mix of family or individual type interventions.

..origianlly working in ed

..working mainly with

..seeing ed as part of generaly

26 **NJ:** And why? Why not a specific model?

27 **Participant B:** I think if we're thinking about, um, just thinking chronologically, let's work backwards; so I completed my family therapy training in two thousand and one, which was a four-year training that had, there was no training at all about family therapy interventions for eating disorders, not at all. So if you think that on a professional training there was none, then what hope was there that in the general, kind of, hurly burly of your general clinical work, there was nobody saying to me you ought to be following a particular model, um, I think I was aware of some of the Ivan's writing in the journal which I was getting before I started my training, but I certainly haven't been trained to use a particular model, I wouldn't have known what I was doing in that sense. Supervision around treating people with eating disorders, um, I wasn't getting any specialist supervision around about that point in my career, um so a lot of it was rather hit and miss and me learning from my misses and hoping I could hit it more often than miss.

..seeing lack of ed in systemic

..seeing ed as part of general

..working with ed without

28 **NJ** So learning from the patient, learning from clinical practice?

29 **Participant B:** Pretty much, pretty much. And I guess trying to surround myself by people who I felt were confident to support my skills or my knowledge, or my creativity…

..learning on the job

30 **NJ** So it feels as if what you're describing, and I want to check this, that you came into your systemic phase of working with eating disorders with a general mental health background some gestalt therapy?

..training originally in non

31 **Participant B:** Yes

32 **NJ:** And then you came across your systemic training and then there's something happening in terms of trying to bring the two together yourself because there was no formal systemic focus on eating disorders. A bit from reading but mainly self-learning from your patient, was there any other sort of wider reading you'd do or was it mainly practice based?

33 **Participant B:** Well you mentioning that, was there any other wider reading, I'm thinking of growing up with fat is a feminist issue you see on the bookshelf at home.

..learning from feminist writing

34 **NJ** okay, when was that written? Nineteen eighties?

35 **Participant B:** Yeh, okay so that was at home, my Mum had that

..learning from own parent

36 **NJ** Okay.

37 **Participant B:** So that's interesting thinking about wider reading I think it was on my radar and certainly I've been asking people at assessments for the entirety of this since the nineties. So you're a girl, so this is a problem that seems to affect girls, it's a very sexist illness, why is it picking on girls? Why is it picking on girls and I've been asking that question of girls, and of boys actually, um yep, for all that time so I think the kind of gendered nature of this particular illness have been on the radar all the way through.

..beginning to see ed as

38 **NJ** So you see it as having a strong gendered nature?

39 **Participant B:** I think it would be difficult not to, look at the stats you know, ninety per cent girls ten per cent boys has persisted across time, and even if you go outside of the, because those are clinic populations, if you go into the community samples, it's different but it's still hugely dominated by girls and women.

..applying genered statistics to

40 **NJ** So thinking specifically of Anorexia as opposed to generic eating disorders, um, and you start to talk about the influence of your understanding of feminist perspectives, gendered perspectives, what, other than your professional training, what personal discourses are there, or societal discourses that influence how you describe or explain Anorexia specifically?

41 **Participant B:** Protest... would be quite a strong one I think, given that self starvation has been used a lot, um, with people who will go on what's called a hunger strike, whereas, you know, the start of starvation is done for protest, for political or often for political reasons, I do sometimes see it as part of the family

..regarding ed as protest

..seeing ed as protest in

..seeing ed as protest in
..considering media as part of
..regarding culture as part of
..considering media as part of
..learning through dialogue
..thinking women care about
..regarding culture as part
..considering media as part
..Being a visual society

politics, it's part of this is the only way I've got to really manage this difficult situation. Um, I think although the kind of research evidence never supports an idea that the media, something about the media that makes a difference. I think there is something about our culture that makes a difference, there is something about… Again this is one of the instances where it would be difficult not to believe this, that the way women's bodies are portrayed but also the way ,a young man explained this to me recently, the conversation about women's bodies is much more out there and the idea that women have to care about their bodies is much more out there compared to boys, where the conversation is not so out there, guys might care about their bodies but it's not out there as this is one of the most valuable or important ways in which you are judged as a person whereas for girls and women, that seems to be the case and that questionnaire, the EDEQ, that has a subscale for shape concern; the community norm is not zero, it's whatever it is, two or something, so we've decided as a culture that it's normal to have a degree of shape concern. Then you've got lots of magazines and lots of celebrities; the Daily Mail everyday will run stories judging people on their size and shape and their sweat and whatever else they decide to judge. We're quite visual as a society;

42 **NJ** I think some objectification process, to an extent, of women.

43 **Participant B:** Yes, um

44 **NJ:** And that's what you're linking the protest to?

45 **Participant B:** Not always, I think it's separate, there probably is an in but

46 **NJ:** And some of it familial.

47 **Participant B:** I think where people get more into recovery they become wanting to protest about this objectification and about what… it kind of dawns on people this is what I've been, I've been subject to… and it's wrong. But I think sometimes its origins seem different, they do feel more a more protesty. So I think those would be two big ones, protest and the kind of the way women's bodies are viewed, assessed and judged and how much stronger that seems to be becoming over time.

..seeing protest in recovery
..considering origins not
..regarding protest and image

48 **NJ** A word I hear quite often in my client group is, which sort of links to protest but is separate from maybe, is that of control, um, in terms of gaining control,

..considering control as factor

does that sit within your experience? Whether you would put that under protest or whether you would think of that separately or?

..considering control as
..connecting control with ..controlling chaos with ed
..not only seeing control in
..using perfectionism to bring
..seeing controllolling eating

49 **Participator:** Probably connected but probably separately and maybe link it perhaps also to things like perfectionism, and a way of managing chaos or perceived chaos. Lots of the people we work with here are feeling, I'm not describing this as people who have had bad things happen so therefor the only thing I can control was this, we do meet some people who feel like the world is not very stable and it's not very controllable and it's unpredictable and it's alarming because of that, so school work I can control that and I can do very well on my tests and I can aim for a hundred per cent, I know that I've got that right there's a right and a wrong. There's similar thing in terms of a kind of an eating disorder context which is; I'm going to eat these things and that will be right and if I don't do that it will be wrong and therefore life will be more ordered and therefore safer.

50 **NJ** Okay.

..linking ed to panic and

51 **Participant B:** I think the kind of safety that control gives people seems to be hugely important and if I talk to people that we see here about if we can transport you to a planet where buses came on time and no teachers were ever ill where everything was as expected, how many disorders do you think you'd have? People say, I wouldn't need any disorders because the world would be lovely it would be easy for me, I wouldn't have panic attacks.

52 **NJ** Talking about making the insecure feel more tolerable.

..using ed to make insecurity

53 **Participant B:** Yes.

54 **NJ** So I think I'm hearing in your descriptions, I just want to check it, there is quite a lot about social constructionist perspectives and there seems to be quite a strong attachment perspective coming through.

55 **Participant B:** Yeh

56 **NJ:** Would you describe it that way theoretically or how would you think about ?

..taking a social constructionist
..not seeing attachment as
..socially constructing body

57 **Participant B:** The social construction stuff, yes, the attachment stuff less so I think if I give you an example of something a young man said to me recently , in relation to the kind of impact of media he described noticing his girlfriend looking at a magazine of boys torsos and it was only within context of his relationship with his girlfriend that he started to compare his body to the bodies of the

..socially constructing body
..becoming aware of body

images, so if you like, what he was witnessing was the social construction between him and his girlfriend of what was the right kind of body to have and what kind of body would be appreciated within the context of his relationship. It's interesting that he gave that as the moment things changed for him because he'd been aware of these images for ages,but they were just out there. When it came to..It was almost an instantaneous process of re-negotiating who thought what was important, and he suddenly realised this was an important thing for his girlfriend and it was therefore important to him and he just really locked onto it.

58 NJ: Right

..considering causation of
..having susceptability to
..stating to do with media as
..seeing genetics as not part of

59 **Participant B:** I do think that… it is tricky because there's a really complex interplay between a person's vulnerability and whether that's to do with a genetic vulnerability or a biological or physiological or some other vulnerability, and what's going on around them because clearly the images that are in the media are available to everybody but not everybody has an eating disorder, not everybody feels compared, so it's not sufficient I don't think to say that that's what's causing this nor is it sufficiently important for me to say, well it's just genetic or because I don't think there is an anorexia gene.

60 **NJ** Well they are currently doing work at the Maudsley… sorry, an international research project which I think Kings is part of, looking at the genetic argument.

..seeing genetics as not part of
..seeing some small link with

61 **Participant B:** There are, but they'll no more find an anorexia gene than the related schizophrenia project found a schizophrenia gene, you will find… They will say what they will hope to find is a gene that will have a big part to play, but it might be a gene that's to do with perfectionism or tolerance of uncertainty or something like that.

62 **NJ** So it's part of the mix rather than a dominant feature…

..regarding anorexia as car

63 **Participant B:** I think so, and I think that's one of the things that makes eating disorders a very interesting area to work in, is the mix and the range of influence is so broad that it kind of makes a mockery of anybody who would try to say I think it's primarily a biochemical, primarily a brain structure or primarily stress related or primarily… I think it really is kind of a car crash of different things.

64 **NJ** And in describing it that way are you therefore saying that every form of anorexia is unique?

..seeing anorexia as having
..seeing anorexia as having

65 **Participant B:** I'm saying, as somebody who came to work here new to eating

..seeing anorexia as having
..seeing anorexia as having

disorders, after a few months it seems to me that the symptoms for everybody with anorexia are really, really similar, alarmingly similar, but that their routes in are radically different and their routes out are also different.

66 **NJ** Right.

..contrasting homogenity and

67 **Participant B:** I think that sums it up really nicely, we have an incredibly homogenous description of symptoms but a very heterogeneous group of people if you think of them as people and as families.

..thinking of biomedicval as

68 **NJ** So I guess that homogenous description is where the biomedical argument holds power?

69 **Participant B:** uh huh

70 **NJ:** To diagnose, to lump and stereotype.

..cosidering homogenous and

71 **Participant B:** yeah and where specialist teams really come into their own but being able to tell the difference between this family and that family, and the other and the other and the other and devise treatment programs that are the same in the areas where the treatment needs to be the same and different in the areas where it needs to be different. You don't just hit everybody with the same thing, we should be one possibility or in my past working life where you hit everybody with different interventions because you don't have any sense of a model, I think it's really important to have a model, but that you have experienced people to deliver the model so you can tell this will work well with this family but less so with this family.

..not hitting evryone with the

..considering importance of

..believing experience

72 **NJ** So there are customisable elements at every stage?

..working with customising

73 **Participant B:** Yes, I think it's crucial.

74 **NJ** Um, I'm aware, from what you were saying earlier, that you now work in what feels like an almost exclusively systemic clinic, I was just thinking though are there any other professional discourses from what you'd normally see as the wider MDT that doesn't seem to sit here but you talked earlier about psycho-analytical colleagues for example, are there other discourses that influence directly your work?

..considering medical risk

75 **Participant B:** I suppose the most often experienced discourse is around, um, medical risk, it comes up a lot and also I don't know the best word to use to describe it but kind of, there's there's also, there's a hatred of, a hatred of people with eating disorders that's akin to hatred of people with alcohol problems or self

..regarding some colleagues

..regarding some colleagues

harm or that kind of thing.

76 **NJ** hatred from who?

..believing some professionals

..believing psychiatrists can

77 **Participant B:** From other professionals, um so a kind of, so like often will think that people who are starved and nearly dead shouldn't be there, um they're wasting our time, our nurses have got real patients to deal with. Um, But also within the psychiatric world there is also a kind of, I think this is mainly an eating disorder, you know so can you deal with them. It's more complex in the psychiatric world.

78 **NJ Um,** You're making me think of the capacity of anorexia to enable people to feel and sometimes act in very deskilled ways and whether there's something quite undermining of the professional position when a professional who's not skilled in eating disorders comes across an eating disorder which undermines their professional identity or their, their their, self image as a competent professional, I don't know if that will mix into that at all?

..looking for certainty in

..looking for certainty in

..needing certainty in treatment

79 **Participant B:** I think, I'm just thinking aloud now, that becomes problematic when people, the people you're describing, want a resolution to that, and the resolution they're looking for is one of certainty, where they're looking for you to cure them of their difficulty by being very assertive and telling them that you need to do a, b and c or better still, I'll take the patient away and I'll do a, b and c. I think what we've learned is certainly dealing with general hospitals is that our ability to tolerate uncertainty and well maybe this, maybe that, let's try this for a couple of days and see if that … it's tricky to manage, they want in discussion with hospitals about guidance and protocols, the kind holy grail for them seem to be something that would fit on one side of A4 and be headed guidance and they wanted a kind of five step program for how the problem should be dealt with. Certainty is key for some people and it comes out, in yeah, a lot in psychiatric colleagues as well, you know, is looking for numbers, you know numbers will help us. So if somebody's weight is this number or that number then they should be in hospital or shouldn't be in hospital, they should go to school they shouldn't go to school. They should be on bed rest or they shouldn't be, you know. There is a lot of looking for that, again in specialist teams I find are much more able to tolerate this number in this person means a different thing to that number in that person.

80 **NJ** I guess you're now reminding me, a few minutes ago, about the context of risk and so I'd be interested in your thoughts about how you balance that notion

of risk where there is a degree of certainty required and how you balance working with that car crash that you described, the unique nature of some of those social constructionist positions, some of the uncertainty that sits, or the ability to tolerate the uncertainty that sits within systemic therapies, how do you manage that, are there times when you come into conflict when your notions of therapies conflict with maybe a need to move into the biomedical discussions or? Are there times of contradictions in your work?

..resolving certainty and

..working in both domains of

81 **Participant B:** Some, but I think we have organised processes here to manage that. So as a kind of clinician and manager, well as a manager I need to know that the risks are being assessed, categorized, ordered and managed, and we have a grid and we have guidance and it has numbers on it and we have a meeting where people who hit these numbers get, you know the patients get all written down and minuted, that happens, but it doesn't happen to the exclusion of the other stuff you know? Um, So we also have, we will take that same case and in a group supervision setting ten minutes later would walk out a much more elaborate creative, discursive, think about how to manage, how to manage those risks, that we don't have to always live in the domain of production around managing risks, we can find much more aesthetic ways of managing risks. I think it's possible to do both, I think where it's problematic is where you're doing one or the other; only attempting to deal with aesthetics or only attempting to deal with the domain of production. It's ultimately; I don't think it's helpful.

82 **NJ** So then that sort of… it sounds like you've come to some sort of resolution bringing those two claims together. I'm starting to think about how that influences your relationship, for the lack of better word for now, with the sufferer or the patient and their family in the context of risk how does that risk influence your relationship to the family, to the sufferer?

83 **Participant B:** I'm not sure I understand what you mean.

84 **NJ** OK, maybe I don't. Um one of the dilemmas that I have in my work is that I need to hold both that risk in mind with which that ability to hold risk in mind also gives me some authority, gives me some power, gives me the ability to move into an action mode, which can range from you know, we've got to regularly monitor you through to we've got to call for a mental health act assessment. And at the same time, that position means that that potential for that to exist is ever present and therefore will have some impact on my relationship with my client, and the

sufferer and the parents or partners may view that in different ways, and at the same time I'm trying to work in the domain of aesthetics and to be creative and to recognise this as an individual form of distress, so I'm interested in how holding both those positions, influences your position towards the client, towards the family.

85 **Participant B:** It's really complicated (laughs), and the ability to attempt to maintain a collaborative relationship with an individual patient whilst openly empowering parents for example to help them eat more food, just that bit's complicated. Managing the imperatives around that; so if your lips stayed blue like that and you're that cold and you're not eating, you will be going into hospital. Yeah, it's a very kind of controlling very bossy thing to do and managing your relationship around that is an incredibly skilful, or requires a lot of skill to be able to do that. There are times when it's easy because the patient is so unwell, it's not a discussion it's not a debate, it's going to happen. That's nice and easy, so when that happens early on in a presentation, you've met them a couple of times and yes it's not looking good, it's not that difficult and that will set up a particular relationship, but on a number of occasions it's interesting, when you get a few weeks or months down the road and you keep that on the agenda; you remember a few weeks ago when the conversation when I said you need to be in hospital, but somebody I'm working with at the moment who's been through that process a number of times and the whole family, all of us have agreed, openly, what our stance is going to be around any future requirements for hospitalisation, we keep that on the agenda. I think getting to know people over a longer period of time is really helpful around that, talking about it, talking to people about, I don't want as a therapist to be controlling your life, and you're describing trying to control your life but actually it's going out of control quite badly, please don't tell me you feel in control of what's happening, because it's clearly not. How do you want, you know, how could we describe this, if you're drowning I'm going to grab you quite hard around the wrist and I'm going to lift you up out of the water, is that a useful metaphor? Um. I think keeping the dialogue open about that all of the time and keeping people aware of the complexity of trying to help somebody who might not feel like what you're doing is help, or who doesn't want that kind of help is really complicated.

..considering complexity of
..needing skill to be
..not being collaborative when
..fining it easier to take
..being collaborative in context
..talking about control by
..describing how to talk about
..being dialogic about risk

86 **NJ** What enables you to navigate that complication from a theoretical stance? If it does come from a theoretical stance

..talking about power
..seeing struggling as
..exposing power in dialogue
..exposing how pwer can feel
..considering usefulness of
..considering usefulness of
..using semantic polarities in
..exposing polarities and power
..thinking of power as status or

87 **Participant B: Yeah,** well I think, you mentioned earlier, power. I think keeping conversations about power there all of the time is really helpful and conversations about power and control and real power and control, so you know a person who is drowning might be thrashing around wildly in an attempt to get more control over what's going on but it's actually not providing them, they're still drowning. So I think having conversations about whether this is real power or not real power, whether parents feel like they have real power to make a difference or whether they feel like they're doing some.. bossy behaviours that don't make them feel powerful at all, they just feel nasty. So I'm not sure beyond that concept of just the power control kind of thing. I can't, you know help but think about the semantic polarities kind of stuff, that Ugazio speaks about, you know is often really helpful, this often in these difficult conversations, often these polarities are around as if they're the only things that exist, you know so. If you try and make me eat that, I'm not going to eat anything, if parents you know will say, well I can't make her eat can I? I can't pin her down and force-feed it, there's lots of these kind of dramatic talks of polarities. And I think that's often that's a really useful concept to help navigate these, there's more to this than the far ends of the spectrum. You asked me about very specific point in the therapy where there is the risk, when the risks are heightened.

88 **NJ** And when they're not, when its not a specific one ?

89 **Participant B:** Well I suppose I was thinking about semantic polarities is fascinating generally in terms of… you know she talks about the coming together of different statuses in families and it's something that I think I see quite a bit, where.. but that's often hidden quite deeply in the family background, it's way off in the wings. Stuff about who's got money, how's that different from status? Who's got status but no money? Whose in-laws are happy with this marriage, whose in-laws are not? Who's, and therefore whose fault is it that the children are not performing as well as they should do and that kind of stuff I find really, really interesting. I think it then gets played out at the semantic level, the kind of success, failure, winner, loser, better than, worse than, prettier than, uglier…

90 **NJ** and this whole thread of power running through everything that you're describing.

91 **Participant B:** Yes, but it's very subtle, it's very subtle, in the kind of, it's power that's not about for example money; it's somehow to do with status or

..thinking of power as status or

entitlement or something like that.

92 **NJ** And you're making me there think of the notion of recognition, that's quite often when people are feeling disempowered that it's thorough a lack of recognition in one form or another. Somebody called Honneth, talks about lack of recognition being linked to lack of self esteem, self confidence um and it feels at times in my experience of practice that a lot of the work is around a lack of recognition within the system, that there is points or different levels of recognition. I was just wondering from your point of view in terms of the power that you hold as the therapist, because part of what you're describing sounds as if , I don't know how much is within your mind and how much is within the dialogue, it sounds like either in your inner dialogue or in your outer dialogue there's some quite sophisticated and subtle thinking going on beyond the basics of, are you eating, aren't you eating, you have to put on weight, you have to do this... How much of that, if I could see you in practice how much of that would be in the dialogue between you and the clients and how much would be held in your head?

..exposing inner dialogue more

93 **Participant B:** Hum... it depends where we are in the development of the relationship, so I guess probably more of it is out in the open than I would see in other people I work with for example, or have worked with in the past.

94 **NJ** So you would see yourselves as being more transparent than.?

..using transparency

..using multiple selves

..exposing gender

..exposing issues

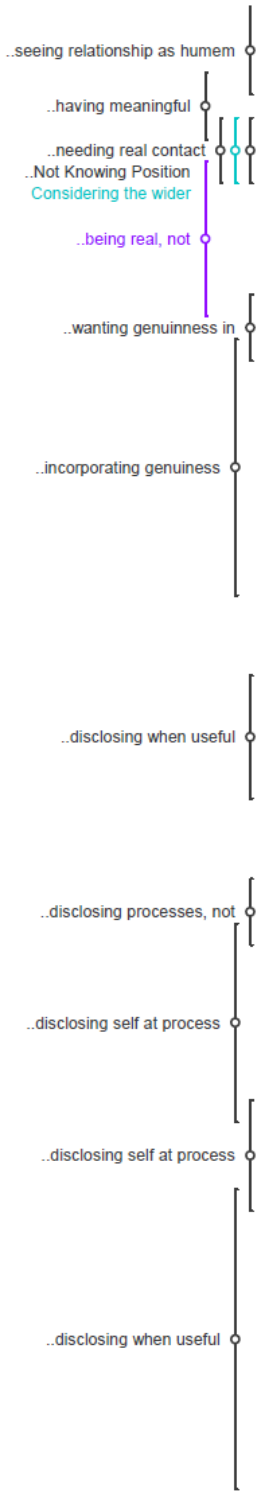
..being collaborative with

95 **Participant B:** I think so, I think I'm very quick to say, we've got a dilemma here, I think as a professional I think this. As a human, I'm feeling like this, I'm thinking this. As a man, I'm right now aware that we've got two men here and you're the only woman, I might put all this out there and say, the dilemma is we have a decision to make, and do you want to tell me where you stand on these issues that I put out there? And then can we think about how those things can help us move to some sort of decision, or do you not think you need to make a decision. So I might put it all out there.

96 **NJ** That sounds transparent and it sounds collaborative. I was very interested in You talked about as a human and at that point you felt as if you were stepping away from your professional identity and bringing a different discourse?

..seeing relationship as humem

97 **Participant B:** Well yes and no, doing a short training we read some stuff by Martin Buber, the I and thou stuff, which I think provides a way, I don't know what's the best way of putting it, it seems to me that from the time I learnt that



it seemed to provide a way to legitimise the fact that this actually is an encounter between two or more human beings, and that we need to have meaningful contact , that would be a gestalt term, and that actually the contact needs to be real, it's not to be fraudulent or me telling you that these are the risks, because those are the risks that I can see just as a professional because then we get, well you all say that don't you, you all exaggerate the risks to try and frighten me don't you? You know, well I want to be in relationships where that kind of thing is going on, I would rather, genuineness in relationships for me is not, is not, its partly a Rogerian kind of thing but is more the way Fritz Perls used to describe it, it's a much more contextual much more real thing, we've lost the thread a little bit, but it's basically important and the genuineness and I am there as a professional and as a human and as a dad and as a man and , you know I think those things can be, yeh I don't think we can exclude those things.

98 **NJ** so would bring those into your dialogue? So would you say as a Dad?

99 **Participant B:** Yeah I would. Not randomly , not always with everybody. Meaningful contact is very important to me and I think if those things are helpful then I will use them.

100 **NJ** Okay, Would that involve sharing incidents from your life for example?

101 **Participant B:** Less so, I don't think the incidents are important I think the processes are. So I might say in a meeting, let's say I had a mother and daughter and a dad, I might say I think a bit similarly or I felt similar to your father in terms of the way he's describing his protectiveness towards you, and I can see it's coming out in this way and I'm recognising that as protectiveness because I get that. Does it feel like protectiveness to you? I might use it that way, I said to somebody else recently,yeh.. the content seems not relevant but processes do, ways of relating do, being frightened of... I might say to somebody look, when you're cross, you're talking as if you're cross but you're looking away from me, it's constantly difficult or what have you , its difficult because these things come up in the moment. I think the rule I have for myself is that if it comes up then it's shareable and I will share stuff that seems unrelated on the basis that if it's come to me at that moment it has some connection. People sometimes will say thanks, really interesting and other times they will say they don't connect at all.

102 **NJ** So I think if I were to think about that theoretically it seems that you're quite a long way away from Minuchin, Haley, even the narrative stuff but it seems to be

quite embedded in the collaborative therapies in the dialogic therapies is that where you would?

103 **Participant B:** Yeh, well I suppose if we were going to go back in time I don't know whether, for example, Virginia Satir was actually at Esalan at the same time as Fritz Perls , but I'd love to know, because they certainly were doing stuff around about the same time in around about the same geographical area and the Carl Whittaker type of approach which again is quite direct, as distinct from directive, He's quite interpersonally direct, I think there is some connection.

..being direct as opposed to

104 **NJ** It feels as if you're being very in the moment, you are drawing on whatever arises from you, you are drawing on multiplicity of voices that might arise, that might come, that might be a human encounter and it might be, yes and if my medical colleague was here beside me they'd be saying this. You know, you're bringing many voices together and Shotter's idea of withness, that you're somewhere within a human encounter, is the sense I'm getting. Would that fit with...

105 **Participant B:** Yes, it would and that could also be quite.. I'm just thinking when I'm doing this there might well be lots of movement so I might be, I might stand up but not saying as someone who let's say worried about it professionally, I might say it as someone who is a bit worried about you and I might move somewhere and be, adopt a more worried posture. You know , somebody, one of my teachers a long time ago said, you can't change other people but you can change you, and she said, at the very least you can change from sitting to standing and it will make a difference to your encounter. At the very least, you can move closer or further away and it will make a difference. Um, and That kind of thing has stuck with me.

..Changing body posture

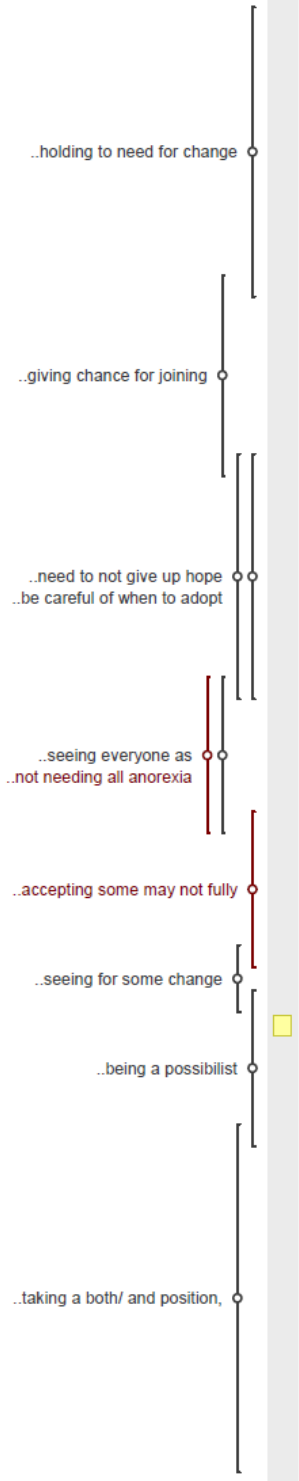
..changing self to be with ..changing self

106 **NJ** So a significant part of your focus is focussing on who you are and changing you? In those moments, in those interactions rather than changing the patient.

107 **Participant B:** I think so,but not without, but I think it would be a lie to say I'm not bothered about whether change happens, actually because I am, it's just if I were to think that I don't have to do any changes and they do I think that's a bit stuck, a recipe for stuckness there.

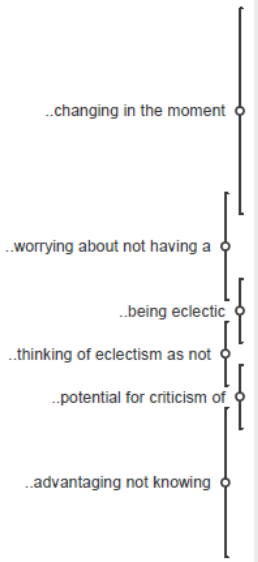
..wanting change ..seeing need for change in

108 **NJ** and in wanting them to change, believing there needs to be change, if we think about anorexia specifically, where would you position yourself between its actually fine to have anorexia, don't worry and this, every remnant of anorexia



has to disappear in this process, where would you position yourself in those polarities?

109 **Participant B:** Like I said with lots of things in this conversation, it depends. So for some people who have, I think spoke to a forty nine year old woman recently who shouted at me, don't try and change me, I've been like this since I was twelve, it's my life, I'm me and you've got no right to change me, so I said, look in this country you don't have the right to just die. So I'm going to take some action to prevent that happen and it would be better if we could agree that you'll go to hospital but if you don't then we'll just make sure that happens. And I said why don't you think about that and we'll meet in the morning, half expecting her to not be there but there she was in the morning with a bag packed, so that was a kind of, that's fine I'll take her position, you absolutely have a right to take that position. There are other people, perhaps younger people, or actually there was somebody a bit older who I felt it would not have been right for me to adopt that position at the outset of treatment, or somebody, she's had anorexia for about four years and is now considering herself really quite good in terms of recovery and she cites the fact that she knew I never gave up hope as being a really valuable thing for her. Do I think that every last remnant has to go? No, no more so than I think every last remnant of the stuff I struggle with has to go, by the end of my life, nonsense, you have got a right to your problems as much as I've got a right to have mine. You know It's complicated some people tell me that all the anorexic voice goes away, other people say well it's there but I don't respond to it any more, and over the years I've come to accept that some people will have a chronic relapsing condition that they have to manage and for other people it will be a bit something that was a bit of a nightmare but it changes and I wish I could tell you at assessment which person was which, cause I can't so I have to go in with maximum hope and I've huge knowledge that this could have a really difficult outcome, and therefore I don't think it's helpful to put myself in a camp. I did used to, I had a colleague who said this is a chronic relapsing condition and I used to say that's a rubbish place to start from, you should start from we can get complete cure, because ideologically there is a better place to start from. He thought that was unrealistic and unhelpful place to start from because it set you up to do a task that you might not be able to achieve, and I think I've shifted my perspective although I've not shifted it all the way there I think I need to be open to more possibility than that.



110 **NJ** I think that's something that's come out throughout this interview, is your, although you do hold positions, it feels as if those positions move all the time based on the complexity of your, those moment to moment's interactions are and how they change.

111 **Participant B:** I'd be interested if that's what has come through because I think that does reflect accurately what I think. Earlier on in the interview I was worried about not having enough of a position or not having one particular piece of theory that informs me the most or, although I'm not massively keen on ideas like, I'm an eclectic practitioner, because I think sometimes that gets used for, I don't really know what I do, of course working in eating disorders there is always massive potential for people like, you don't really know what you're doing, but knowing that there is huge potential for that is really helpful, and that you're now good or you're not good enough phenomena, again an advantage to working in a specialist team is that we know that that's part of the disorder, that people bring. We know that often that's part of the strong family process and one that when things are not going well people would like to put on to us, the staff here, other professionals, we expected more change, we're a bit disappointed perhaps we should refer to somewhere else, all that kind of stuff, it's really helpful that we remind ourselves regularly that we are good enough, we do know what we're doing and that this is a tough, nasty illness.

112 **NJ** So something about your clinic more specifically is your colleagues who put a safe enough boundary around you to actually be relatively loose with the positions you take, in cases they're high risk, there is quite a lot of fluidity. And I'm struck by what you said about being both a professional and a human and a man, and the ability to bring those different perspectives of yourself.

113 **Participant B:** Yeah, and also age, Nigel. I think age and stage of career and where I am in the organisation helps that, you know. I've been doing my job a long time, I've met a lot of people, I've worked with a lot of people, I'm at a point where I can say, I've got a lot of experience.

114 **NJ** So is there something in there about being powerful enough to not have to use power practices?

115 **Participant B:** I reckon, I reckon cause if that's called the I don't really care anymore what people think of me because I'm fifty I've done a lot of things, I've been in this organisation a long1 time, I'm well respected in the organisation I

..not needing to use power
..not needing to find blame
..treating with compassion not
..using compassion to

don't need to prove anything to anybody. If I didn't do another day's work, yeah, it does make a difference and I do say to the other staff, there are times when you just need to take a bit of a detached position, it is what it is, it's not your fault or my fault or anybody's fault, it just is what it is, let's just deal with it, let's just manage it and deal with the situation with compassion and not with power over, not with, you're at that weight so that's not going to happen so we're going to do this and we're going to do that, you know? You can get the same outcome very differently and you can do it with compassion and with regret and sorrow, I wouldn't want this to be happening to my worst enemy but it is what it is and we need to look after you, and I'm not being mean I don't want you to die.

116 **NJ** So quite a relaxed position that comes with the authority and the experience?

117 **Participant B:** I think so, I mean things stop being relaxed when you have to try and get all the paperwork and all the nonsense done, but in terms of work with families, yeah, I think age experience, caring, it sounds weird but caring a bit less about how you look and what the right thing is, believing that it's often not a right thing, that there's just loads of wrong things but we've got to just try and find the rightest thing and being confident and comfortable enough to be open with families and say, we'd all like to say there is a right way to manage this, but as you know this is really complicated. We could do this, it would upset you, we could do that, it would upset me, what should we do, should we pick one? Should we budget, compromise? What should we do? That's the transparency bit again. Let's share the decision making process, and that has got easier as I've gotten older, I turn fifty this year and people say about I just turn a year older it doesn't make any difference, turning eighteen it's not really different, turning sixteen it's not really different, I think for me it did make quite a difference.

..relaxing with complexity
..sharing difficult decisions
..easier to be relaxed with age

118 **NJ** So it's something about not only anorexia it's about your relationship with yourself and who you are and what positions you can take?

119 **Participant B:** Being a man, I wouldn't want to miss out because I think there are massive differences for me working with anorexia compared to female colleagues. Is it okay to jump on to that topic?

..being a man as difference

120 **NJ** Please, I was about to say what do you feel we haven't talked about.?

121 **Participant B: Okay.** Because the impact of working with mainly girls and women with eating disorders, I suspect that the difference, or the impact of me is different, these different areas and my female colleagues and I know from talking

..comparing devoid with male

..comparing devoid with male
..not using male body to
..having difficulty as female
..being comfortable with own
..using humour

to the patients that they will say that their relationship with me is different and is devoid of the comparison stuff that they do with their female therapists. So the shape of my body is less relevant than it is of the female colleague, age is also helpful, I'm a middle-aged man, girls say to me why would I, on what dimension do I compare myself to you? Whereas you know, I think, younger women have a much harder time in terms of managing that dimension of their relationship. I think that opens up a) – I get that conversation going fairly quickly, I don't have any problem at all doing assessments they ask people to put me in a line of who's fattest, you know? I don't know whether that's because of my age, I couldn't care that much what I look like now, it's all too late, but certainly that the ability for girls to talk about body comparison with somebody who they're not comparing themselves to I think is easier, because it's laughable, and I do use humour a lot. I think it's humour other people call it something else.

122 **NJ** What sort of humour?

..using irreverance

123 **Participant B:** Um, Well that's interesting, what sort of humour. Um, I did offer a young person and her family to do the entire session using sarcasm because that seemed to be her preferred mode of conversation, and she was tremendously enthused.

124 **NJ:** She was going to win.

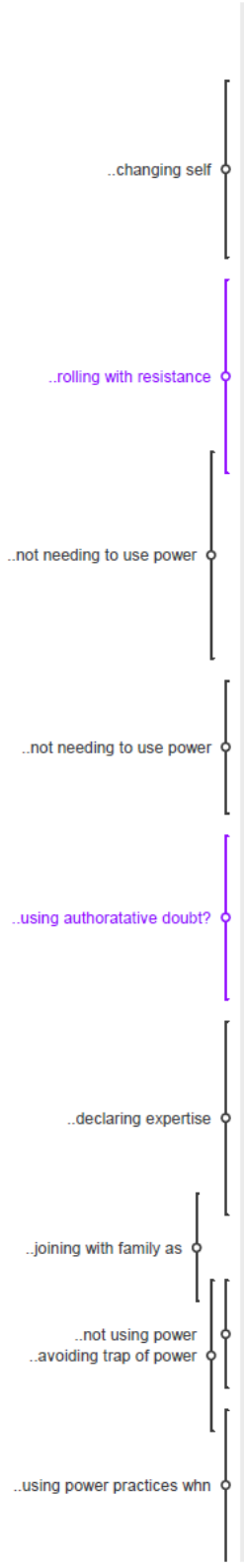
..using irreverance

125 **Participant B:** Yeah. We had a bet and It got quite difficult because if you try and do it on purpose it's really tricky,

126 **NJ:** So irreverence humour?

..using humour with discretion
..using humour with discretion
..taking one down position
..using self deprecating

127 **Participant B:** Yeah… but I think..but because I do it a lot and in my training David Campbell asked me once, what are you going to do when your kind of humour doesn't work in that kind of family? And I haven't particularly thought about that beforehand, but I do now, I don't use humour indiscriminately um, there's a difference in using humour to avoid tricky stuff than using humour to engage with tricky stuff and I think I'm not particularly interested in the former stuff, but there are times, when many a true word spoken with jest and I can get something into a conversation in jest, or can pick up on someone else's joke and say, many a true word spoken in jest. I'm not picking on you but let's just think about that , you know, so humour is important and self-deprecating humour quite a lot, that's a method of adopting a one down position , because if I can laugh at myself and other people can laugh at me it can give me permission to..



128 **NJ:** And again something about the power?

129 **Participant B:** Yeah, it is interesting because I do feel I've got better and better over the years at, being like water, there's a zen Buddhist saying, that if you put your hand in…

130 **NJ** You can't step in the same river twice.

131 **Participant B:** Yeah, and the kind of , I will just roll with the resistance I don't feel the need to block and know you know, Okay then, if we go that way, go with it go with your thinking, where are we going to get to? You okay with that, let's say it didn't quite work out how you wanted, what do you think Mum what do you think, shall we go that way? It's interesting, this conversation, because I have a lot of power in my job, I have a lot of power in this building, I have a lot of power in the trust, I've got to go to an area strategy meeting in an hour and a half's time and I'll say stuff that might make a difference to how we organise things, but having more power makes me feel like I need it less or use it less, or.

132 **NJ:** That's what I'm hearing, It gives you the ability in your clinical work to not actually use power practices.

133 **Participant B:** Um, which is,I haven't really looked at it that way round.

134 **NJ And** being transparent, self-deprecating, transparency but also transparent about who you are, about the relationship, very open in the conversation is what I'm hearing. It is the antithesis of the expert petition although at times you are calling upon the expert position for position in terms of medical risk.

135 **Participant B:** Yeah, again we have a way of using our technology which is we openly admit to having expertise and so we will say to people we have lots of expertise in treating eating disorders, a lot of experience of that, we've no expertise in you and your family, we require you to bring that expertise in the same way that you require us to bring our expertise. And if we make this work really well we will inform each other and again if it works well, you will be saying that you felt like a team with us. If it doesn't go well is when we position ourselves in a power over position or families come in a, let's imply that and then afterwards complain that they got done to. But we should know better, to fall into that. But you know, there are times when you know, we had a couple recently where there's been a safe guarding issue and we have had to inform statutory agencies, social care and um and things are happening that are dangerous that should not be happening and so you know, I'm not saying we

..using power practices whn

wont, or I won't use a power practice when I need to, but I will when I need to, not when I don't need to.

136 **NJ** Is there anything that I haven't given you the opportunity to talk about in terms of what influences how you position yourself on anorexia?

..unmotivated by working with

..caring about service

137 **Participant B:** I think, I think this is important, I didn't come into working, I've always worked with people with anorexia nervosa , there was somebody before I mentioned to you in hospital, but I think it is important to mention that I didn't come into this line of work specifically because I had a special interest in anorexia nervosa. This team exists because I thought the way that patients with anorexia nervosa were not being properly treated so we just did a pilot scheme to try and get things to be a bit better and there was a coincidence of me balancing a bit more responsibility and doing that pilot project and my boss saying, why don't you set up a service? My drive for this project is more to get a project to run well than it is to treat anorexia, that's not quite true; it's both of those things. And I do think it makes a difference that I care about the service and the delivery of it, rather than caring solely about treating anorexia.

138 **NJ** And what difference does that make?

..not being obsessed with ed

..caring about service delivery

139 **Participant B:** I don't know Nigel I think it does though, I think I'm just, it's not like I'm obsessed with eating disorders and anorexia. I am very focussed on having a service run well and to the best of my and my team's ability. I sometimes think it could have been something else, I could have said in the very same team meeting where I said, we're not doing very well with people with anorexia, I could have said, we really need to be treating people with depression a little bit less medically and a little bit more… can we do a family therapy clinic for depression?

..organising context for change

140 **NJ:** I'm just wondering whether what you're describing is an ability to work with it without being evangelical about it?

141 **Participant B:** Yes I think it's something like that, it's something like yeah, I don't know. It's, I don't know, a kind of emphasis on organising a process that will organise a context that will help something get treated well.

..organising context for ..being concerned with

142 **NJ** Okay, so it's more about, what's jumping into my mind is it's more about that human encounter, having a process in which distress could be alleviated and the context in this instance has to be anorexia. I was thinking about the position you take, which is, with exception of the medical risk, which sounds very

collaborative, very fluid, very expertise but not using power practices, which is about your problems and how you deal with those through your life, I've got my problems and how I deal with those. That's a very different process, than I'm passionate about anorexia and I'm going to destroy this anorexia and go do battle with it, get rid of it.

..organising context for
..being concerned with

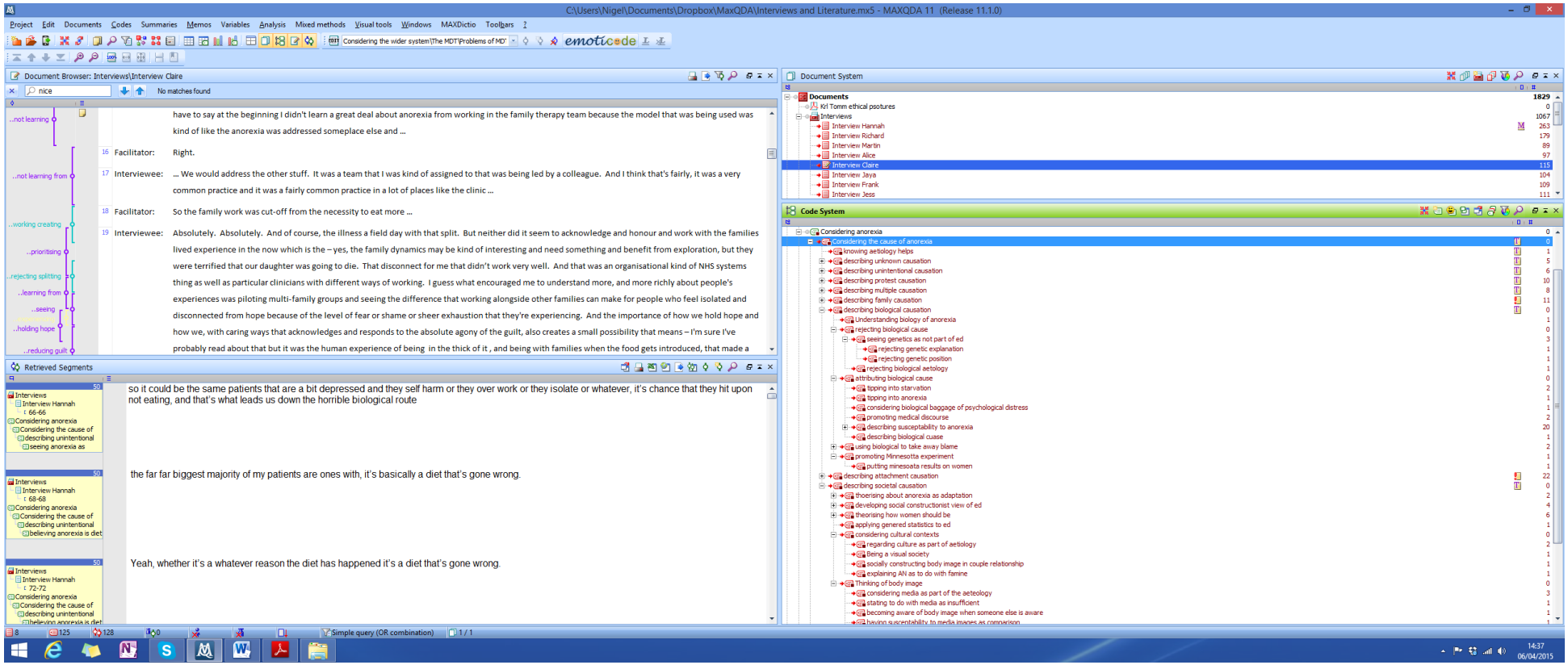
143 **Participant B:** Yeah I think that's right, that's a fair description, I didn't have some great wake up moment around anorexia, you know, I didn't have a personal encounter with it as a child; I don't have a parent with it. Food and weight issues have not been some massive part of my life, which for some people that is the case, and I do find it somehow, it feels like an advantage to be more connected to the organising of the right context than being more connected to what it is we're trying to treat. It's what we work with in family therapy we talk about context and process rather than detail.

144 **NJ** Thank you is there anything else that you feel…?

145 **Participant B:** No it's been a very satisfying interview.

146 **END OF TRANSCRIPT**

7.5 Appendix 5. Screen Shot of MAXQDA



7.6 Appendix 6. Principal Composition of Theoretical Sets

Set: History

Set	Category	Axial code	Focused code
History, self	Considering the family therapist	All	All
History, professional	Considering the family therapist	Training	All
		Recounting ED experience	All
		Having a role as a therapist	Relationship to change
			Gaining Post as Family Therapist

Set: Context

Set	Category	Axial code	Focused code
Context, work	Considering the wider system	The MDT	All
		The NHS/Agency	All
Context, societal/cultural	Considering the patient	Positioning of the patient	Seeing anorexia as restricting
			Seeing anorexia as empowering
	Considering anorexia	Responding to anorexia	Naming stereotypical perspectives
		View on anorexia	Viewing anorexia as friend and foe

Set: View

Set	Category	Axial code	Focused code
	Considering anorexia	Responding to anorexia	Emotional responding to anorexia
			Confirming dominant discourses
		View on anorexia	Viewing anorexia as not all bad
			Viewing anorexia as bad
		Considering the cause of anorexia	All

View, patient	Considering the family therapist	Therapist positioning on anorexia	Expert position
		Intervening	Focusing on behaviour
	Considering the patient	Positioning of patient	Seeing anorexia as empowering
			Fighting anorexia
			Experiencing treatment
		Perceiving patients	All
View, family	Considering the family therapist	Having a role as a therapist	Being self of the therapist
	Considering the family	Responding to families	All
		Positioning on families	All
		Perceiving families	All
	Considering anorexia	Considering the cause of anorexia	Describing family causation
View, self	Considering the family therapist	Therapists positioning on anorexia	Expert position
		Having a role as a therapist	Describing feelings of working with anorexia
			Needing to be as therapist
			Being self of the therapist

Set: Position

Set	**Category**	**Axial code**	**Focused code**
Position, expert	Considering the family therapist	Therapists positioning on	Expert position

		anorexia	
	Considering the family	Positioning on families	Supporting parents or family
	Considering the patient	Positioning on patients	Discounting patients
	Considering anorexia	Considering the cause of anorexia	Knowing aetiology helps
Position, unsettled	Considering the family therapist	Therapists positioning on anorexia	Not-knowing position
			Unsettled position
		Having a role as a therapist	Incorporating psychological and medical
Position, not knowing	Considering the family therapist	Therapists positioning on anorexia	Not-knowing position
		Intervening	Focusing on beliefs
		Having a role as a therapist	Doing tasks of the therapist

Set: Action

Set	**Category**	**Axial code**	**Focused code**
Action, leading.	Considering the patient	Positioning on patient	All
Action, positioning alongside	Considering the patient	Positioning on patient	All
Action, positioning behind	Considering the patient	Positioning on patient	All
Action,	Considering the	Having a role as a	Doing tasks of the

engaging	family therapist	therapist	therapist
Action, comforting			
Action, supporting	Considering the family therapist	Intervening	Focusing on contexts
		Having a role as a therapist	Doing tasks of the therapist
	Considering the family	Positioning on families	Supporting parents or families
Action, challenging	Considering the family therapist	Intervening	Focusing on beliefs
			Focusing on behaviour
	Considering the family	Positioning on families	Supporting parents or families

7.7 Appendix 7 Examples of Free Memos from MAXQDA

Memo text
some families only want to look at medical
The notion of anorexia as bad is a powerful discourse, and is juxtapositioned to the pro anorexia community. In some cases there is certainty that it is bad, an illness as described by Hannah (and the diagnostic manuals). At the same time other participants saw beyond this to consider the felt advantages of a relationship with anorexia.
The unsettled position is not just about when the therapist feels torn or uncertain but also about contradictions, when the therapist states one position but takes another.
if we are successful in using power practices to bring about recovery the danger is that we do not actually promote sustainable recovery. Later on anorexia or other forms of distress regulation may appear. Power therapies may work better with younger children and appear to be a good result but may not be building sustainable strategies for the future. We need to be careful in looking at recovery to consider the route there!
IO is not sleight of hand to get to point of professionals ambitions . It is about facilitating a process in which knowledge and options are increased as we walk alongside the patients. There may be different destinations arrived at in this way over the expert position
need to emphasise that dialogism is a way of being
Consider graces and multiplexity. Expand from a second to third wave feminist perspective
It is important to stress that dialogism and IO is not an alternative to other systemic ideas but encompasses them as part of the polyphony
IO is about being alongside, not following and therefore agreeing nor leading and so not being collaborative. It is totally fine as we walk alongside to be collaborative and disagree.
I need to consider the difference between various eras of feminism
It is interesting how more than one interviewee asked, later, how they fitted in with the other interviewees responses. It strikes me that this may be linked to gaining professional capital and response to the gaze of colleagues. Whilst seemingly confident in responses an uncertainty emerged later.
All of this extracts for this code are from Hannah. There are some contradictions, for example in not blaming family but then citing the idea that it can be connected to marriage partners. Hannah seems very keen to move from a position that attributes blame (hence being so dominant in the genetic explanation) but in doing so may be losing the systemic notion of relationships. Being part of a dynamic is not about blame. Indeed it can be seen as a systems failure (see Dorothy's paper)
A common theme is the understanding of anorexia as a symptom of distress, although there are also differences in this thinking to look at!
is engagement a power practice?
I think that here there may be here some contradiction with FT1's belief about anorexia being biological.

The variation in therapist positions can be an argument for the dialogic. Ideas can be fore and back grounded but we need to remember that we don't really know how to work with anorexia at the moment. In taking an IO (informed orienteering) perspective we can encompass many possibilities and get nearer to a fit with the clients world that brings about the possibility of change
Collaboration in context of risk is tricky. I would maintain though that this can still be possible in taking a position of its not collaborative to let you die?
link this to Jim Wilsons position of possibilism
Power of benevolent position
Honneth Tuesday, April 29, 2014 9:13 PM Has roots in object relations so compare with attachment but adds issues of self-respect etc Anorexia may give self-respect where it has ceased to exist. See intro page xv1 Consider how treatment and ultimate knowledge k of legal sanctions a sense of self-respect is right to be treated as others and how self-esteem is diminished. The treatment can also become the problem. Honneth states that self-esteem can be gained through value of employment but if the capital relates to another Field in Bourdieu terms but is sought in a more socially acceptable Field then capital will mean little hence perfectionism is never achieved Daniel stern 1997 drew attention to the interactional nature of attachment Family Therapy is to do with all parties recognizing each other and anorexia and justice (see Peterson doctorate)can be viewed as a an shalt at recognition hence Honneth's ideas of recognition are of interest Comparison of Petersons doctoral description of N abuse centre with an end service in which there may be compassion but also an attempt to change anorexic behaviours the less the self confidence in a context of love the more that loved ones and professionals intrude and diminish legal rights and self-respect the more that soldierly diminishes along with self-esteem the more that self-confidence is sought through anorexia attempting to gain self-respect but self-esteem doors not increase A dialogic process that contributes towards the building of self-confidence, respect and esteem. All require a relational experience
Much as one cannot empower another from a position of power to build recognition in another in Honneth's terms needs to be process of building mutual respect not port for the suffering of the other which can be benevolently intentioned colonization.
Therapeutic relationship forming as type of seduction or power practice

‘Anorexics’ have been oppressed. The treatment objectifies and dehumanises then it replicates the oppression. But how to not treat as fellow humans and allow anorexia to flourish. A double bind?
Complexity masks simplicity and simplicity reveals underlying patterns. Like cricket rules do not make for predictable outcomes
How to not work with or objectify the patient. Treatment can be a form of domination. Can be process of othering. Treatment may be a form of symbolic violence. The question is how to work in a manner that encourages agency
In some models the biological is kept separate from the psychological, for instance in Ali Borden's position of not discussing weight until it is close to admission. In the process of informed orienteering I would propose and ability to encompass the biological, and discussions around risk, at the same time as addressing other psychological factors.
inpatients regularly say to me " if I get (physically) better how will people know that I’m not well? In treating the medical alone in the early stages are we setting up a dynamic in which the above will follow. Informed orienteering will address both, in accordance with NICE guidelines. The guidelines are often interpreted as stages but need this be the case or can the work be done in parallel?
IO can encompass both the exploratory and the directive (stop look listen).
A critique of narrative is that it is not systemic. A reason to move from Hepworth’s preferred solution to a more dialogic (that may incorporate narrative thinking, especially around subjugated discourses and thin descriptions, but not necessarily externalisation. I prefer to think of foregrounding and backgrounding various aspects of self
It is not uncommon for therapists to take a stance of the cause of anorexia being unknown, and indeed many models (eg Maudsley) point to this idea. On the other hand families are often concerned as to the cause. This may be just that they are perplexed, or more complex, for example in wanting to overcome their own feelings of guilt or possibly to see what they could have done. can do differently
It s no longer fashionable in FT to look for causation that may be, in some ways, blaming of parents. In working with ED a common discourse is that the cause(s) are unknown. This in some ways may be an attempt to move beyond the family blaming stances of earlier systemic models. At the same time something is lost in abandoning contributory hypotheses. A sense of the complexity that led to such a way of responding to/ coping with life is useful in guiding conversations that are useful for change.
All of these codes came from the interview with Hannah, who held a strong biological hypotheses. I think her motivation is one of removing blame and indeed her belief that it is a strategy for only a limited number moves away from the other interviews. At the same time my experience is that no person was aware of the consequences or power of the early relationship with anorexia. In the beginning it seems to be felt as giving control (capital?) and it is often only later that they are aware of how they have become trapped within behaviours.
multiple causation is a strong code with agreement from most participants. It follows the understanding of anorexia as complexity. some of the feminist stances miss the complexity by taking a narrative of male domination. The 3rd(?) wave of feminism takes a more social constructionist stance and may be useful in adding

to the complexity narrative
Biological causation is one the most contentious issues amongst the difference in the participants. There are clear links with the Minnesota experiment in describing starvation in MEN. It is clear that an understanding of the medical side of anorexia is needed to do this work. However, there may be a potential trap for the FT in getting too caught up in medical areas. This may have happened with Hannah who declares her search for knowledge about the medical. This in turn may be linked also to the need for capital amongst the MDT where FT is alone in not working with individuals and having a systemic focus.
The societal aspect was surprisingly not touched on too much by the interviewees. I was expecting more ideas around the societal and cultural aspects of anorexia, although this may also have to do with how little I drew this out. Certainly Richard, Martin, Alice, Jaya and Frank took strong constructionist positions but I feel I did not question enough around these issues, specifically in terms of how they drew upon this thinking in their direct interventions
Causation is generally avoided in descriptions of anorexia, in great part as a part of the move away from blaming parents, but also because of the complexity of anorexia. Most of the participants were in accord that there are multiple causes and complexity.
Anorexia as not all bad seems, to me, to be a more useful position than that of the pro or antic groups. The ambivalence around recovery can often be, as well as the difficulty of habituated behaviour, around balancing the advantages and disadvantages. Recovery is often around a tipping point in the balance between these two positions that can, in the words of Martin it is " a comfort and reassurance , it's a friend it's a foe , it's both at the same time"
Purposely not done analysis of language hence grounded theory as I want not to merely analyse but to reflect on experience of reading
Triangulate by feeding categories to participants
future research might be position therapists take towards anorexia across the life cycle
The process has become a dialogic for of grounded theory. Firstly I had a reflexive relationship with the emerging literature. The interviews then informed by view which moved and finally my analysis was the culmination of a dialogue between the literature my practice and the interviews. All from a subjective viewpoint
the process of asking about their background was both a research question and a way of warming the interview context
Nice replicates family therapy as focusing on problem in that it recommends it to focus on rating disorder not context