The role of socio-cultural perspectives in eating disorder treatment:

A study of health professionals

Abstract

Eating disorders (EDs) are now often approached as biopsychosocial problems, and are widely recognised as multifactorial in origin. But it has been suggested – particularly by feminist scholars - that all is not equal within this biospsychosocial framework, with the 'social' aspects of the equation relegated to secondary or facilitating factors in treatment contexts. Drawing on data from 12 qualitative interviews with health professionals in a UK region, this article examines the extent to which socio-cultural perspectives on eating disorders (EDs) are valued and explored in ED treatment, with a particular focus on questions of gender (and femininity). Given that girls/women are disproportionately affected by EDs, the article explores to what extent the relationship between EDs and cultural constructions of femininity is actively

addressed *within* treatment. The study revealed high levels of inconsistency in this regard, in so far as some health professionals thought that such issues should be central to treatment, whereas others had 'never really considered' them before. In addition, the study examines the potential limitations to the ways in which such socio-cultural issues are perceived and addressed. Not only was the onus often on the patient to flag the relevance of such issues (rather than these being anticipated and embedded within treatment), but socio-cultural perspectives on EDs were covered little in training, making it potentially difficult for health professionals to know when such concerns were being raised. Furthermore, in drawing on the interview data, the article explores why the often 'obvious' relationship between femininity and EDs may currently be marginalised in treatment, building on a feminist critique of what counts as 'evidence-based' treatment and why.

Key words:

Gender and health * Discourse analysis * mental health * eating disorders

Introduction

Eating disorders (EDs) are now often approached as biopsychosocial problems, because they are widely recognised as multifactorial in origin (Culbert, Racine & Klump, 2015). As such, contemporary ED treatment often takes a multi-dimensional approach that moves beyond a focus on weight and food, and guidelines set out by the National Institute for Clinical Excellence (NICE) advocate the inclusion of 'psychosocial' elements – particularly those pertaining to 'weight and shape' - alongside the management of physical symptoms (NICE, 2004). This guidelines gesture here to what are often seen as the most common 'social' factors implicated within EDs (Levine & Smolak, 2014): gendered idealisations of thinness and consequent prescriptions and pressures concerning body shape. But it has also been

suggested that there is a substantial and unwarranted imbalance within this biospsychosocial framework, with the 'social' aspects of the equation – such as those mentioned above - relegated to secondary or facilitating factors within treatment contexts (Bordo, 1993; Holmes, 2016, Katzman & Sing, 1997). In its extensive review of treatments for Anorexia Nervosa (AN), for example, the NICE guidelines offer no suggestion as to how to address the 'psychosocial' elements they outline, and such perspectives are not even mentioned in the discussion of Bulimia Nervosa (BN), Binge Eating Disorder (BED) or Other Specified Feeding and Eating Disorder (OSFED). This is indicative of the fact that although sociocultural perspectives on EDs represent a visible area of study and have a significant empirical foundation (Culbert, Racine & Klump, 2015; Levine & Smolak, 2014), very little has been written about them in the context of ED *treatment.* The reasons for this are complex and multifaceted, and can only be understood in relation to the sociocultural approaches themselves and their intellectual, epistemological and clinical status.

The interest in exploring sociocultural perspectives on EDs has emerged from the overlapping fields of sociocultural and feminist approaches to eating and body distress. To take sociocultural models first, these have primarily focused on factors related to the idealisation of thinness in women (Culbert et al, 2015, Levine & Smolak, 2014), and the stigmatization of body fat in Western cultures. In demonstrating that the idealization of thinness in women *and* the prevalence of AN and BN increased during the last century (Culbert, Racine & Klump, 2015: 5), it is suggested that exposure to Western ideals of appearance generates body dissatisfaction and dieting behaviours which elevate the risk for ED development. In responding to the significance of gender as a risk factor for eating problems, preventative efforts have commonly targeted the internalisation of the thin ideal and wider body dissatisfaction, and the most successful interventions have been seen to reduce 'thinness expectancies' (Culbert, Racine & Klump, 2015: 5), and disordered eating

practices in populations of girls and women (Stice, Becker & Yokum, 2013). But in terms of considering why there may be little empirical work on the significance of sociocultural approaches within ED *treatment,* it is clear that both preventative interventions and risk factor research sit at one remove from clinical practice (as both are concerned with the stage before an individual becomes really 'ill').

Yet there is empirical evidence to suggest that gendered constructions of the thin ideal and consequent body dissatisfaction are also implicated within the *maintenance* of EDs (albeit with variances across ED subtypes (Stice, 2002)) – thus warranting the inclusion of gendered-focused interventions within treatment contexts. A primary example of the latter is body image work (a term which encompasses a range of different approaches from the psychoeducational to the cognitive), and this necessarily takes in social and cultural contexts in so far as notions of the 'ideal body' are 'socially shared' rather than 'the unique and idiosyncratic production of the individual…' (Gleeson & Frith, 2009: 82). But although there is growing evidence base for such interventions (Mountford, Brown, Bamford, Saeidi & Morgan, 2015), the efficacy of body work within ED *treatment* has been explored far less compared to preventative contexts, perhaps suggesting **a lower interest to prove etc.**

 In addition, the extent to which body image work incorporates a clear focus on *societal* contexts may be variable, and the concept may often be treated as an 'individual property best examined at the individual level' (Gleeson & Frith ref), In this regard, it is also relevant to consider how pervasive such interventions are across clinical contexts. Although it has been stated that **'**body image therapies have become widely dispersed throughout eating disorder services' (Morgan, Lazarova, Schelhase & Saedidi, 2014), there is empirical evidence to suggest that they remain marginalised (Ferrer-Garcia & Gutierrez-Maldonado, 2012). Indeed,

this article forms part of a larger study of the role of sociocultural perspectives in ED treatment, and a survey conducted for the research across 86 UK treatment sites (including National Health Service [NHS] and private sites, in-patient and out-patient services), revealed that only 23 included body image work as a regular aspect of treatment, and not all of these explored the societal contexts for body ideals.[i]

See reviewer on femininity as performativity

It is also the case that the concept of body image as the main terrain upon which to address the social/ cultural dimensions for EDs has itself been critiqued. Feminist approaches – the other key area of work offering sociocultural perspectives on EDs - have suggested that the concept of body image may occlude the range of meanings expressed by eating/ body distress (Katzman & Sing, 1997; Piran and Teall, 2012). In response, such approaches tend to situate EDs in relation to the *wider* social expectations surrounding western femininity, ranging from gendered discourses on appetite, sexuality, economic power to social roles (Malson, 1998; Orbach, 1986; Saukko, 2008). The significance of the media in propagating a slender ideal has certainly been recognised in feminist work (Bordo, 1993; Orbach, 1986). But feminist scholars and therapists have also been wary of over-emphasising 'the inscriptive power of cultural images of thinness', and thus the characterisation of EDs as 'body image' problems (Malson, 2009, p. 124), suggesting that this may miss the meanings of eating/body distress as they unfold within wider inequities of gendered power (Katzman & Sing, 1997, p.388). In discussing qualitative interviews and larger clinical group studies in which girls/women talk about their experience of an ED, feminist work has emphasised how disordered eating may not necessarily be motivated by the drive for pursuit of thinness or any 'distortion' of body

image, but rather by wider experiences of 'restricted agency' that are structurally *gendered* (Piran & Teall, 2012).

In this regard, feminist work has provided substantial qualitative evidence about the ways in which EDs emerge from, and are maintained by, social constructions of femininity (Burns, 2004, Gremillion, 2003, Holmes, 2016, Malson, 1998, 2009, Saukko, 2008). In so doing, feminist work has argued that eating/ body distress should be situated within the discourses and practices of *normative* femininities (thus critiquing the medical construction of the problems as eating 'disorders'). For example, feminist work has explored the cultural conflation between eating and sexual desire, situating eating/body distress in relation to the ways in which women are called upon to exert greater regulation of 'appetite' – both in relation to food intake and sexual desire (Orbach, 1986, Bordo, 1993, Malson, 1998, Burns 2004). Alternatively, and in relation to AN, feminist scholarship has theorised the body as a site upon which contradictory discourses on femininity might play out: thinness and starvation are seen as rendering femininity small, weak and fragile, whilst the emaciated body has been read as a form of corporeal resistance - the rejection of feminine subjectivity through an escape into a childlike, boyish or degendered form (Bordo, 1993, Malson, 1998). In this regard, feminist approaches to EDs do not distinguish between gender as a 'risk' or 'maintenance' factor: they see the aetiology, symptoms and the very nature of EDs as deeply imbricated within western cultural discourses on femininity.

But it has been suggested that such approaches may find limited application in current treatment contexts, both in terms of conceptions of what EDs 'are' (Katman & Sing, 1997), and as based on limited empirical evidence of patient experience: Holmes suggests for example that even when cultural discourses surrounding femininity are perceived by patients to be fundamental issues, they may be marginalised or ignored (Holmes, 2016). Many of the early feminist interventions - which emerged in the 1980s, often from the perspective of

feminist psychotherapy - were developed from *within* treatment contexts by women who were practising therapists or counsellors, and their early work featured case studies of women who had been helped by approaches that centralised the relationship between EDs and cultural constructions of femininity (Lawrence, 1984, Orbach, 1986). The reasons for changing treatment paradigms are complex and multifaceted, but the decreased visibility of feminist work may have been shaped by a climate which foregrounds features of EDs that translate into conceptions of mental illness (Levine & Smolak, 2014). There has also been a concerted push toward evidence-based treatment, and although there *is* evidence for the feminist approaches to EDs, it does not necessarily conform to the (masculine) objectivist discourses of science which dominate ideas about treatment efficacy in the field (LaMarre, 2015, Holmes, 2016).

But such explanations are speculative: although the extant evidence suggests that sociocultural issues such as gender may be marginalised in clinical contexts, there has been little sustained research which investigates lived examples of *treatment practice* in this regard. Interviews with health professionals can provide a valuable bridge in addressing gaps between research and practice in ED treatment (Turner, Tatham, Lant & Mountford, 2014), and can contribute to our understandings of treatment practices and challenges (Jarman, Smith & Walsh, 1997; Reid, Williams & Burr, 2010); training (and training needs) (Turner et al, 2014), and how 'patients' are conceived and constructed (Malson, Finn, Treasure, Clarke & Anderson, 2004). Interviews with health professionals can thus offer insight into how the sociocultural elements of EDs are conceptualised within treatment; how or why they might be marginalised (and the extent of this disparity); and whether this is conceived of as an issue or 'problem'. As such, the purpose of this study is to explore health professional views on the role of sociocultural perspectives in ED treatment, with a particular focus on cultural constructions of femininity – which this article takes to mean the cultural expectations,

meanings and roles that are mapped onto subjects biologically defined as female. In doing so, it seeks to answer three key questions which emerge from the literature above: given that females are disproportionately affected by EDs, to what extent do health professionals address the relationship between EDs and cultural constructions of femininity within treatment, and how is this shaped by training provision? If such issues are addressed, how are they incorporated or approached? What are the implications of the results for thinking about how the 'social' aspects of the biopsychosocial equation are enacted in practice?

Methodology

Recruitment and sample

The study was undertaken across a region in East of England, and after ethical clearance for the project was granted by the author's university and the relevant NHS trusts (June 2016), all the services were contacted by email with an invitation to participate in the study. This included three NHS community services (one adolescent, one adult, and one combining both), an independent residential facility offering specialist inpatient care to NHS and private patients; and a registered charity providing counselling and support to young people and adults. The charity deals with all types of eating problems and often sees itself as a service for prevention/ early intervention, mainly offering a one-to-one counselling service. In the in-patient and community services, treatment is offered by multi-disciplinary teams which include different combinations of psychiatric, therapeutic and dietary interventions. The three community services care for patients with a primary diagnosis of a moderate to severe ED (principally AN, BN and BED), whereas the in-patient clinic deals with chronic cases (across ED diagnoses but most commonly AN).

At the request of two of the NHS services, follow-up meetings were arranged to outline the aims and scope of the research in further detail. Following this contact, and email exchanges with the other services, participants came forward from each of the treatment contexts after the study was advertised by service gatekeepers (such as managers or clinical leads). Purposive sampling was then used to ensure that a range of roles were represented across the study – such as support workers, occupational therapists, counsellors and psychiatrists. It was anticipated that the specific role and/or training of a participant may shape perspectives on the issue being explored, so it was considered important to include a range of different roles within the sample.

Twelve participants were interviewed in total: 11 female and 1 male, with ages ranging from 25-56 (mean age 36). Although this represents a clear gender bias, it accurately reflects the predominance of female personal employed by the services in the study. Of the twelve participants interviewed, six worked within the NHS, and six within the independent and/ or charity sector. The sample included therapists and counsellors ($n = 3$), psychologists ($n = 2$), a psychiatrist ($n = 1$), a nurse ($n = 1$), an occupational therapist ($n = 1$), and participants whom occupied a range of supporting and facilitating roles directly involved with the care of patients ($n = 4$). In terms of clinical orientation (where this was relevant to the role or discipline), the sample included psychodynamic ($n = 3$), integrative ($n = 1$), systemic ($n = 1$) and cognitive ($n = 2$) specialists, as well as participants who had experience or training across more than one of these fields ($n = 2$).

The interviews were all undertaken by the author between July-September 2016, and were variously conducted at participants' workplaces, public meeting spaces or via telephone. The interviews lasted for approximately one hour and participants gave verbal consent for the

interview to be recorded and used for research purposes at the start. The interviewer then asked participants the following from a list of predetermined questions: 1) what participants perceived the causes of EDs to be and how this understanding shaped their work 2) to what degree participants addressed socio-cultural issues – in this instance, particularly the relationship between EDs and cultural constructions of femininity – within the treatment they provided 3) how their work was shaped by wider institutional frameworks (e.g independent or NHS) and directives about the types of treatment delivered 4) if they thought that socio-cultural factors were adequately addressed within current treatment practices.

Conceptualising gender

As the framing of this article and the interview questions suggest, EDs have historically been perceived as gendered problems, primarily affecting girls and young women in Western societies. But it is clearly important to acknowledge here that eating problems are not confined to cis-gendered girls/women, and to think about the implications of this for the focus of this article. The last fifteen years or so has witnessed a rise in the visibility of males being diagnosed with EDs (Cohn, Murray, Walen & Wooldridge, 2016) - with estimations reaching as high as 25% for AN/ BN and 36% For BED (Hudson, Hiripi, Pope & Kessler, 2007) - and there has been a call from scholars to think about the sociocultural contexts of masculinity within which such problems may flourish (Soban, 2006). In addition, emerging evidence suggests that transgender individuals are more at risk from EDs than cisgender populations (Algars, Alanko, Santtila & Sandnabba, 2012) – arguably adding credence to the sociocultural and feminist arguments that the aetiology and experience of eating/body distress may be profoundly and complexly implicated within the negotiation of dominant gender norms. But feminist work on EDs has done little to examine the connection between

eating/body distress and gender minorities, or advanced gender analyses of EDs in the male population.

On a wider scale, feminist thought has consistently work to unhinge biological sex from gender (with the latter being understood as the cultural constructions through which the concepts of 'woman'/ 'man' come to signify). But it has been suggested, by post-structuralist feminist scholars in particular, that the feminist aim to challenge and change the 'structure and value system of gendered social orders' has all too infrequently disrupted the binary divisions upon which they rest (Butler, 1990, Lorber, 2000). The effect of this is a reification and naturalisation of such gender divisions; the homogenisation of gender categories (assuming, for example, the existence of 'woman' as a unified category); and a denial of the 'multiplicity' of fluid gender identifications which exist on a continuum (and which are less exclusive to gender and sexual minorities) (Butler, 1990).

 In this regard, in exploring the ways in which EDs may both express and emerge from Western cultural constructs of femininity, feminist work has largely focused on cisgendered (white) women within an often heterosexist framework (Jones & Malson, 2013; McDonald, 2014). It is doubtless the case that the feminist work could have been less heterosexist and more transcultural and intersectional in its focus – and work which complicates this field is beginning to gather ground (Huang, Cummins & Lehman, 2007). But it is also important to stress here that the conceptual frameworks employed by many feminist scholars in their analyses of EDs were precisely intended to explore how *binary cultural constructions of gender* were implicated within the development of eating/body distress, giving rise to the clear gender bias in ED populations which were, and still are, predominantly made up of cis-gendered girls/woman. In addition, postructural feminist work on AN has sought to theorise the ways in which the starved body might be seen as signifying shifting and ambiguous 'messages' about gender: it has been figured as an attempt to become more 'boyish' or

masculine (Bordo, 1993), as expressing an ambivalence about binary constructions of gender, as well as a bid to 'hyper-conform' to them (by being small, petite and 'fragile') (see Malson, 2009). This does not circumvent the critique about feminist research functioning to reify gender binaries even whilst it critiques them (Butler, 1990, Lorber, 2000), but it does contextualise the epistemological base of such work, as well as the complexity of its arguments about EDs as both an expression and negotiation of gendered norms.

I acknowledge both the complexity and limitations of these frameworks here, and do not seek to endorse nor promote a gender binary that is divisive, homogenising, heterosexist or exclusive (relying on conceptions of biological sex alone). Indeed, the study also seeks to raise questions about the adequacy and implications of gender paradigms in ED treatment, including those offered by feminist scholars. Nevertheless, the study was precisely interested in how the prevalence of cis-gendered women – historically the most 'obvious' and visible population found within ED treatment – were positioned within understandings of sociocultural perspectives in treatment. Discussions of male and transgender individuals in ED treatment have specifically foregrounded the need to explore and address the particular sociocultural discourses on gender that may be implicated and expressed through such experiences of eating/body distress (Soban, 2006, Duffy, Henkel & Earnshaw, 2016)). These arguments are indisputable, but they tend to assume that, in terms of cisgendered female patients, such issues are *already addressed* in established and expert ways, despite there being little or no research which examines this issue. As such, although the interviewees were free to talk about any aspects of the relationship between gender and sociocultural perspectives on EDs in their treatment context, the study did specifically raise the issue of the relationship between EDs and cultural constructions of femininity. All participants described how cis-gendered girls/women represented their primary patient base (with either little or no contact with male or transgender individuals to date). As the fact that girls/women are

disproportionately affected by eating problems has been seen as one of the most visible markers of the sociocultural aspects of EDs, asking health professionals about their treatment practices in this regard provides insight into the significance and value afforded the 'social' aspects of the 'biopsychosocial' equation in clinical contexts.

Data analysis

The interviews were recorded on a digital voice recorder and transcribed by the author, and the participant data was then anonymised at the point of writing.[ii] The data was analysed using thematic discourse analysis – with the latter being particularly concerned with how language actively constructs 'reality' within wider relations of power (Potter & Wetherell, 2006). Such an approach goes beyond 'the semantic content of the data, and … starts to … examine the underlying ideas, assumptions, and … ideologies that are theorized as shaping or informing' what is said (2006: 84). This is pertinent to the study undertaken here in so far as the 'underlying ideas, assumptions and ideologies' about the significance of addressing the sociocultural significance of femininity in treatment were subject to analysis.

The data was approached using the six-stage process for thematic analysis defined by Braun and Clarke (2006). The first stage involved the author familiarizing themselves with the data, and the transcripts were read and re-read so as to produce notes on preliminary ideas and observations. Second, initial codes were identified from this process across the full data set. Third, these initial codes were used to generate broader thematic categories - as based on the prevalence of such themes within the data as a whole. Fourth, the themes were then tested against the coded extracts as well as the transcripts in their entirety. In stage five, the themes that were identified inductively (Braun and Clarke, 2006) were defined as 1) the focus on the individuality of the patient and how this was framed in relation to socio-cultural explanations

of EDs 2) the extent to which issues of gender – especially those relating to femininity - were seen as visible/ invisible in ED treatment 3) the relationship between training and sociocultural perspectives 4) perceptions of why socio-cultural perspectives on EDs might not be central to treatment, with a particular focus on questions of 'evidence'. In step six, the thematic categories were then analysed in detail and data extracts which vividly represented these themes were selected for inclusion. This also involved placing the themes in relation to the research questions and the literature, considering, for example, how the participants spoke about the potential significance of addressing femininity in ED treatment, and how these discourses related to the arguments that sociocultural issues are seen as secondary or marginal factors within clinical contexts.

Results and discussion

Theme # 1: The individual and the social

The participants believed that many factors may cause or precipitate an eating problem, and that these would be different from case to case, and the emphasis on multi-causal contexts is consistent with the contemporary idea of EDs as complex biopsychosocial illnesses (Cuthbert, Racine & Klump, 2015). Whilst some placed an emphasis on the biological predisposition of the individual, others foregrounded personality traits (ranging from anxiety, perfectionism to sensitivity), family dynamics, to wider social/cultural frameworks - such as constructs of sexuality, body ideals and gender roles. Unsurprisingly, those who thought that sociocultural factors played an important role in the aetiology and maintenance of an ED were more likely to foreground the significance of addressing these issues in treatment. Participants offered various – and sometimes radically divergent – views on this issue, ranging from an insistence that it was a vital aspect to consider in treatment, to the suggestion

that such an issue didn't really 'come up'. In exemplifying the view that a focus on the cultural construction of femininity should be central, one of the therapists explained how:

> I find it hard … to see quite how you can have a thorough eating disorders treatment approach *without* talking about gender and sexuality… I think it is always in my mind - I'm always listening, waiting for it to come up… or thinking about how to make that connection [original emphasis] (P9)

Here, the participant suggests that the framing influence of gender and/or sexuality is intrinsic to how she conceptualises EDs, and thus her encounters with her clients. This view sat on a continuum with the perspectives offered by other participants in the study who articulated such views as: 'It's not the main factor but it is an important one – I think the societal context is really important and I think the messages to women are really important' (P2), 'if it comes up we would talk about it' (P5), to 'it's not something that I explicitly address or which comes up regularly' (P8). Although there were no simple or consistent divisions between the services in this regard, the socio-cultural aspects of EDs appeared to be most central to the work of those from the charity – notably the context least connected to a medical model of ED treatment. At the same time, it was clear that, for many of the participants, the idea of recognising social commonalities between patients sometimes sat in tension with a clear desire to consider the patient as an *individual.*

The importance of treatment being sufficiently responsive to individual needs and experiences has been increasingly articulated in both scholarship and practice (Reid, Williams & Burr, 2010), and this was echoed by the health professionals in the interviews undertaken here. For example, although the participants were happy to discuss their

perspectives on the potential causes of EDs, there was frequently a reluctance to generalise *too* far, because:

> Every person is valued as a unique individual and their eating disorder will be
> very individual to them – we can't compare it to anyone else's… But it's all
> about the underlying issues which are as unique as every person we see… (P1).

As suggested by the word 'valued', the emphasis on the individuality of the client/ patient is articulated positively here – in terms of meeting their particular needs with due respect and care. This is clearly important, but as discussed in the framing of the article, feminist approaches are also wary of individualised conceptions of EDs (Malson, 1998; Rich, 2006) which may reduce societal factors to 'personal' problems or 'dysfunctions' (Schubert Walker, 1987, p.6). But the feminist approaches do not deny the specificity (nor agency) of the individual, but are interested in the 'role of social structural factors in shaping *individual's* experiences [my emphasis]' (Piran, 2010, p. 187), or what Zerb Enns calls 'the *distinctive* denotation of gender in each person's experience [my emphasis]' (1993, p. 17).

In some of the participant interviews, what feminist approaches to EDs would regard as evidence of a patient negotiating cultural expectations surrounding gender and/or femininity were framed as very individual or *personal* aspects of a patient's identity or story. For example, one participant recalled a female patient (with a diagnosis of AN) who began to change the ways she dressed during treatment:

> She said I want to start wearing essentially man's clothing, and … for her that
> was a massive thing ... I guess we all had an inkling that she wanted to dress more
> masculine because she wouldn't ever look kind of feminine … For her it was
> about identity and working out 'who am I?' … That's how she felt most

comfortable dressing… But it was so sensitive, so we kind of tiptoed around it

until she brought it up… (P4).

In terms of thinking about how issues of gender may be conceptualised in treatment, this response is useful and revealing in several ways. First, although AN has been associated with a potential rejection or eschewal of gender binaries (in terms of the 'de-gendering' of the body), the references to 'masculine' and 'feminine' modes of identity suggest the difficulty of working without recourse to this traditional dichotomy. Indeed, this example can be seen as raising questions about the adequacy of conceptual or treatment models which primarily assume a gender binary – including those offered by the feminist paradigms. Second, even whilst the participant acknowledge the relevance of social constructs such as masculinity and femininity, the issue is presented as one that is very personal to this patient, and perhaps one that needs exceptional handling ('so we kind of tiptoed around…'). Although the issue is indeed potentially sensitive, there is now a considerable literature on how an ED may be a way to negotiate 'non-normative' gender *and* sexual identities in ways which make it difficult to see this patient as 'unique' (Duffy, Henkel & Earnshaw, 2016; Holmes, 2016; Jones & Malson, 2013; MacDonald, 2011). Third, and related to this, the patient was framed as memorable by the participant because she was seen as distinctive – offering a moment when questions around gender suddenly became visible - as opposed to the more 'obvious', but often unacknowledged, preponderance of female patients in the clinic. In fact, although the participant recognised the overwhelming predominance of cisgendered female patients under her care, she struggled to name other instances when gender was relevant, or had 'come up'.

Further foregrounding the perceived tension between socio-cultural perspectives on EDs and a desire to acknowledge the individuality of the patient, there was also often the suggestion that such issues were best addressed in one-to-one settings. As one participant explained:

I would say that it should be in individual one to one stuff. In group… [work],

you might get as far as saying 'that's interesting', but that is about as far as it

maybe goes because obviously you don't want to expose people too much in

groups … But in individual work …. if people bring it I want to talk about it

because I think that's really important (P3).

This response again couches such issues as both sensitive and personal, and it is clearly

important that health professionals are alert to the difficult nature of such topics, and respect

the privacy of the individual. But even though group work is in fact common within in-

patient settings, there is little possibility in such conceptions that, in dealing with *social*

constructs and discourses, patients might benefit from the *collective* recognition or sharing of

the gendered scripts that may have disrupted and compromised their sense of self. In contrast,

group work was seen as central to the emergence of feminist therapy from its origins in the

1970s (see Zerb Enns, 1993), with a collective context seen as crucial for the recognition and

exploration of female experience and oppression. Issues such as EDs and body dissatisfaction

were among the specific problems addressed by these early feminist interventions (Katzman,

Weiss & Wolchick, 1987). But discussions of these possibilities, and evidence of their active

use in treatment, appear to peter out by the late 1980s - the potential reasons for which are

explored below.

Theme # 2: The (in)visibility of gender

The second theme is closely related to – and emerges from – some of the issues raises by

theme one above. Foregrounding the ways in which interviews actively produce (rather than

simply collect) data (Ribbens, 1989), the process of taking part in the study also prompted

some participants to consider the relationship between gender and treatment in ways they had not before. One participant reflected on this issue in the following way:

> We work generally with females, but I don't think we refer to it, in a conscious … way…. I don't necessarily bring [gender]… up but I think it does come out, in subtle ways, in terms of when they are talking about what they are doing to themselves – whether they are punching their chest because they don't like their breasts or even when people kind of strap themselves so that their chest looks flat. So they are all things that mark a progression towards womanhood that they are trying to step back from… It does make sense but I suppose I never really stopped to think about it, or think about it in terms of how I might … approach it (P10).

The reference to 'it does make sense' suggests that the participant is considering and evaluating a perspective that she would not normally take (or has not been encouraged to take) in her work, although whether the actions she describes could be seen as in any way 'subtle' is debateable. Similar patterns of reflection and recognition appeared in other interviews:

> Well now I think about it I've come across quite a lot of people not wanting to bother people or take up space and I wonder if that is gender specific? I don't know as [gender]… has never come up explicitly but I think there are ways in which it has come up, looking back on it now – about society and being a woman, but it has never been explicitly something that's come up (P6).

The oscillation here between suggesting that discourses on gender do/don't 'come up' may suggest an uncertainty about how and when to recognise their articulation. But it also

indicates the view - appearing in many of the interviews as well as the quotes used in theme one - that the relationship between eating/body distress and cultural expectations surrounding femininity needed to be 'brought' or raised by the patient (or researcher) in order to be acknowledged. The idea that the patient should be responsible for setting the agenda of their own treatment (in terms of being expert on what forms of treatment they need) is problematic. This also seems doubly concerning if the confidence to recognise or 'see' this issue is inconsistent or variable. Even when it came to participants with substantial years of experience in the profession (and with training across different clinical orientations), what might be called a literacy in reading gender politics varied greatly: some were clearly confident in addressing this area and spoke explicitly about recognising the role of gendered discourses in the development and maintenance of eating problems, whereas others admitted quite openly that they were less sure. This frequently led to discussions about the scope of training in the field.

Theme # 3: Training

Only two participants in the study – with different professional roles and backgrounds - believed that their training had prepared them to understand and address some of the sociocultural dimensions of EDs. As one explained:

> As I'm a clinical psychologist… I had a lot of training about socio-cultural issues and gender and things like that… so we are trained to consider those things in whatever field we go in. … But it does depend on where you go in the country so [as where I trained]… they are really hot on that…But each course does vary politically… (P7).

Although the participant acknowledges her training was not necessarily specific to EDs, she suggests that it gave her tools to apply to her chosen field. But there is equally an

acknowledgement here that such training would depend on the role ('As I'm a clinical psychologist…') and that, in addition, institutions or programmes would vary considerably in their inclusion of these perspectives.

 In the accounts offered by the other participants, it was often suggested that training had not covered these issues at all, and this was again evident across roles and different clinical orientations. As one participant reflected:

> In terms of thinking about why people get EDs and in treatment … we didn't really talk about societal influences particularly in terms of eating … It was very kind of tick boxy in terms of getting certain things done at a certain point. I guess the only time for me … when it comes back in again is when it comes to body image (P6).

Other participants, and particularly those that worked at the ED charity, had often come to EDs - or the study of identity and psychology more broadly - through feminist literature, and had deliberately pursued this angle outside of their formal training. As one commented: 'I would say I've done that more on my own really…. I don't remember any social or cultural context in my training' (P2), whilst others spoke of reading canonical feminist texts, such as Simone de Beauvoir's *The Second Sex* (1949) (P1), or Susie Orbach's *Fat is a Feminist Issue* (1978) (P9) in ways which had shaped their thinking and their work. As part of these discussions, participants who worked at the independent sites included tended to express the belief that they had more freedom than the NHS services in choosing what to focus on and how. In fact, there was a generalised perception across most of the interviews that non-NHS treatment contexts may have more space and autonomy to explore the kind of sociocultural

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issues discussed here. As will now be discussed below, this dynamic was frequently framed in relation to the contemporary importance placed on evidence-based treatments.

Theme # 4: Evaluating evidence

The concept of evidence-based treatment was certainly discussed in positive ways in the interviews, with participants suggesting that it was crucial to deliver evidence-based treatments, rather than allowing the focus to be determined by the predilections or specialisms of clinicians. But in terms of the perceived role of sociocultural issues, the significance placed on evidence-based protocols was also cast in negative terms. Raising issues which have shaped feminist critiques of ED treatment (LaMarre, 2015) and which were acknowledged in the introduction, one participant who works from a psychodynamic perspective offered the view that:

> We are living in a CBT [cognitive behavioural therapy] strangle-hold … I think that cultural issues now get marginalised because of the rise of evidence based therapies and the way that term gets used to beat up everybody else… But it's also about other disciplines getting their acts together to produce enough evidence, and in that regard, CBT has absolutely taken the ball and run with it….
> (P9)

A psychodynamic perspective is particularly interested in the underlying issues involved in the aetiology and expression of the ED. As such, it is understandable that this participant might be particularly concerned about the marginalisation of 'cultural issues', and place this in opposition to the symptom (and symptom reduction) focus of CBT. But the participant specifically suggests that the rise of CBT has had negative consequences for the focus on the sociocultural dimensions of EDs – not that they are different approaches which simply co-

exist. As the participant acknowledges, enhanced CBT (CBT-E) (Fairburn, 2008) is currently seen as having the biggest evidence base in the field of ED treatment (Cook Cottone, Beck & Kane, 2008, NICE 2004) (although the evidence is notably stronger for BN/ BED than AN). But whilst arguing for the potentially problematic consequences of this focus, the participant also foregrounds the importance of other approaches investing in the production of evidence in order to make their case – an area in which CBT-E has been the most prolific.

This idea of what types of evidence count and why was actively explored in other interviews, suggesting that this is not simply a debate germane to the academic debates in feminist research. So a participant with training in psychodynamic, cognitive and systemic therapies offered the view that a focus on socio-cultural approaches to EDs did not fare well within the current treatment environment and a 'kind of trialist mentality of what counts as evidence':

> So take CBT as … there's the best evidence for that … but that's because it's very manualised – so you can prescribe it and deliver it according to a certain fixed model like a pill … [But a focus on socio-cultural issues like gender], well that might kind of meanders where it wants, so you can't standardise it… But these ideas change over time – so previously there was an emphasis on very family systemic formulations in which [an ED is]… about trying to … avoid taking on a woman's role… [That]… is less so now because CBT and medicine tend squash it… So there are different models which have been more prominent and you hear less about those gender ideas at the moment (P5).

This response highlights how it is not simply a case of evidence being produced. Rather, it is about particular *kinds* of evidence that fit a manualised, repeatable and scientific norm. Further suggesting links with feminist critiques in the field (Bordo, 1993; Malson, 1998), the

response also foregrounds the idea of ED treatment as a construction which is subject to changing trends and influences, as well as the norms of evidence evaluation in the field.

These characterisations of treatment speak to the extent to which feminist psychology and CBT have often been seen as antithetical: from a feminist perspective, cognitive approaches are seen to pay scant attention to the 'socialized role expectations and power imbalances that impact upon the thoughts and beliefs individuals have' (Akman et al, 2001, p.218). There are clearly epistemological and methodological differences at the heart of these approaches. But they are not always seen as diametrically opposed, and feminist approaches have been married with CBT in potentially productive ways (see Akman et al, 2001; MacDonald, 2011). In fact, one of the participants from the adult community service - the treatment context most invested in CBT-E - argued that the approach could and did encompass the role of sociocultural influences in the development of eating/body distress. In talking about body image work, she insisted that it was not just about addressing 'perceptual distortion' in the patient and went on to observe that: 'but I suppose it depends how you as a clinician define body image. [For me] …it's a much wider complex term than just what I see in the mirror' (P7). Although this particular clinician believed that the treatment practised at her service adhered closely to manualised versions of CBT-E (Fairburn, 2008), the fact that such different opinions could be offered on the approach (including people with experience in the field) may suggest flexibility in how 'evidence-based' treatment is actually delivered. Indeed, the participant went on to offer a contradictory appraisal of how 'the evidence base will *dictate* what people deliver. But I think people's training and background has a *big impact* on how we think about the patients who come through our door…[my emphasis]' (P7). Although the idea of evidence-based treatment is often used in such a way as to imply a neutral, standardised and 'unbiased' framework, it is important to recognise that the

application of such approaches is still guided by the subjectivities, specialisms and training of the clinician (Jarman, Smith & Walsh, 1997).

Discussion and conclusions:

A great deal has been written about EDs from a sociocultural and/or feminist perspective, and there is a substantial empirical foundation to support the idea that sociocultural factors play a role in both the aetiology and maintenance of EDs (Levine & Smolak, 2014, Malson, 1998). But as very little has been written about this in relation to treatment practices, this article has aimed to contribute to current understandings of how/ whether these issues are actively addressed within clinical contexts – with a particular focus on the relationship between ED treatment and cultural constructions of femininity.

In terms of the limitations of the study, the sample ($n =12$) is clearly small and although it included a cross-section of views from both independent and NHS services, these cannot represent the treatment contexts in their entirety, nor can the findings be generalised on a national scale. The focus on the relationship between EDs and cultural constructions of femininity as representing sociocultural issues in the field is also limited: sociocultural factors cannot be reduced to gender (and nor do they affect only cisgendered women), and constructions of gender are in any case produced within intersectional frameworks of power (making it problematic to extract 'gender' as a singular concept). Nevertheless, this study raises some issues of concern when it comes to the value placed on sociocultural perspectives on EDs in clinical contexts.

Katzman and Sing observed in 1997 that the integration of socio-cultural factors into 'diagnostic formulations and treatment plans [for EDs] has lagged noticeably. As a result, a

"respectful nod" is offered to culture while an undue emphasis on individual pathology has persisted' (1997, p. 389). In terms of the results of this analysis, this conception would not fit the practice of *all* of the participants interviewed for this study, and in this regard, the data does *not* suggest that a focus on questions of gender is absent in ED treatment. But the data does provide insight into a context in which Katzman and Sing's conception remains resonant. All of the participants acknowledged that girls/ women represented their primary patient population. But the idea of addressing the significance of what was often presented as a seemingly 'obvious' fact did not shape treatment practices of all of the health professionals. In fact, the considerable differences between the participants was notable in itself in so far as familiarity with sociocultural issues emerged as a specialism, rather than a core area or skill (and these differences could not simply be mapped onto or explained by, different clinical orientations). Furthermore, the training of the participants had rarely (and mostly never) explored such perspectives on EDs. Given that eating problems are now widely seen as involving complex 'transactions' among biological, psychological *and* sociocultural influences (Culbert, Racine & Klump, 2015), this is a significant finding in its own right. But it is particularly concerning given that over half of the participants suggested that a patient would have to explicitly flag the relevance of gender for it to be addressed. As such issues were often not covered in training, this raised the question as to how they were actually 'recognised' by the participants, and some found themselves reflecting on the relationship between EDs and femininity *for the first time* in the interview context.

In terms of why such issues might be marginalised, the data presented here points to perceptions of 'evidence' in evidence-based treatment. Some of the participants thought that sociocultural issues were given little or no priority in current conceptualisations of evidence-based treatment, and that they did not sit neatly with the *type* of evidence such discourses

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promote and endorse. That is not of course to suggest that they rejected the very concept of evidence-based treatment, nor CBT-E (as the approach with the largest evidential base). Rather, the emphasis was more on how current conceptualisations of evidence-based treatment might limit opportunities to explore such wider questions of identity, even when they were seen by participants as being highly relevant to the aetiology and experience of an ED.

Implications for treatment

These findings have several implications for thinking about research and practice in relation to ED treatment, specifically with regard to questions of gender identity. Feminist qualitative work on EDs has demonstrated how eating problems in part emerge from, and are maintained by, Western cultural prescriptions of femininity and gendered experiences of 'restricted agency' (Piran & Teall, 2012). If it is the responsibility of the patient to recognise and bring such complexities to treatment – in contexts which may have little expertise in recognising and understanding the relationship between eating/body distress and gender – then the problems and struggles faced by the patient may go unacknowledged and unheard. Clearly however, this is potentially the case for *all* patients, regardless of their gender orientation.

Feminist research has largely focused on the plight of cisgender women – historically the most visible in the demographics of the ED 'population'. But it is crucial to find ways of widening this scope to think about the purchase of the feminist paradigms (in both research and practice) for male patients (Maine & Bunnell, 2008; Soban, 2006), transgender individuals, as well as those who identify outside the gender binary (whilst respecting the different cultural constructs of gender which may be at stake in each case). Indeed, a qualitative study examining transgender individuals' experiences of ED treatment suggested that clinicians exhibited 'a lack of gender awareness', and that it was difficult for participants

to find clinicians 'who were capable of working with gender identity and eating disorders' (Duffy, Henkel & Earnshaw, 2016, 142). Although not seeking to play down the particular challenges faced by transgender individuals, these responses could also have applied to some of the perspectives and experiences discussed by the 12 health professionals in this study – even though they were largely talking about cisgendered females. In this regard, there is a wider issue of at stake here in terms of how the biopsychosocial equation may undervalue the 'social' components of the matrix (at the level of both training and treatment), and the implications of this for the experience of (diverse) patients.

Future studies should look at both clinician and patient experience on a wider scale in order to provide a more detailed and comprehensive picture of how - or whether - ED treatment is encompassing what are seen as core sociocultural concerns in presentations of eating distress. In turn, if such issues are to be adequately explored and addressed within treatment – and if drawing on the history of feminist work in this regard there is the possibility of one-to-one therapy and psychosocial groups - it will be important to build a larger evidence base. Although this study has raised issues about the power of biomedical paradigms to dominate and define what counts as 'evidence' in ED treatment, feminist and sociocultural paradigms will nevertheless need to provide further empirical substantiation of the value of these approaches in contemporary clinical contexts.

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i The survey covered 86 treatment sites in the UK which were located by searching for ED treatment services in major cities via the Beat website (http://helpfinder.b-eat.co.uk/). The website for each treatment context was then surveyed for details of the treatment programme before the service was then contacted by email or phone to confirm or clarify the range of treatment offered. Services were explicitly asked whether/ to what extent they addressed sociocultural concerns such as (but not limited to) questions of gender.

[ii] Names have been replaced with a participant number (i.e. P1) which reflects the order in which the interviews were transcribed.

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