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KITCHEN CONVERSATIONS: DIALOGIC SPACE IN A CULINARY SETTING FOR ADOLESCENTS FACING ANXIETY

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Dedications

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Forward

Personal Narrative

As I reflect very thoughtfully and intentionally on my life journey, from childhood through adulthood, from the perspective of a woman my age, there is a particular and quite substantial period where neglect and abuse defined my lived experience. The trauma from that time, from ages 6 to 15 years old, generated continual, ongoing exposure to horrific experiences and toxic stress that were damaging, with consequences continuing for many years after the maltreatment stopped. Having been exposed to situations my brain perceived as life-threatening, my body instinctively and continually prepared for a "fight or flight" response. This natural response evolved as a means for human survival; consequently, because the endangerment continued over an extended period of time, I experienced a repetitive, intensified state of arousal that was expressed as hyper-vigilance, anxiety, and distress.

For children who live in an environment that they perceive to be negligent, unsafe, or abusive, children's brains and bodies grow differently. This situation is sometimes called Developmental Trauma Disorder (van Der Kolk, et al., 2019). I was no exception. As a result of the traumatic exposure sustained during several significant periods of my development, I developed feelings of mistrust, humiliation, fear, and loss, all of which shaped my identity. I struggled to process and integrate information properly, self-regulation, and a sense of my own power, which was denied because I was in perpetual survival mode. I both anticipated and expected trauma to reoccur, and the fear of rejection or victimization was central to establishing my relationships. I had difficulty with trust and could not feel safe, including with authority figures and professionals. My view of the world and my place in it was confusing and chaotic as a result of my disorienting and disturbing childhood experiences.

When I was about eight, my mother, who decorated cakes as a hobby, began teaching me those skills. I remember her requiring me to practice borders and roses repeatedly, often while in tears, because she had just scolded me for not doing it "right" and then required me to do it repeatedly. I spent hours and hours practicing, learning, and building skills through sheer determination and the desperate desire to earn my mother's approval. I began decorating cakes for events and others when I was ten, and one of my decorated cakes was published in "Maid of Scandinavia," an international magazine. By 12, I had made my first wedding cake by myself, earning compliments from numerous people, even some I did not know. I entered local fairs, winning "Best of Show" several years in a row, and at 15 years of age, I was offered a job decorating cakes at the local bakery. Because I wasn't old enough to work, I waited a year and began decorating cakes at Napa City Bakery on my 16th birthday. This would begin the life-changing experiences and conversations that shaped my young adult life and reinforced my newly emerging affirmative identity story.

So, how did this shift in my identity begin to materialize? I had learned a skill, and I was good at it! I had developed mastery through the perseverance of trying to do something that was difficult and succeeding at it. As a child and adolescent who had experienced repeated trauma, I believed that I was powerless to create change and have meaningful relationships. However, developing mastery gave me a feeling of control in my world – a sense that I could, in fact, influence what happened around me and to me and that I had the ability to change outcomes for myself. This was the turning point, the moment that I began questioning the validity of the fear, shame, distrust, and worthlessness that had been projected onto me and from which my childhood identity was formed. Deep down inside, tucked far away in my memory, was the belief that I had value, that I mattered, and that there were people in this world who would love

me and care for me. Papa, my maternal grandfather, taught me those things so many years earlier when I was just three years old, and we cooked potato soup together on Tuesdays.

Throughout the years, the kitchen has remained a most significant and sacred place for me. It is the place where I feel the most comfortable and the most authentic. It is where I spent most of my adolescent and young adult years, working, continuing to increase my skills, and developing mastery of them. Further, it was the space where I felt a genuine sense of connection, sharing, and nurturing, just like when I made soup with Papa. This environment lent itself to be a place of great comfort and stability for cultivating relationships and conversation, creating meaning, and discovering new ways to go on together.

As I reflect on the journey, I understand that it is no coincidence I continued to pursue years of training to become a pastry chef. My positive identity was intrinsically secured to what I could do and how well I could do it. For many years, this served as an anchor for my emotional constancy and was what encouraged me to believe in and trust myself. I learned that with a plan, hard work, and mastery, I could indeed change the trajectory and outcomes of my life, and I could possibly even dare to dream of the life I would prefer and find my way from here to there.

Overview of Dissertation

This dissertation examines the experience of anxious adolescents participating in a culinary arts program in a school setting. The philosophical orientation that guides this research is social construction, and the specific practice guiding the culinary arts sessions described here is called collaborative-dialogic practice. Both social construction and collaborative-dialogic practice will be introduced below. The first section, Chapter 1 (introduction), details the conversational similarity found in two different contexts – the kitchen and the collaborative therapy room, followed by the recount of an important experience that served as a catalyst for this study. Next, background information on anxiety in adolescents, the social construction of anxiety and its treatment, social construction as a philosophical orientation, collaborative-dialogic practices, and culinary therapy will be explained. This introduction concludes with a look at mental health care and education and, lastly, the research questions that guided this study. Following this general introduction, Chapter 2 describes the methodology used in this study and addresses ethical considerations. In Chapter 3, the study's results, including tables that represent coding across the entire data set, as well as thematic maps, are presented. Lastly, discussion and implications, including the essential findings, study strengths and limitations, suggestions for future research, and conclusions, complete Chapter 4.

Chapter 1: Introduction

1.1 Background to the Study

Having worked for 30 years as a European-trained pastry chef, I have had many kitchen conversations with colleagues and clients, creating genuine connections and meaningful and multiplicative relationships. In my later training as a Marriage and Family Therapist, I noticed the similarity of those kitchen conversations to collaborative-dialogic practices. At the center of collaborative-dialogic approach is the practitioner's position or "way of being" (Anderson, 1997). It is a way of relating and "being with" another that communicates their importance and that they are recognized, valued, and appreciated (Anderson, 2012a). This position or stance invites a certain kind of interactional process, a relational process that generates the potential for transformation and generative change.

The kitchen is the heart of the home, the gathering place from where the comforts of food and drink, nurturing, community, comfort, and connection are found. The kitchen lends itself to be a space where significant and intimate conversation takes place and, therefore, offers a natural and relaxed setting for a therapeutic process. A study by Haley and McKay (2004) of inpatient mental health patients suggested that the participants in baking sessions had increased concentration, coordination, and confidence, which was experienced as improved confidence. While the literature on culinary arts therapy, exclusively for mental health care, is limited and the approach novel in the therapeutic domain, as well as in the culinary domain, I propose that the merging of these two disciplines, mental health care through a collaborative-dialogic lens and culinary arts, has the potential to produce an important change in different ways. I am passionate about integrating my experience in these two disciplines to positively influence psychosocial outcomes for numerous adolescents struggling with anxiety while simultaneously making it

easily accessible to many adolescents by providing it in the school setting.

1. Motivational Experience

One of the inspirational moments that engendered the research questions for this current study was a written statement by an adolescent who participated in culinary therapy. I will talk here about the experience and how culinary therapy impacted a young man's life. A 16-year-old adolescent male, Drew, who participated in culinary therapy with me, could not successfully attend school and was homebound for one and a half years due to his struggle with debilitating anxiety. Since school itself was a trigger for his anxiety and thus a difficult place to be, I suggested to Drew that some clients enjoy having conversations in the kitchen while we work together to create a product. Drew, who was already an accomplished baker, was keen on moving our conversations to the kitchen and decided he would like to learn more about chocolate.

So, we began. This process of teaching and learning about chocolate in the kitchen offered a unique environment for transformative dialogue. The focus on our shared experience of 'doing together' invited connection, collaboration, and conversation. The process of becoming conversational partners, through our shared experience of creating and learning together, was both relational and generative and was improved by the way we oriented ourselves and the way we responded to and acted toward each other, both in dialogue and in co-creating a tangible product. Our dialogues concerning anxiety entered the conversation organically when Drew introduced the topic. Sometimes, it was just a brief thought or observation. At other times, he would allow himself to be vulnerable and reveal very personal information, but always in his own time. These moments of deep connection and sharing were like fragments of colorful and textured materials being woven into our story, a beautiful tapestry that is unpredictable and

inimitable.

Over time, I became increasingly aware that our shared experience was creating change for Drew. Then I became curious about the meaning of his experience after reading his short essay for college admission. I am including the essay that Drew submitted for college acceptance with his permission.

> "*My extracurricular activities are drawing, writing, and creating hand-made French chocolates. Growing up, I was unable to practice drawing as my overwhelming anxiety immobilized me. This was also true for my writing. I love how drawing and art can transmit emotions through either the most simple or complex mediums. I also truly love the written word with all the clever and intricate phrases one can create. Drawing and writing seemed locked inside me, along with the emotions that such expression might reveal. As I studied French chocolate making, over the past 2 years, our kitchen conversations ranged from tempering chocolate and chocolate as an art form to deconstructing learned ideas about anxiety. As my skill level increased, I began making chocolates for friends, family, and some to sell during the holiday season. As I unlocked this unique form of self-expression and learned new ways to think about anxiety, I also unlocked the artist and writer within*."

My first reaction when Drew handed me this essay and said, "I think you should read this," and anxiously hurried away, was that he needed help with something but was unable to ask aloud. Then, I read his essay. I was deeply touched that he wanted me to know the importance of what we had co-created and experienced together. I read it again and again, taking it in and trying to process and make sense of what he had written. I was surprised and amazed. Then, my curiosity was piqued. I read the essay again, slowly, looking for clues and understanding of

Drew's experience. What happened in those culinary arts sessions that made a difference? How did Drew experience the process? What meaning did he make from our time together in the kitchen? How did this shift occur for him? When did he notice a change or shift? How did he notice? How was this therapeutic intervention different from previously experienced therapy? What happened (or didn't happen) that allowed Drew to unlock his self-expression? Who else had noticed? Had his parents also noticed a shift? What was different? What did they experience as he participated in culinary therapy? How did this impact his relationship with his family? Did this impact his academics? Did his teachers notice anything different? Did the relationship he had with his teachers shift? Was the quality of his work or the timeliness of submitting assignments impacted? There were so many questions, such curiosity, and a desire to know what we had "done" so I could co-create this kind of experience for others. What I did know was that I had found something I didn't know I was looking for (Anderson, 2009).

1.2 Youth, Anxiety, & Identity

Anxiety disorders in childhood and adolescence are among the most widespread psychiatric disorders diagnosed globally (World Health Organization, 2021; Cresswell et al. 2013). The main types of anxiety disorders that present in childhood and adolescence include panic disorder (PD), social anxiety disorder (SAD), generalized anxiety disorder (GAD), obsessive-compulsive disorder (OCD), separation anxiety disorder (SAD), selective mutism (SM), and specific phobias (SP) (Grant, 2013; World Health Organization, 2021, National Institute of Mental Health, 2022). Anxiety disorders are described and classified in different diagnostic systems, for example, the Diagnostic Statistical Manual of Mental Disorders (DSM-5-TR) or the International Classification of Diseases (ICD-11) (Beesdo et al., 2009; Creswell et al., 2014). In these systems, the existing anxiety disorders have similar clinical features, for instance,

extreme anxiety, symptoms of physiological anxiety, behavioral problems such as avoidance, and distress and/or impairment (Beesdo et al., 2009). However, there are differences, and though anxiety disorders are narrowly classified, such as panic disorder, agoraphobia, and other phobia subtypes, there is a significant degree of variance.

Anxiety is sometimes written as a brain's response to danger and will prompt an attempt to actively avoid the perceived threat. This brain response is an emotion that exists in infancy, childhood, adolescence, and throughout adulthood, with the expression of this anxiety on a continuum that ranges from mild to severe (Beesdo et al., 2009). The condition is not typically pathological because, in many scenarios, it is adaptive in facilitating the avoidance of danger (Beesdo et al., 2009) triggered by perceived threat (Pine et al., 2009). It can be difficult to determine whether an adolescent's symptoms of anxiety are pathological or developmentally appropriate worries and fears (Cresswell et al., 2014). An established conceptualization is that the condition is maladaptive when it interrupts normal functioning, for instance, when it is linked to avoidance behavior that occurs when the condition is severe and persistent (Beesdo et al., 2009). Therefore, an extreme presentation of normal events with continued and/or excessive intensities of anxiety and avoidance that are tied to subjective distress and/or impairment characterize the pathological form of the condition. The specific side effects of anxiety include poor social and coping skills that result in avoiding interacting socially, loneliness, perceptions of rejection, substance abuse, psychosomatic illness, problems forming new friendships and low self-esteem, poor school attendance, and underperforming on schoolwork (Weeks et al., 2009; Locke et al., 2015; World Health Organization, 2021). As these adolescents who continue to struggle with the symptoms of anxiety enter adulthood, they are commonly at risk for lifelong psychiatric disorders (Creswell et al., 2014).

1. Adolescents and Their Vulnerability

The literature describes adolescence as a developmental stage that transitions an individual from childhood into adulthood. This stage is marked by significant physical changes that take place during puberty and includes vital cognitive and social development (Chaudhary & Jain, 2014). This adolescent stage is considered to start at approximately twelve years of age and end at about twenty years of age, where evolutionary instincts are replaced by increasingly refined social and cultural influences (Chaudhary & Jain, 2014). Due to the numerous changes and transitions that occur during this developmental phase, adolescents are met with an increased level of susceptibility to anxiety (Grant, 2013).

This adolescent period sets the stage for future belief systems regarding the self and others, developmental concerns, and relationship factors that contribute to the onset of anxiety (Weeks et al., 2009). During this period, parents and other significant adults offer guidance to adolescents as they transform from impulsive, reactive children into unselfish and moral beings (Chaudhary & Jain, 2014). However, throughout this critical period of development, adolescents are much more likely to be influenced by the examples and guidance they receive from their older siblings and friends, and it is from there that they develop their emerging identities and their views of the world around them (Chaudhary & Jain, 2014). In this critical period of identity development, when adolescents try out different roles and attitudes in varying contexts, they often compare themselves to their peers, looking for signs of approval or a sense of similarity. However, many adolescents perceive themselves as less than or not good enough, thus developing a negative attitude about themselves and their ability to be accepted or successful in the world they live in. A negative self-image for an adolescent may play a critical role in the development and continuation of anxiety symptoms (Blasi et al., 2014).

These self-conceptualizations and world perceptions often form the very foundation for the initiation of anxiety disorders in adolescence, making this vulnerable period central to the development of psychopathologies. Ginsburg et al. (2014) point out the necessity of successful and accessible treatment of anxiety disorders in adolescents as they are described as "highly prevalent and impairing and considered gateway disorders in that they predict adult psychiatric problems."

2. Prevalence of Anxiety in Adolescents

The global prevalence of the condition in adolescents is dependent upon each unique study as there is a disparity in the figures. They may range from between 15% to over 30% compared to adults, with a range of between 10% and 20% (Tassin et al., 2014; World Health Organization, 2021; Unicef, 2021). However, these figures are undoubtedly underestimated because the condition often remains undiagnosed among many children and adolescents due to the internalized nature of the symptoms of anxiety (Deb & Walsh, 2010). Anxiety affects more than 260 million youths globally, and it is the sixth leading cause of disability ("World Mental Health Day," 2017; Olofsdotter et al., 2016). Anxiety is among the most common psychological disorders among school-aged children and adolescents globally (Deb & Walsh, 2010), and, when combined with depression, represents 42.9% of mental disorders among adolescents (Unicef, 2021).

In the United States, the lifetime incidence of anxiety among adolescents was estimated to be 31.9%, with 8.3% being found to have severe impairments. According to the most recent NIMH data, its prevalence among females between 13-18 years of age was 38%, while for males of the same age group, it was 26.1% (National Institute of Mental Health, 2017; Unicef, 2021). Anxiety is considered to have the greatest burden among individuals aged between 13 and 15

years old (Olofsdotter et al., 2016; Unicef, 2021).

There has been a sharp rise in anxiety disorders in recent years, with it becoming the most frequently experienced form of mental illness for adolescents in the United States (Anxiety and Depression Association of America, 2019; National Alliance on Mental Illness, 2017; Tassin et al., 2014; Shrobsdorff, 2016) and carries with it a substantial number of adverse effects on the social, emotional, and academic success of adolescents (Locke et al., 2015). With this growing epidemic of anxiety symptoms in adolescents there are high percentages of behavioral issues, academic underperformance, social anxiety, emotional distress, and overall dysfunction plaguing youth in the United States.

3. Specific Approaches for Treating Anxiety in Adolescents

Many empirically supported approaches for the treatment of anxiety disorders in adolescents have been developed and are largely centered around cognitive-behavioral approaches. Literature is abundant with cognitive-behavioral therapies, but limited research is available for other therapies (ie., psychodynamic, person-centered or experiential, systemic, or post-modern approaches), much less comparing efficacy across approaches. However, one 50-year review of research on treatment for child and adolescent anxiety by Higa-McMillan et al (2015) identified 6 treatments that were considered well-established, 8 that were identified as probably efficacious, 2 as possibly effective, 6 treatments were considered experimental, and 8 that were deemed of questionable efficacy. In their findings, cognitive behavioral therapy (CBT), along with other therapies defined as cognitive-behavioral in approach, had strong support as the most successful, and it was recommended that clinicians select from these first-line approaches when working with adolescents (Higa-McMillan et al., 2015). It is further noted that in level 2 (probably efficacious) 3 types of therapy were not CBT or defined as primarily cognitive-

behavioral (attention control, cultural storytelling, and hypnosis) that offered possible alternatives to CBT approaches (Higa-McMillan et al., 2015) (See Table 1)

Table 1
Best Support / Well-Established Treatments

Level 1 ***Best Support/Well Established Treatments***	***Level 2*** ***Good Support/Probably Efficacious Treatments***	***Level 3*** ***Moderate Support/Possibly Efficacious Treatment***
CBT	Family Psycho-education	Contingency Management
Exposure Therapy	Relaxation	Group Therapy
Modeling	Assertiveness Training	
CBT with Parents	Attention Control	
Psycho-education	CBT for Child and Parent	
CBT plus Medication	Cultural Storytelling	
	Hypnosis	
	Stress Inoculation	
Level 4 ***Minimal Support/ Experimental Treatments***		***Level 5*** ***No Support/Treatments of Questionable Efficacy***
Biofeedback		Assessment/Monitoring
CBT with Parents Only		Attachment Therapy
Play Therapy		Client-Centered Therapy
Psychodynamic		EMDR
Rational Emotive Therapy		Peer Pairing
Social Skills		Psychoeducation
		Relationship Counseling

(Higo-McMillan et al., 2015)

In the United States, mental health care is generally prescribed by primary care physicians who will refer the individual to a psychiatrist if they feel medication is warranted or to a psychotherapist or psychologist for talk therapy. The type of therapy an individual receives is most commonly determined by what an insurance provider will cover. The insurance company's decision on the type of care they will cover is driven by science, experts in the field, patient safety, and cost-effectiveness. For several years, and currently, the American Academy of Child and Adolescent Psychiatry recommends cognitive-behavioral therapy (CBT) and/or selective serotonin reuptake inhibiters (SSRIs) be offered to patients 6-18 years old who have been diagnosed with social anxiety, generalized anxiety, separation anxiety, specific phobia, or panic disorder (Walter et al., 2020). As a result, the majority of adolescents who receive

treatment (those with insurance coverage) for anxiety are treated with CBT and SSRIs. For adolescents on government-assisted medical care (Medicaid), evidence-based approaches that are recommended as first-line treatment include pharmacotherapy (SSRIs) and psychotherapy (CBT. Those adolescents whose families can afford to pay a therapist privately and not rely on insurance have the privilege to choose a preferred treatment modality and represent a very small percentage of adolescents. Given that cognitive-behavioral therapy and pharmacotherapy using SSRIs are considered first-line treatments for adolescents diagnosed with anxiety in the United States (Hill et al., 2016), it is important to look more closely at the efficacy of the treatments to help create the context in which the rates of adolescents diagnosed with anxiety continues to rise.

As previously discussed, in the United States, the psychotherapy gold standard is CBT. It has characteristics and components that include the therapist identifying an adolescent's maladaptive thought and behavior patterns, psychoeducation, relaxation skills, cognitive restructuring, which is the transformation of thought patterns related to anxiety into more balanced/neutral thoughts, and exposure therapy (Deb & Walsh, 2010). Similarly, pharmacotherapy for adolescent anxiety includes SSRIs as a recommended first-line medication. Though prescribed as a monotherapy, it is most often prescribed in combination with CBT (Siegal & Dickstein, 2020) as the most effective for the short-term treatment of anxiety (Walkup et al., 2008). In a 2018 study by Ginsberg et al., 22% of adolescents with anxiety were in stable remission, 30% were chronically ill, and 48% relapsed (Bertie et al., 2022) after 12 weeks of CBT, SSRIs, or a combination of both, according to their multi-year study. Although CBT together with SSRI's is considered to be more effective than either independently, it is imperative to note that the US Food and Drug Administration issued a warning of the potential for suicidality among those 25 years and younger who are prescribed anti-depressants (Siegal &

Dickstein, 2020). This is quite troubling and a risk that should be avoided, given that in 2021, more than 1 in 5 (22%) of high school students in the United States seriously considered suicide, and 1 in 10 (10%) attempted (Center for Disease Control and Prevention, 2021). Creswell et al. (2014) state that after weighing the risk of harm to adolescents prescribed an SSRI, recent guidelines suggest that pharmacological treatments should not be given. The risks vs. benefits need to be carefully weighed to avoid causing more harm when considering a therapeutic approach to use with vulnerable adolescents struggling with anxiety (Pine et al., 2009).

Of further concern, Rapee, et al., (2005), warn that the application of CBT brings forth questions on the possible adverse effects of CBT on anxious children. Particularly concerning to Rapee, et al. (2005) is the effort to treat younger anxious children. The exposure therapy component of CBT involves exposing a child to some measure of distress as a means to build tolerance, but this may cause additional trauma and elevated anxiety. The vulnerability of children is far greater than that of adults, firstly, because they depend on adults to act on their behalf, and secondly, because treatment during childhood has more long-lasting effects than treatment in adulthood on brain systems stimulated by emotionally provoking experiences (Pine et al., 2009).

CBT does not show stable long-term remission and has significantly high non-completion rates (Heiervang et al., 2018; Asarnow et al., 2019). In Scholten et al. (2013) it was specified that the recurrence rate for anxiety disorders in adolescents was 23.5% over a 2-year follow-up period. Ginsburg et al. (2014) found in their follow-up study that of those adolescents (46.5%) with a favorable response to treatment for anxiety disorder, nearly half relapsed at approximately six years after treatment. When assessing the effectiveness of CBT for adolescent anxiety disorders as compared to active control conditions, the effect appeared to be relatively small

(Heiervang et al., 2018). According to a review by Reardon et al. (2020), CBT was no more effective than self-help books or other active therapies. Although CBT was claimed to be highly effective and was listed as a first-line treatment in a systemic review and meta-analysis by Sigurvinsdottir et al. (2019), it was further indicated that CBT was not more successful than placebo therapies. Baker et al. (2021) proposed that more effective treatments for anxiety in adolescents are needed, given the limited success of CBT.

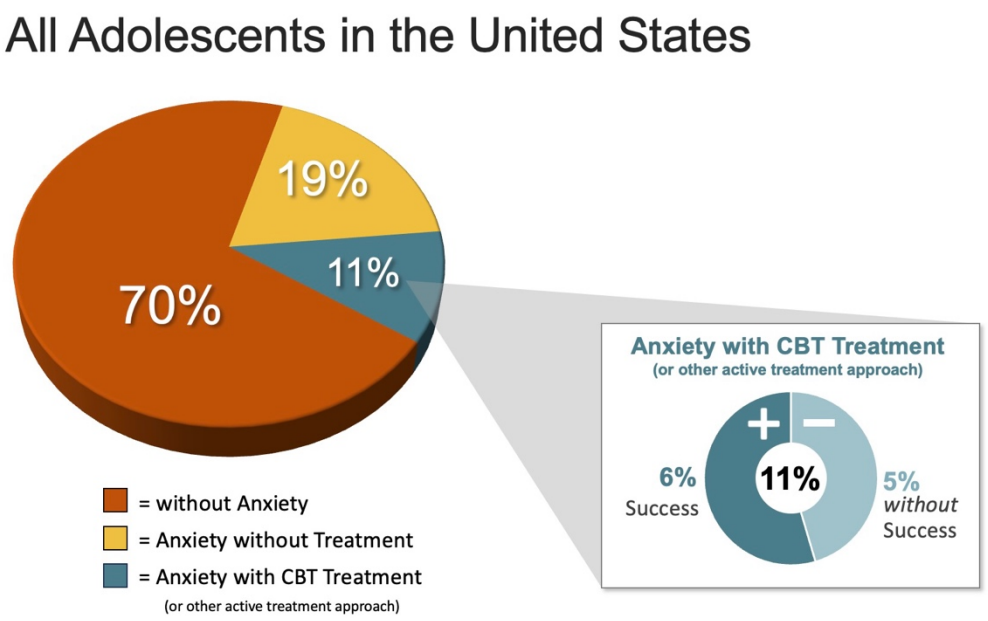
The literature suggests that regardless of the magnitude of anxiety disorders in adolescents, stigma, lack of awareness, and shame prevent the majority of them from getting help (Child Mind Institute, 2015; Radez, 2022). Anxiety affects roughly 30% of adolescents in the United States, some estimates suggest that as many as 80% of affected adolescents never get the help they need (Child Mind Institute, 2018). In studies on adolescents struggling with anxiety by James (2015) & Radez et al. (2022), it is suggested that only about 35% of adolescents with anxiety diagnoses receive treatment, with just over one-third of those treated reporting a decrease in their symptoms (Baker et al., 2021; Loerinc et al., 2015) regardless of the treatment approach.

Because CBT has been studied extensively as an approach for treating adolescents with anxiety, there is an abundance of literature available that indicates CBT has the same efficacy as other active therapies (Baker et al., 2021; Creswell et al., 2018; Reardon et al., 2020) and as usual care in community clinics (Southam-Gerow, 2010). If, in fact, CBT and other treatment approaches share the same efficacy in treating adolescents struggling with anxiety, then research demonstrating margins of success for CBT would be presumed to be similar to other types of therapies for anxiety in adolescents. For instance, in studies by James et al. (2005) and by James et al. (2020), 56% of adolescents were considered successful after a course of CBT treatment. Still, the study authors further concluded that there was a natural remission rate of roughly

28.2% for adolescents on the waiting list. Using the higher percentage rates of treatment success established in the studies by James et al. (2005) and James et al. (2020), only 6% of adolescents with anxiety who participated in CBT as treatment had a positive outcome. This would be considered a low success rate even within the medical community. (See Figure 1)

Figure 1

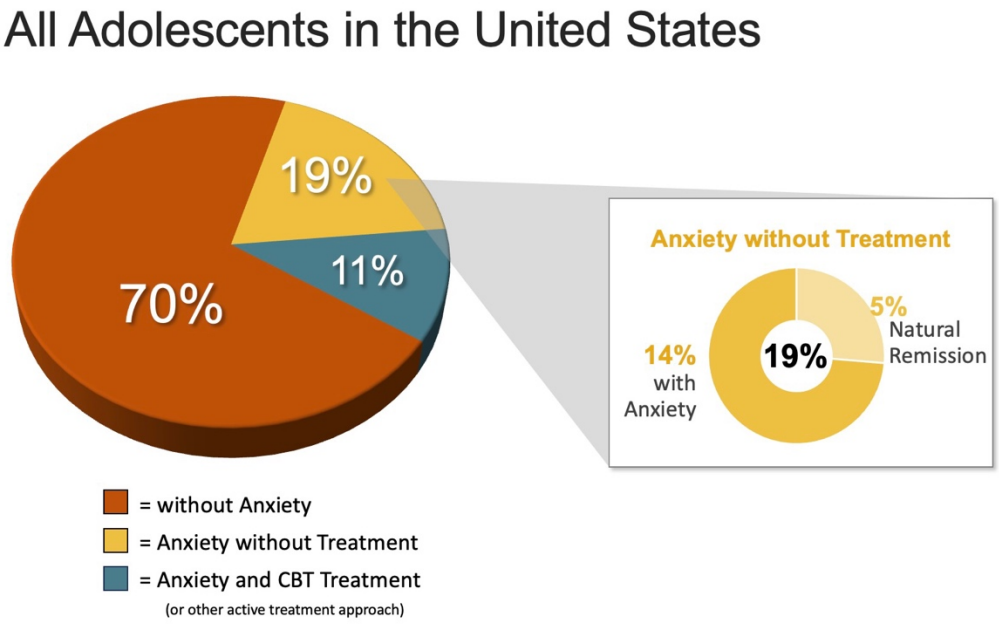
Adolescents with Anxiety Who Experienced Treatment Success



(James et al., 2005; James et al., 2020)

Southam-Gerow's (2010) study demonstrated that CBT, as a treatment modality, did not produce superior clinical outcomes than usual care at a community clinic or alternative treatments in a systemic review by James et al. (2012) and that there was limited quality evidence that CBT was more effective than wait lists or no treatment. There is little to no gain in utilizing CBT as a treatment modality for adolescents with anxiety when comparing its 6% success rate to the natural remission rate of 5% for adolescents with anxiety who received no treatment at all. (See Figure 2)

Figure 2
Adolescents with Anxiety Who Experienced Natural Remission



(James et al., 2005; James et al., 2020)

So, Are We Really Helping Adolescents? Cognitive Behavioral Therapy was designed for and used with adults (Siegal & Dickstein, 2020) over 40 years ago. Many empirically supported treatments applied to adolescents are either downward adaptations of interventions originally developed for adults or upward extensions of treatments originally developed for children (Kendall, 2006). CBT treatment for adolescents with anxiety is one such treatment design that was downwardly adapted from an efficacious treatment for adults into a treatment plan for use with adolescents that has shown long-term low success rates. One possible reason for the lack of efficacy could be attributed to the absence of alignment for the adolescents' developmental levels. “They are not just little adults” (Kingery & Bergman, 2006). There are challenges in combining cognitive behavioral and developmental methods (Ollendick et al., 2001, Southam-Gerow & Kendall, 2000, Stallard, 2002), but treatment for adolescents must be

developmentally oriented, focusing on biological, cognitive, emotional, and social functioning (Grave & Blissett, 2004). The focus of CBT is primarily on the cognitive domain since its treatment is predicated on the assumption that altering one's thinking is an important precursor to more adaptive functioning in the emotional, behavioral, or social domains (Kendall, 2006).

The central idea supporting CBT is that an adolescent's thoughts, feelings, and behavior all work collectively with the goal of the adolescent learning to identify and change the thoughts and behaviors sustaining the problem, also referred to as cognitive restructuring (Siegal & Dickstein, 2012). The downward adapted treatment protocol for CBT teaches adolescents how to recognize the deficits and distortions in their thinking, reality test them, and then challenge the irrational thoughts and develop coping skills (James et al., 2005). In accordance with CBT, this is accomplished through modeling, role-playing, relaxation training, and, most notably, exposure or desensitization training (Deb & Walsh, 2010).

The CBT therapist's role is to identify the adolescent's maladaptive thoughts or assumptions and share with them what is wrong and why (Tolin, 2016). This firmly establishes the expert role of the therapist, which lends to the adolescent feeling pathologized and flawed in their mental health context. The adolescent's failure narrative is supported by the assertion that the expert is "right" and, therefore, the adolescent must be "wrong," and it naturally follows that their struggle with anxiety is their own fault.

An adolescent facing anxiety sees themselves as a failure in every context. They often feel that they are failures academically due to low performance, failures at successfully attending school, which is pathologized as "school refusal" (Fremont, 2003), they are failures socially, feeling lonely and without friends, they believe that nothing they do is ever good enough as they can only accept perfection from themselves, and they often believe they are a burden and

disappointment to their parents.

Modifying CBT. To increase the efficacy and accessibility of CBT, researchers, clinicians, and therapists began altering this form of therapy to make this downward adaptation of adult therapy more suitable for use with adolescents. One modification to the traditional model of CBT was *Collaborative CBT* where it was suggested that when an adolescent is cognitively ready, the therapist can involve them in their own cognitive behavioral case formulation and goals for treatment since this would appeal to their desire for autonomy and a sense of control over how their therapy progresses (Sauter et al., 2009). However, Sauter et al. (2009) explain that the therapist would construct the case formulation and then share only parts of it with the adolescent, such as the hypotheses and core beliefs, when the therapist deems the adolescent is ready. But this is not a collaboration; rather, it is an invitation to re-construct an already predetermined case formulation. An opportunity for genuine sharing of thoughts or ideas and generativity of new ideas or possibilities doesn't exist as the agenda has already been established by the therapist. If the adolescent disagrees with this pre-determined plan that excluded their input, then it is determined that they were not mature enough; they are less cognitively developed, and the adolescent's failure narrative is reinforced.

Brief CBT was developed with the intention of making CBT more affordable as the traditional cognitive behavioral intervention is expensive, limiting treatment access (Thase et al., 2020). Brief low-intensity CBT consists of a self-guided or parent-guided process with materials for treatment provided through an online course or through workbooks and study materials and includes 30-minute support sessions by a practitioner or support person for a total of six hours or less (Shafran et al., 2021). Because brief low-intensity CBT is manualized, the treatment protocol is "one-size-fits-all," and adolescents do not benefit from adjustments with regard to

their social, emotional, and cognitive levels of development (Kingery et al., 2006). Brief CBT outcomes were clinically similar to full CBT treatment, according to Cresswell et al. (2017), with more than half (53%) relapsing within one year, 79% of those occurred in the first 6 months after treatment completion (Shehzad et al., 2017). The high relapse rate, which is more than double the relapse rate for traditional CBT, indicates a need for booster sessions or relapse prevention when using brief low-intensity CBT (Shehzad et al. 2017), which incurs additional costs, often negating the $928 average savings by using brief CBT (Thase et al., 2020).

Activity-based CBT has been recommended as a way of encouraging an adolescent to actively participate in the therapeutic process by using an interactive and playful approach and then adding guided questions (Sauter et al., 2009). Stallard (2002) suggests that a good way to boost an adolescent's self-esteem during CBT is to respond empathically to their problems, as you are then working with their ego-centrism instead of against it. However, the therapist must be careful not to show too much empathy so it doesn't feel fake (Stallard, 2002).

When working with "school refusers" or adolescents struggling to attend school due to severe symptoms of anxiety, it can be quite challenging to involve them in a therapeutic process. Heyne et al. (2002) suggest that a therapist can try different attitudes and behaviors to encourage adolescent participation, such as honoring the adolescent's point of view, active listening, relating to the adolescent in an understanding and tolerant manner, fostering a positive opinion about the adolescent; interpreting their behavior in treatment; and engaging them with caution in a realistic way. This set of techniques calls on the therapist to create altered versions of themselves to craft the illusion of care, concern, value, and interest in the adolescent. This process is based more on the therapist *acting* in a prescribed way, not one of genuineness and benevolence. The outcome of this type of therapeutic approach is frequently a case of the

therapist working against themselves as adolescents are keen on recognizing insincerity and, as a result, typically resist participation (Stallard, 2002).

In a study by Taylor et al. (2017), the results showed that when using CBT as a treatment modality, positive emotions were the most important predictor of an anxiety reduction. It was also suggested that increasing the focus on positive affect during CBT treatment for anxiety may increase the success of treatment outcomes (Bosley et al., 2016). "Positive CBT" was proposed by Bannink (2014), who suggested shifting the focus in treatment to what is "right" with the client rather than a focus on what is "wrong" with the client for a more favorable outcome. However, this runs counter to the tenets of CBT, where the focus is on identifying maladaptive cognitions and behaviors. So, would that imply then that traditional CBT could be thought of as "Negative CBT"? Or that CBT, in which the therapist (expert) finds the maladaptive behaviors and cognitions of the adolescent and points them out so that the adolescent can better understand their problems and difficulties (Sauter et al., 2009), should be fundamentally changed when treating adolescents? Perhaps, since "even those using and promoting CBT have recognized that it doesn't work well" (Heiervang et al., 2018).

Changing the Focus: Rethinking CBT. It is essential in child development to focus on and reinforce positives as a way to shape behavior (Moren, 2022; Gasparovich, 2008). It has been well established that positive reinforcement is a way to both recognize and encourage specific desired behavior and that any behavior followed by a positive response would undoubtedly be repeated (Sigler & Aamidor, 2005; Yadegar, 2018). According to Law et al. (2012), recognizing positive behavior is essential for developing adolescents as it promotes the formation of their identity and the development of their moral reasoning.

Positive reinforcement was found to have a "better effect on reducing stress, anxiety and

improving mood, confidence, and short-term memory," while negative reinforcement increased anxiety and stress levels (Lim et al., 2019). Noticing and expanding on a child's strengths and protective factors builds their resiliency and serves to prevent or manage anxiety (Gasparovich, 2008). Ignoring unwanted behavior is central to positive reinforcement. Alternatively, when undesirable behavior is repeatedly pointed out and highlighted, as in CBT, there is attention fixated on it, and, therefore, it is likely to reinforce that particular negative behavior pattern (Siegal & Dickstein, 2020 & Sigler & Aamidor, 2005) while again reinforcing the adolescent's failure narrative, further wounding the vulnerable adolescent's sense of self.

4. *An Alternative to the Tradition*

Cognitive behavioral therapy is considered a modernist approach to psychotherapy. It is a precise way of seeing the world with a linear view of known reality that views differences as dysfunction and the individual as the "problem" that needs to be solved (James et al., 2023). On the other hand, social construction takes a very different view. Rather than a single, fixed view that lends itself to sameness, social construction is a philosophical orientation that includes such concepts as multiple realities, multiplicity of meaning, and a relational process of meaning-making.

Social Construction: The Philosophical Orientation. Social construction offers an alternative to the dominant discourse we have been discussing (Anderson, 2012b). This dominant discourse is often referred to as our modernist tradition. Modernism focuses on what Sampson (1993) refers to as the "self-contained individual." In fact, modernism has become so commonplace in our world that we rarely question the utility of focusing on the individual in an attempt to understand the social world. Modernism (also often referred to as individualism) posits an autonomous individual endowed with emotions, traits, characteristics, ideas, mental

states, etc. In addition, modernism assumes that there is a real-world "out there" and, armed with the right tools and looking in the right place, we will discover that reality.

But social construction asks us to rethink our modernist tradition (Gergen & Gergen, 2008). Reality, to the constructionist, is an achievement of people engaging with one another and their environments. What comes to be "real" for people depends upon history, culture, context, and relations. This suggests that there are multiple realities rather than a singular one. What we come to know and believe as truth results from people interacting in context. And those interactions, as we know, rarely remain stable. Thus, to the constructionist, meaning is pliable and multifaceted.

From a constructionist perspective, knowledge development is not necessarily constrained by previously constructed beliefs, thereby opening possibilities for multiple (and often contending) worldviews (Gergen & Gergen, 2008). To position ourselves as curious about competing and complimentary beliefs and values (i.e., meanings), invites the welcoming of other voices, reflecting on and challenging our own beliefs and ideas, and considering different sensitivities. Such a positioning generates new meaning and knowledge. In this research, I explore how using a constructionist approach to explore the helpfulness of a culinary arts program for young people dealing with anxiety might create the possibility for youth to move beyond pathology toward potential.

This is not to say that I accept anxiety as a thing, as there are many different ways of understanding "anxiety." The following list of attributes of a person offers some other possible ways of understanding anxiety: highly sensitive, intuitive, compassionate, aware of the environment, situationally aware, attuned to others and their expectations, observant, self-aware, introspective, and humble. I question the utility of the diagnosis of anxiety.

Recently, The New York Times published an article entitled, “Are we talking too much about mental health?” (Barry, 2024) where they point out that adolescents today narrate their diagnoses and treatment on Instagram and Tik Tok. It goes on to say that it may not be helpful to put a label on your symptoms as research in the United States shows self-labeling of anxiety as associated with poor coping skills, like avoidance and rumination, and indicates that students who self-diagnose or label tend to have less control over their symptoms, are unable to put their difficulties in perspective and catastrophize (Barry, 2024). Jessica L. Schleider, a researcher in the United Kingdom and co-author of one of the studies represented in the New York Times article, indicated that her research revealed that those who self-label “appear to be viewing it as a biological inevitability” (Barry, 2024) and, therefore, feeling hopeless don’t make efforts to improve and cope less. Dr. Schleider, along with co-author Dr. Foulkes, introduce the idea of *prevalence inflation,* which is defined as the reporting of mild or transient symptoms as mental health disorders with Dr. Foulkes going so far as to suggest that we need to pause and potentially re-route the current direction of standard anxiety protocols as there is likely overdiagnosis, incorrect diagnosis, or overtreatment (Barry, 2024).

However, it is something that young people are diagnosed with, or they identify that it is a challenge that they confront. Throughout this dissertation, I will continue to use the term anxiety, not because I believe that’s what it is, but for ease of reading.

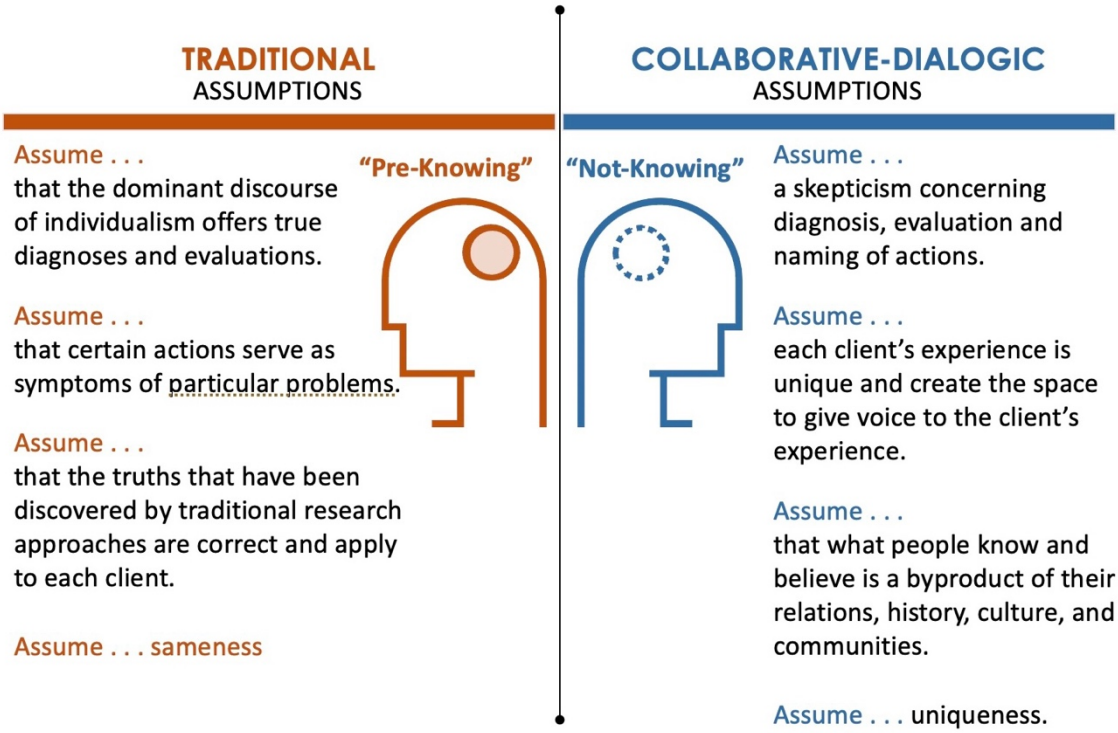
Collaborative-Dialogic Practices: One Elaboration of Social Construction.

Collaborative-dialogic practices are a particular way of interacting with one another that is influenced by a social construction perspective and post-modern philosophy. This specific kind of interaction is informed by a set of guiding assumptions that invite us to consider language and knowledge in different ways and how these may shift therapeutic treatment and the way we think

and act. From a collaborative-dialogic lens, the way in which we think about and relate to ourselves, others, and our world in a spontaneous way is referred to as *perspective-orienting* and reflects an attitude that differs from theoretical assumptions, techniques, and devised methods from pre-knowing modalities (Anderson, 2012a). (See Table 2)

Table 2

Traditional Assumptions vs. Collaborative-Dialogic Assumptions



Perspective Orienting Assumptions of a Collaborative-Dialogic Practice.

Maintaining Skepticism. Maintaining a critical and inquiring attitude about dominant discourses and resisting the appeal and consequences of these inherited psychotherapy traditions is essential. We can maintain skepticism through the practice of being a reflective practitioner, which means continually examining any discourse or knowledge that purports to be the truth and entertaining alternatives (Anderson, 2012a, 2012b).

Avoid Generalization. The risk of assuming that dominant discourses can be generalized across peoples, groups of people, and their situations can lead us to look for the recognizable, and then find exactly what we think we know we were looking for, thus missing out on that which is unique and exceptional. The generalizing of knowledge limits both the client and our possibilities (Anderson, 2012a, 2012b).

Privilege Local Knowledge. Ordinary people with first-hand knowledge of themselves and their situations carry with them their own customs, expertise, and narratives built upon their truths, beliefs, and understandings. This wisdom is formed and used inside their society, neighborhood, family, or work environment and may be more relevant for that community. Local knowledge is attended to, foreshadowing the dominant discourses and universal truths that might otherwise influence us (Anderson, 2012b, 2013).

Realistic Effects of Perspective Orienting Assumptions. These assumptions invite critical reflection on our current ways of thinking and categorizing and encourage a different way of hearing and seeing, which becomes our "way of being" – or a way of positioning (Davies and Harre,1990) ourselves in each interaction. These assumptions support a distinctive attitude regarding our clients, our relationship with them, and how and what we want to accomplish. From these perspective-orienting assumptions, our clients and their circumstances are perceived to be unique, and if we can shift our understanding and acknowledge those factors that were limiting us (i.e., the knee-jerk diagnoses and evaluations spawned by dominant discourses), we may hear that which was familiar in a new and novel way (Anderson, 2012a). From this interpretive process, a new understanding emerges, and pre-understanding may also shift in the process (Anderson, 2012b).

Collaborative-Dialogic Practice. Seven interconnected features serve as action-orienting

characteristics that underscore a specific and thoughtful sensitivity from where the therapist's words and actions become known as a response to the other and emphasize a shift from the concept of the therapist "guiding" the client using his/her expertise (Anderson, 2007). The distinctive stance of collaborative-dialogic practices conveys a means of "being with" that indicates an attitude toward another that they are special, unique, recognized, and appreciated as having something of value to say and hear (Anderson, 2012a). It is a way of thinking, talking, and acting "with" and responding to the other rather than talking at them, to them, for them, or about them (Anderson, 2012a). "Withness" is a way of positioning oneself as a partner within the therapy process instead of as an expert observer analyzing from the outside (Anderson 2012a). Withness is a relational activity that occurs in dialogue where we are instinctively and genuinely responsive to the other as an alternative to only thinking, seeing, and responding in terms of what is already familiar: that which we already think we know. This philosophical stance, as well as withness relationships, where partners engage in a circular, reflexive conversational process that invites and encourages a process of therapy that supports a therapeutic relationship that is less hierarchical and more equitable. When people participate more equitably, therapy becomes more participatory and mutual (Anderson, 2012a, 2012b).

This philosophical stance communicates a message of value and belief. This way of being invites congruency as a person, a way of integrating the professional and personal. This allows us to be fully present with the other, respond and interact in the moment, and do what the occasion calls for (Anderson, 2012a, 2012b). (See Table 3)

Table 3

The Stance of Collaborative-Dialogic Practice

TRADITIONAL PRACTICE	COLLABORATIVE-DIALOGIC PRACTICE
Directional | Intentional	Mutual Inquiry
The Therapist is the Expert	Relational Expertise
Pre-knowing	Not Knowing
Non-Transparent	Being Public
Linear View of Reality A⟶ B	Being Sponstaneous & Living with Uncertainty
Client Needs to Change	Mutually Transforming
Pathologizing	Orienting towards Everyday Ordinary Life

Mutual Inquiry. The practitioner and client become conversational partners through a common activity of mutual inquiry. This process involves addressing something by doing it together and being with the other. From a position of curiosity, the practitioner invites the client to participate in a bi-directional conversation to learn about the client's local knowledge. Together, creating from within their relationship, they negotiate their way forward, both how they will move forward, and their direction. The practitioner is not a guide for the path of the conversation instead they are a participant in it (2012a). Together, practitioner and client engage in a process of story-telling, re-telling, and new telling that gives novel and rich perspective and possibilities that were previously unimagined (Anderson, 2012b).

Mutual inquiry also involves hospitality. Hospitality includes all little details in the way a client is greeted and met with as that sets forth the tone and quality of the relationship and conversation at its generative possibilities. The therapist has the role of both host and during the

therapy sessions. The host's manners, preparations, tone, and responses need to convey a message of particular worth and special importance to their visitor as being someone unique and appreciated. This host and guest metaphor emphasizes the notion that a client is like a foreigner coming to a strange land and the importance of being courteous, sensitive to their uneasiness, and careful to not intrude (Anderson, 2012a, 2012b). It is simply using good manners and creating a relationship that is more of a companionship (2012b).

The therapist responds in a way to engage and participate in the conversation, but without the intention of directing it. Each participant's responses influence the direction and formation of the conversation. A therapist may comment, question, nod, or remain silent, but these responses are generated from within the conversation and relate to the client's words (Anderson, 2009). Responses are not influenced by thoughts or ideas from outside the current conversation or a perceived truth about the client. As a result of this conversational and relational process, new knowledge and meaning starts a shift in the familiar for themselves, which affects the people and events in their lives (Anderson, 2012b).

Relational Expertise. Relational expertise could also be described as the idea that clients are the most knowledgeable about themselves and their context: The therapist has expertise in creating a space and process for collaborative relationships and dialogic conversations. Focusing on the client's expertise, we draw attention to the resources the client brings to the conversation. This serves as a reminder that the therapist's knowledge is not privileged or valued more or considered more trustworthy than the client's. The practitioner does not pretend to lack knowledge; however, when viewed from a collaborative perspective, he recognizes the client's expertise as a different kind (Anderson, 2012b).

Not Knowing. Not knowing refers to two things: one, how a practitioner thinks about the

construction of knowledge, and two, the intent and manner with which knowledge is introduced into the consultation (Anderson, 2012a). It is an unassuming approach regarding what the therapist believes he or she might know, along with the confidence that the therapist does not have private information and thus would be unable to completely know another person (Anderson, 2012b). The practitioner responds in a way that indicates he or she always needs to learn more about what has or has not been said. Knowingness may constrain the therapist's capacity for learning about and knowing the other (Anderson, 2012b).

Critical to the dialogical process for a collaborative therapist is the knowing, highlighting the importance of knowing the other in the way they would like to be known at that time instead of knowing about them (Anderson, 2019b). Pre-knowing or better-knowing risks placing people in categories defined by types of problems or identifying them as certain types of people (Anderson, 1996, 2012a) and can limit a therapist's ability to learn about the exceptionality of that person and the uniqueness of their life. A collaborative therapist might introduce knowledge as a simple way of contributing to and, perhaps, stimulating the conversation, therefore posing possibilities for dialogue and thought and suggesting a potential way of continuing to talk about what is essential to the client (Anderson, 2012a). The therapist is attentive to and remains consistent with the client's response, which includes the ability to let go of our knowing if it does not resonate for the client as well as refraining from inferring the non-fit in a judgmental manner. (Anderson, 2012a).

Being Public. Being public does not refer to self-disclosure but rather to a way of being open and generous with our internal thoughts. It has more to do with a therapist's inner dialogue and the possibilities it can generate for conversation or ways to be in conversation. The goal of being public is not to control the conversation but to participate in it (Anderson, 2012a).

Being public is respectful, and putting forth private inner thoughts is ethical. Wondering what someone is thinking about but not comfortable enough to say or what the motivation is behind the questions they are asking can be unsettling for a client and inhibit genuine conversation. A consequence of not sharing inner dialogue is possibly closing off the therapist's capacity to hear the other and missing new understandings and meaning. The dialogue may stagnate as a result (Anderson, 2012a).

Being Spontaneous and Living with Uncertainty. An ordinary and spur-of-the-moment conversation has a back-and-forth nature. It does not have a step-by-step procedure with pre-scripted inquiries or techniques, but rather, it is a series of responses, one to another, each inviting and informing the other's response.

A client may bring a specific problem or situation in mind, but the conversation will frequently change the course of conversations during therapy (Anderson, 2012a). "As conversational partners, walking alongside each other, client and practitioner coordinate their actions as they respond to each other. Hence, their path and destination are unpredictable and uncertain" (Anderson, 2012a, p. 139). Therapeutic conversations that emerge from this perspective, are organic, spontaneous, and are more like ordinary, everyday conversations. As in all unplanned, spontaneous activities, there is some measure of uncertainty. A collaborative therapist embraces this uncertainty and views it as an opportunity for new possibilities rather than as a risk. They have adopted a level of confidence in their ability to respond to whatever the occasion calls for (Anderson, 1997, 2012a, 2012b).

Mutually Transforming. Collaborative-dialogic therapy promotes mutual transformation through relationships and the conversational process. Therapists and clients are vulnerable to change through their relational and dialogic practice. The therapist actively participates in the

interactional course of the conversation by continually responding with the client and his or her inner dialogue rather than engaging in an inequitable therapist-driven endeavor or assuming a passive role. Being conversational partners invites continual coordination of our actions as we respond with and are consequently affected by each other (Anderson, 2012a, 2012b).

Orienting Towards Everyday Ordinary Life. Collaborative therapy appears the same way as we talk and interact in our everyday ordinary lives. In our routine lives, we try to determine our "way about" and how to "go on" Wittgenstein (as cited in Anderson, 2012a). Clients in all practices venture to "find ways to move forward and carry on with their lives" (Anderson 2012a, 2012b).

Summary of Collaborative-Dialogic Practices. Maintaining a stance of possibility as opposed to a stance of deficit regarding clients means viewing each person as having the ability to create a rewarding life and believing that human beings are instinctively resourceful and resilient and want healthy relationships and satisfying lives (Anderson, 2012b). Collaborative therapists view discourses of pathology and dysfunction as constraining since any deficit discourse could possibly limit a client's eventual success (Anderson, 2012b). Our words, language, and descriptions, to some extent, shape the client we meet. Therefore, moving from a hierarchical, expert model to a more egalitarian model where people maintain their pride and dignity, as well as their culture, language, and history, would allow therapists to meet each client as someone they have not met before (Anderson, 2012a).

Social Construction, Collaborative-Dialogic Practices, & Anxiety. Earlier, I reviewed literature about 'anxiety' and used language to describe anxiety in the way it is presented in the scientific literature. This worldview about anxiety and treatment, like everything else, is socially constructed. To speak of the social construction of anxiety is to understand that what comes to be

commonly labeled "anxiety" emerges through a process whereby a given population – in the present case, a population of medical experts (e.g., the panel of experts charged with entering diagnoses into the DSM-5-TR) – negotiates that specific behaviors will be called anxiety. Once this community of experts names the actions that "count as" anxiety, the label proliferates throughout the medical/psychological community, providing a diagnosis with preferred treatment plans to those so identified. Eventually, the professional language of anxiety seeps into the common discourse of the general population. Gergen (1994) refers to this process as the cycle of progressive infirmity. We see this cycle repeated in a teenager's self-diagnosis: "I am dealing with anxiety." In other words, once anxiety is constructed as a bona fide "problem," it is used to assess our own and other's actions. Once this language is in place, it generates values and beliefs (a common moral order), thus validating this specific worldview and becoming the dominant discourse (McNamee, 2015). To the extent that we employ a diagnosis of anxiety, we continue to build upon it, accepting it as a universal truth and further contributing to its use as a taken-for-granted agreement.

Nonetheless, there are risks in assuming the validity of dominant discourses, whether deliberately or unintentionally created. It would suggest that this universal truth could be indiscriminate and, therefore, applied across all classes of people, all cultures, and all problems and situations (Anderson, 2013; Anderson, 2012b). Accepting this dominant discourse could guide us to create categories and look for prescribed similarities and patterns that might hinder our ability to notice what is distinctive and novel about each person, group of people, or condition (Anderson, 2012b). There is a possibility that we may see people, along with the events of their lives, in generalized and predictable ways rather than cultivate a practice of viewing the relational process as unique. In other words, rather than identify a problem as

located within a person, we acknowledge how the unfolding relational processes in which people engage construct identities. For example, from a constructionist stance, we would say that anxiety is a feature of a particular relational dance, not a quality of a person. Anxiety has become such a dominant discourse in our culture, yet it is important to note that it is only one of several possible discourses. Thus, the question concerning which construction is most useful to the person must be considered.

Other Possibilities for Treating Anxiety in Adolescents. Essential to intervention and prevention of anxiety in adolescence is social-emotional learning and ensuring access to mental health care (Barry, 2024; World Health Organization, 2021). The World Health Organization recently stated that regarding anxiety the "statistics seem discouraging" ("World Mental Health Day," 2017) as the number of adolescents struggling with anxiety continues to surge. With all the import that is recognized for the developing adolescent and the high risk and incidence of anxiety disorder, I believe it is our responsibility to reflect on that which we "know," our learned ideas about anxiety and its treatment, and consider possible alternatives to reach the most appropriate treatment that is also easily accessible to adolescents. This treatment approach needs to be one that supports the individual development of the adolescent while simultaneously reducing symptoms of anxiety. It is consistent with the literature that the optimal modality of treatment for adolescents with anxiety requires specific attention to developmental needs (Alfano, 2002; Baker et al., 2021; Kingery & Bergman, 2006; Sauter et al., 2009). The primary developmental changes of adolescence are biological/puberty, psychological/cognitive, and social role redefinition, which have not been given the attention they deserve in developing adolescent treatment of anxiety (James et al., 2020).

5. Exploring Developmental Stages

Not much is known about the best way to deliver treatment according to an adolescent's chronological age and developmental status (Baker et al., 2021; James et al., 2020). Several protocols for CBT have been established for adolescents (Rapee, 2005), including a manualized treatment protocol, often criticized as being too "cookie cutter" (Kendall et al., 2013, p. 44). A one-size-fits-all manual is inadequate as a treatment guide for adolescents struggling with anxiety, as the biological, social, emotional, and cognitive developmental levels of adolescents of the same age can vary greatly (Kendall et al., 2013).

Adolescence, a time of remarkable growth and development, increased vulnerability to anxiety, and a period of transitory and rapid mood changes (Bonovitz, 2021), presents challenges for mental health treatment. Adolescent girls, on average, begin puberty two years earlier than boys, which creates a significant gap developmentally along gender lines as there is evidence that social–emotional processing is influenced by the pubertal stage (Burnett et al., 2011). Different risks associated with the early onset of puberty and those maturing later can impact an adolescent's mood and affective expression (Bonovitz, 2021). Early maturing boys and girls share risks for adaptational difficulties, substance abuse, and early sexual and other risky behaviors (Kendall, 2006). For boys and girls maturing later, there is a risk of depression and body dissatisfaction, inadequacy, and social rejection (Benoit et al., 2013). Nevertheless, these could be attenuated through individualized treatment modalities that meet the adolescent's particular developmental levels (Kendall et al., 2013) and are flexible and spontaneous, allowing for the fluid nature of development.

Understanding Developmental Processes. Theories and knowledge about an adolescent's social, emotional, and cognitive developmental processes are nothing new. Since the early 20th century, several theorists have studied and developed models that illuminate and

investigate different characteristics of childhood development. These developmental theories focus on cognitive, social, and emotional growth and provide a way to recognize, describe, and predict behaviors through the lifecycle. Over the years, several theories for child and adolescent development have appeared to explain various aspects of human growth.

For instance, John Dewey valued personal involvement in knowledge development, supporting the idea that children know their world through interaction with their environment and that knowledge is constructed by the children themselves (Lutz & Huitt, 2004). Dewey further promoted the idea that cognitive development resulted from a shared ongoing relationship between thinking and doing (Lutz & Huitt, 2004).

Jean Piaget was among the first to hypothesize that children's minds are not simply smaller versions of adults or less intelligent than adults but that they think differently (Cherry, 2022). He proposed that many factors impact how children acquire knowledge and develop and that a fundamental change in their thinking exists. Piaget theorizes that children progress through four stages, creating knowledge and intelligence through the innate continuous activity of self-construction, rather than being passive recipients of knowledge (Dincer, 2021; Lutz & Huitt, 2004). According to Piaget, constructed mental schemas or structures allow children to interact with and adapt to the environment (Lutz & Huitt, 2004). As a child interacts with the world around them, knowledge is created, and mental schemas occur. If there is an incongruity, the perception of the environment is altered to incorporate new information with the previous schema, or the schema itself, can change due to the environment (Lutz & Huitt, 2004). Through this process, the child adapts to their environment and it is from achieving that balance between mind and environment that a child moves to the next developmental stage. Piaget's four stages of cognitive development are known as:

Sensorimotor stage: Birth to 2 years

Preoperational stage: Ages 2 – 7

Concrete operational stage: Ages 7 – 11

Formal operational stage: Ages 12 and up (Dincer, 2021; Mcleod, 2023).

Piaget suggests that three types of knowledge must be present in all cognitive developmental stages: social, physical, and logical-mathematical (Lutz & Huitt, 2004). Social improvement is only gained through interaction with others and based on action (Mcleod, 2023). Physical development is particular and only gained through hands-on interaction with the environment (Lutz & Huitt, 2004.) According to Lutz and Huitt (2004), logical-mathematical development is generated through actions and manipulating objects into different patterns and contexts, allowing for generalities and concepts to be created.

Based on Piaget's four stages of cognitive development, the student participants in this study were located in the formal operational stage, where they most significantly would shift from their earlier inductive reasoning to deductive reasoning, grasp abstract ideas, and increase their logical thinking (Mcleod, 2023). In this developmental stage, adolescents become adept at seeing multiple possibilities as solutions to problems (Cherry, 2022).

Lev Vygotsky's social development theory focuses on the impact of society and culture and their integration into a child's thinking through the use of language (Lutz & Huitt, 2004) and the process of meaning-making (Mcleod, 2020). Vygotsky suggested that learning is not an independent journey of discovery; instead, it is an essential social process, one of collaborative dialogues with more knowledgeable members of society where children develop cultural values, viewpoints, and problem-solving approaches (Mcleod, 2020). Vygotsky believed that higher mental abilities only developed through interactions with those more knowledgeable, thereby

increasing not only the quantity of information and the number of skills a child develops but also affecting the development of formal reasoning (Lutz & Huitt, 2004; Mcleod, 2022). This higher-level function, formal reasoning, is created through attention, memory, thinking, and language, with society being the most critical factor for cognitive development (Lutz & Huitt, 2004). Vygotsky attributed children's cognitive development to adults in society that involve them in thought-provoking and meaningful activities (Mcleod, 2020). Because this is a social process where a child relies on others to help them understand the world, Vygotsky believed that social learning must occur before individual cognitive development and that each child's experience is unique (Mcleod, 2020) and not automatically reached due to physical development.

Vygotsky's sociocultural theory posits that parents, friends, and the community are essential in developing higher-order functions. Vygotsky theorized that learning is a social process. By engaging with others, learning becomes part of how an individual understands the world. His Zone of Proximal Development established the space between what children could do with help and what they could do independently (Lutz & Huitt, 2004; Mcleod, 2022). With the help of others who are more knowledgeable, children can learn and increase their skills and scope of understanding. Vygotsky’s theory that learning is an active, social process occurring through hands-on experiences has been influential in the field of education.

Jerome Bruner theorized that cognitive development in children follows a step-wise progression building upon itself by subsequent stages, as Piaget hypothesized. Bruner's idea that cognitive development occurs through interaction and experience, creating more intricate mental structures, is consistent with other theorists before him. Like Dewey and Vygotsky, Bruner's work is thought of as interactional. However, Bruner disagreed that a child can only process certain types of information at specific stages but that even tricky concepts can be taught to any

child at any time with appropriate instructional support (Bruner,1985; Bruner, 2009).

Bruner also considered the effect of cultural and societal differences, noting that members of different cultures make meaning from their experiences in dissimilar ways (Lutz & Huitt, 2004). Bruner's theory of children's cognitive development proposed that three modes of representation must be present (Bruner, 2009; Lutz & Huitt, 2004). These three modes of internal representations, enactive (action-based), iconic (image-based), and symbolic (language-based), were influential in everyday education applications (Bruner, 2009). The modes of representation demonstrate how knowledge is stored in the memory, and though loosely successive, they "translate" into each other (Bruner, 2009).

Erik Erickson viewed the lifespan of human development through the psychosocial lens, emphasizing the importance of cultural and social influences (Gross, 2020). His theory of lifespan development was the first and most influential. It provided a way to evaluate personality development as an unfolding process that begins at birth and continues through old age (Syed & McLean, 2017). Central to Erickson's theory is identity, the fundamental organizing principle that constantly develops throughout the lifespan (Syed & McLean, 2017), as it is the mindful sense of self that we develop relationally through social interactions and new experiences.

Erickson's eight stages or "tensions" are with all individuals throughout the lifespan, but various tensions are more important at different times. Each tension shows up just before the primary development period and will continue throughout the lifespan (Orenstein & Lewis, 2022 Syed & McLean, 2017). From Erickson's perspective, human development is never complete; we are always in the process of negotiating from birth through old age, adjusting the tensions as we go along. Conflicting psychological proclivities define Erickson's eight fundamental stages or tensions:

Trust vs. Mistrust (Infancy)

Autonomy vs. Shame and Doubt (toddlerhood)

Initiative vs. Guilt (early childhood)

Industry vs. Inferiority (middle childhood)

Identity vs. Role Confusion (adolescence and emerging adulthood)

Intimacy vs. Isolation (emerging adulthood and adulthood)

Generativity vs. Stagnation (adulthood)

Integrity vs. Despair (old age)

Though adolescents could be working through any developmental stage or tensions below their current stage, Erickson posits that most adolescents are focused on themselves during the Identity vs. Role Confusion stage (Syed & McLean, 2017). The conflicting or opposing qualities creating tension for adolescents can be simplified during this stage as "ego identity" and "confusion" (Orenstein & Lewis, 2022), with identity development as the goal. According to Erickson, adolescents who develop their identity (through beliefs, values, experiences, relationships, and memories) generate the qualities of loyalty and faithfulness, form genuine friendships, and have decreased levels of anxiety, but those who are unable to develop their identity bear the makings of rejection and denial while suffering increased levels of anxiety (Orenstein & Lewis, 2022; Syed & McLean, 2017).

Erik Erickson's work influenced many other areas of research. Today, his stages of development serve as a foundation for many mental health providers when caring for patients who are undergoing life cycle changes or struggling with adjustment.

6. Learning: An Interactional, Relational, and Social Process

Dewey theorized that learning occurred through interaction with the environment and

from thinking and doing. Piaget posited that knowledge is self-constructed through activity and that social, physical, and logical/mathematical knowledge must be present in all cognitive developmental stages and is only gained through social and environmental interactions and using manipulatives to create different patterns and contexts. Vygotsky viewed learning as a social process, using collaborative dialogue and including more knowledgeable members of society to involve children in thought-provoking, meaningful activities, thereby increasing skills and understanding. Bruner's idea is that a child's intellectual development occurs through interaction and experience and that children can learn complex concepts with appropriate teaching (Bruner, 2009). Finally, Erickson's lifespan theory centered around identity development, which he believes is developed relationally through social interactions and new experiences. While other principles of these theorists may differ, they all seem to agree that learning and acquiring knowledge is an interactional, social, and relational process. It would seem to follow that if the goal is to create treatment approaches for adolescents that are developmentally appropriate, a focus should be on the relational and social processes of interaction where learning and knowledge are generated.

7. Adolescent Self-Esteem

It is well-documented in the literature that adolescents with anxiety have lower self-esteem when compared with healthy adolescents (Maldonado et al., 2013; Nguyen et al., 2019). Notably, in a recent study by Fernandes et al. Newton et al. (2021), it was established that self-esteem significantly mediated the relationship with increased anxiety. That is to say, the higher the level of self-esteem, the lower the level of anxiety (Newton et al., 2021).

Self-esteem, commonly defined in the United States as confidence in one's own worth or self-respect (Self-esteem, 2011), can also be thought of as emergent identities that result from

social interactions that hold a preferred, positive, identity story. Adolescents struggling with symptoms of anxiety would gain from an activity that supports social interactions that generate possibilities to develop positive attributes. Shifting the generative focus of treatment from one that promotes an adolescent's negative self-narrative to one that supports the growth and development of an adolescent's preferred identity story provides an adolescent with the opportunity to be immersed in a positive, meaningful, forward-thinking, and exciting unfolding process of self-discovery. In this way, the symptoms of anxiety naturally decrease as the adolescent's identity develops and a new, more desirable, positive narrative of possibility becomes their prominent identifying feature.

1.3 Culinary Therapy

1. Culinary Therapy: Diverse Health Benefits

Current literature suggests that cooking, as a therapeutic approach at times also referred to as cooking therapy, culinary therapy, culinary medicine, or culinary arts therapy, is effective in the prevention of diseases such as obesity, type 2 diabetes, metabolic disease, eating disorders, and is also beneficial for the adolescents' nutritional profile (Aycinema et al., 2017; Rees et al., 2012; Reicks et al., 2014). One culinary arts therapy program utilizes cooking together as a means of providing couples therapy to experience a heightened relationship with each other through food. Its focus is on socializing, communicating, learning to cook together, and the satisfaction of having created a meal while effectively working on their relationship (Redd, 2015).

Past studies have reported the efficacy of this form of therapy for the improvement of adolescent's health habits. For example, D'Adamo et al. (2015) created a program aimed at improving diet quality and nutritional behavior for urban (predominately African American)

adolescents. One hundred and ten students participated in the 6-week "Spice My Plate" program. Participants were randomized to the control group or the intervention group. Significant ($p \leq .05$) differences were seen between the control and intervention groups in whole grain intake, lean protein, and low-fat dairy (D'Adamo et al, 2015). The authors posit that the "Spice My Plate" program can help improve health habits of urban adolescents (D'Adamo et al., 2015).

In a study by Utter et al. (2015) the researchers conducted a multiple regression analysis involving 8500 students investigating the cooking ability, frequency of cooking, nutritional behavior, mental health, depressive symptoms, and family connections. This study revealed that cooking ability was significantly ($p = 0.01$) positively associated not only with positive nutritional behavior but also with better mental wellbeing, strong familial ties, and lower depressive symptoms. The authors suggest that research is needed to "examine the relationships between cooking and health that may include measures beyond nutrition, such as social relationships and emotional wellbeing" (Utter et al., 2015, p. 35).

Santarossa et al. (2015) performed a study evaluating a nutritional education program, the Kinect-Ed presentation. The program goals were to improve self-efficacy for cooking food, preparation techniques, food preparation frequency, family meal behaviors, and increased familial dining frequency (Santarossa et al., 2015). Two hundred and nineteen young adolescents participated and completed pre and post presentation surveys. The t-test analysis revealed significantly ($p < 0.01$) increased familial dining frequency, preparation frequency, self-efficacy for cooking, and food preparation techniques (Santarossa et al., 2015).

Finally, Gatto et al. (2015) investigated the effects of a 12-week gardening, nutrition, and cooking intervention (named "LA Sprouts") on diet, obesity, and metabolic disease in low-income Hispanic adolescents in urban Los Angeles. One hundred and seventy-two children were

randomized to the intervention group and 147 to the control group (Gatto et al., 2015). Pre and post-intervention data collected included a food frequency questionnaire, BMI, percentage of body fat, waist circumference, and fasting blood glucose levels (Gatto et al., 2015). In comparison, the intervention group had a significantly greater reduction in BMI ($p=0.01$) with a decrease in waist circumference ($p < 0.001$) than the control group (Gatto et al., 2015) The authors concluded that this intervention reduced obesity and nutritional risks**.**

These benefits are noted as educational, increasing the health profiles of adolescents, and encouraging the focus on positive experiences. Some studies involving culinary arts therapy have found significant increases in familial dining, meal preparation, self-efficacy for cooking, and food prep techniques as well as reduced obesity and nutritional risks when evaluating nutritional education programs (Whalen, 2014). Often, the weight gain is at least partially a side effect of the many medications used to treat mood disorders, such as anxiety (Whalen, 2014). In these programs, however, the mental health benefits are secondary to the participant's physical health, skill acquisition, and psycho-educational benefits.

In a survey of 8,500 adolescents in New Zealand, cooking ability was positively associated with lower levels of self-reported depression, better mental well-being, and better family connections (Utter, et al. 2016). Chen et al. (2012) found that women in Taiwan who cooked frequently were less likely to engage in behaviors like smoking and more likely to engage in socialization, indicating that cooking may encourage social and psychological benefits. Haley and McKay (2004) reported that for 12 mental health inpatients who participated in baking sessions it led to better self-image, primarily as a result of improved confidence, concentration, and coordination. Participants reported that it was rewarding and beneficial for them to keep or share a product they baked. The cooking process allows patients to build their confidence by

focusing on experiences that are positive.

This type of culinary therapy is being used specifically with adolescents at a treatment center in Connecticut, United States (Ohana, 2022). Kocet (2021), the program director and a professor at The Chicago School for Professional Psychology (TCSPP), stated that there is music therapy, dance therapy, art therapy, and drama therapy, in the mental health field, but cooking therapy had not been created. In 2014, he developed and now teaches a culinary therapy course for mindfulness to mental health counselors at TCSPP. Recently, the availability of culinary classes has been increasing in treatment centers as a therapeutic intervention for mental illness. The list of benefits of culinary arts therapy, according to Ohana (2022) – a Licensed Social Worker and passionate cook – includes gaining insight into one's behavior, mindfulness, learning about social skills/cues, stress management, time management, and brain development through using the senses.

Culinary Therapy: Addressing Mental Health Problems. Kocet (2021) defines culinary therapy as a way of addressing mental health problems through the use of cooking and the client's varied relationships with food. Clark et al. (2015) offer that under the supervision of a professional chef, nutritionist, and occupational or mental health therapist, patients learn about diet and nutrition, develop a healthy relationship with food, improve eating behaviors, and improve cooking self-efficacy.

One practical goal of culinary therapy is learning new skills and developing mastery, which adds to a person's identity story. Culinary therapy requires an integration of processes: socioemotional, cognitive, and physical. Learning how to cook or bake involves demonstration by the professional and is positively reinforced throughout the active process of co-creating through tasting the product themselves and by sharing what has been created with others. Social

cognitive theory posits that individuals learn through observation and modeling and that activities will likely be repeated if positively reinforced (Bandura, 2004). For the individual learning and practicing these new abilities, the development of mastery occurs.

Culinary therapy also sets the stage for a client-centered approach to mental health care that places the emphasis on collaboration by working together as partners in the therapeutic relationship as well as co-creators of a tangible product. This collaboration leads to a more spontaneous and flexible therapy that can easily fit the uniqueness of each client and their particular situation (Anderson, 2007). By working together as partners in an environment of honesty and respect, clients are able to engage in meaningful conversation about what they want to change (Anderson, 2009).

Culinary therapy is a mindful activity, with step-by-step instructions, that engages a lot of attention, creativity, coordination, reasoning, and self-connection and builds self-esteem (Haley and McKay, 2004; Herbert et al., 2014) while creating a safe dialogic space for meaningful conversation, reflection, and transformation.

2. Culinary Therapy Using Collaborative-Dialogic Practices

Culinary therapy is a method that is already known, however, situating it in a collaborative-dialogic perspective makes it quite different. Using a collaborative-dialogic approach aims to create a relational process that invites the continual creation of possibilities both through conversation and the process of co-creating a tangible product. Maintaining a positive outlook concerning clients includes the confidence that each person has the ability to lead a satisfying life, viewing human beings as instinctively resourceful and resilient, and wanting healthy relationships and life (Anderson, 2012a).

The *perspective-orienting assumptions* of collaborative-dialogic practices underscore the

natural unstructured characteristics of day-to-day living and the exceptionality and individualities present in each person and setting (Anderson, 1999). Through the process of self-reflexivity, a shift is created in the way of thinking, from accepting and perpetuating the prevailing dominant discourse of how to treat anxiety in adolescents to questioning the context of how this situation was established and broadening the perspective. In this way, the story is expanded, inviting alternative understandings into the conversation (McNamee, 2015) and creating new possibilities for moving forward.

As an approach "that informs a process that is distinct to each client and each meeting with them" (Anderson, 1999, p 132), collaborative-dialogic practices are well suited for attending to the individual needs of each client. To be precise, "the professional adapt their responses to the uniqueness of each client, talking with them about what is important to them with the intent that the encounter will generate transformative potential" (Anderson, 1999, p 132). Culinary therapy, from a collaborative-dialogic orientation might be more accurately referred to as a "culinary arts program" as the name is more inviting and inclusive, offers possibility, and is not language that implies a deficit.

1.4 Culinary Arts Program in the School Environment: An Alternative and Effective Intervention

1. Accessibility to Mental Health Care for Vulnerable Adolescents

The United States has a healthcare structure that is much more privatized than its European counterparts and has a relatively low proportion of publicly funded health insurance programs (Keisler-Starkey & Bunch, 2021). In their study, Keisler-Starkey and Bunch (2021) determined that 66.5% of people in the United States had private health care insurance but that many of those plans did not cover mental health care or had a costly co-pay or deductible that

prevented them from attaining services. Keisler-Starkey and Bunch (2021) reported that 34.8 % of people in the United States were receiving public assisted health care and that 8.6% or 28 million people, had no health care benefits at all. The rate for children living in poverty without insurance increased to 9.3% in 2021, according to Keisler-Starkey & Bunch (2021). The Centers for Disease Control (CDC) (2020) reported that 4 out of every 10 children under 17 years of age did not receive care for a diagnosed anxiety disorder. It is not difficult to understand that this deficit in mental health services for children is a result of inadequate health care coverage or the simple lack of health care coverage at all (CDC, 2020). Consequently, at a time when our children are at their most vulnerable developmental stage, adolescence, and enduring a rising epidemic of anxiety, nearly one-half of all adolescents facing anxiety do not have access to the mental health care that they need and deserve (CDC, 2020; Keisler-Starkey & Bunch, 2021).

Providing culinary arts program in the school setting makes mental health care accessible and available to nearly all adolescents. By linking mental health care to the educational system, which is governed independently by each state in America (in Texas, it is considered a fundamental right), we can safeguard these critical services for most school-age children, regardless of their healthcare coverage or ability to pay, by making them free of charge and available to all students.

2. School Environment as a Safe Space

Young people spend much time at school and often spend several years at the same campus (Gee et al., 2020). School staff have opportunities to develop safe and trusting relationships with these young people as they enjoy extended interaction time with them. This increases the possibility for school staff to notice any change in behavior of a particular child, or the development of a new behavior that may be of concern (Gee et al., 2020). For a student who

may be suffering difficulties at home, school often is a place of refuge, a safe space where they have support and stability. Offering mental health care in a school environment increases the likelihood of the student receiving the maximum benefit from therapy as they are in a familiar, calm, safe, and trusted space. Because it is a safe space, students are more likely to request talking to a therapist on their own accord when they are not feeling well emotionally. Further, when a concerned staff member who has a trusting relationship with a student suggests that a conversation with a therapist might be helpful for a struggling student and offers to assist the student by personally introducing them to a therapist, the student is more likely to feel cared for and safe participating in therapy.

3. Culinary Arts Program in a School Environment: Linking Mental Health Care to Education

In a study by Nguyen et al. (2019), researchers established that self-esteem [emergent positive identities] is correlated with anxiety. Based on the findings of the study by Nguyen et al. (2019), it was suggested that there is a need for a school-based program directed at proactively increasing students' self-esteem [emergent positive identities].

Participation in culinary arts program supports education both academically and in social and emotional learning by increasing knowledge, reinforcing language, mathematics, and chemistry proficiency, promoting skill building, mastery, social skills, and relational competence through cooking or baking together, collaborative dialogue, and meaning-making. A culinary arts program in a school setting would complement the philosophy and goals of social-emotional learning to "help young people thrive personally and academically, develop and maintain positive relationships, become lifelong learners, and contribute to a more caring, just world" (Casel, 2022). A culinary arts program would also improve educational equity by establishing

learning environments and experiences that emphasize trusting and collaborative relationships in combination with rigorous and meaningful curriculum and instruction (Mahoney, 2018).

For adolescents with current symptoms of anxiety, a culinary arts program in the school environment provides an opportunity that is convenient and accessible, encourages school attendance, and supports academic success, which is most often negatively impacted by anxiety. A culinary arts program can empower the acquisition of knowledge and skills along with the capacity to achieve personal and shared goals, manage emotions, and begin and maintain healthy relationships, allowing for the adolescent's identity story to be enriched (Casel, 2022).

There are many students, faculty, and staff members in a school setting providing abundant opportunities for students participating in a culinary arts program to share what they have co-created in the kitchen. Sharing something you have specially made with your own hands is an intimate gesture; you are sharing part of yourself with others. Receiving compliments from eager tasters helps with positive reinforcement of success, feeling appreciated, and recognition for the achievement of skills. This is especially helpful for adolescents who may be reserved, as it provides an informal means of meeting people and engaging in conversation without the focus being entirely on themselves.

Academics, social-emotional learning, and building healthy identity stories are fundamental measures of education and human development (Casel, 2022). Providing this type of opportunity from within the school setting allows for easily accessible care to the greatest number of adolescents in a natural living environment.

4. Concrete Organization of Culinary Arts Program in a School

A culinary arts program in the school environment requires a private space that provides participants with privacy and could be established as a kitchen work area for one-on-one

sessions. Ideally, there would be a small kitchen or breakroom area that could be utilized for this purpose to begin a program. While it is convenient to have a lot of equipment, as it expands the possibilities of products a participant can choose to create, there are several items that can be made with the minimum of a microwave, portable burner, sink, and refrigerator. To name a few: chocolate truffles, pralines, chocolate fudge, caramels, toffee, and custard.

Above all else, safety is of the highest priority in a culinary arts program. This applies to both the professional and the participant. The space where the kitchen area is located, must be safe according to school building codes and sanitary, cleaned with disinfectant before and after every session to ensure no cross-contamination occurs. All equipment must be free of damage or malfunction and the refrigerator must maintain an internal temperature of <40 degrees F. All ingredients must be kept in food-safe, air-tight containers and clearly labeled with expiration dates. Any hand tools such as whisks, spatulas, portion scoops, and knives must be kept in a locked drawer, cabinet, or toolbox. All participants must wear closed-toed shoes, long pants, and a blouse or shirt with at least elbow-length sleeves. This is essential for the prevention of cuts or burns. Bib-style aprons would be provided by the school and laundered between uses. This type of setup would provide the minimum to begin culinary arts therapy and could support one-on-one sessions with participants. This would be best suited to students who were currently facing struggles with anxiety.

In an ideal situation for a culinary arts program, there would be the possibility of a large classroom with several small kitchen workstations or a large commercial-like kitchen for groups of participants to work in. The same safety and sanitation requirements would need to be in place, including additional equipment such as stand mixers, cooling racks, freezer capacity, and ovens. Additional safety and sanitation training and precautions would need to be established. As

a result of a larger kitchen setup, the variety and quantity of items that can be produced are significantly increased. Most importantly, this would allow culinary arts sessions to be offered to small groups of students, together, as a proactive intervention. One additional consideration is if a culinary arts program is offered as a course in a school setting, it would be essential that the instructor complies with all educator training and certification requirements for teaching what is often referred to as Vocational Education or Trade and Industrial Education and follow guidelines for standards of knowledge and skills when designing curriculum. Involving community partners, such as bakeries, pastry shops, or restaurants, and creating an advisory board ensures that current required culinary skills for employment in the local area are met through the program and can offer continued training and possible employment through externship opportunities for students.

1.5 Purpose of this Study & Research Questions

As previously shown, anxiety in adolescents is a rising epidemic that urgently needs alternate and easily accessible therapeutic approaches or strategies for efficacious treatment. Adolescents are developmentally more vulnerable during this time than any other, as they form their identities and determine how and where they fit in with their peers and society. This is a critical time in their lives that carries with it the significant risk of developing disabling anxiety, thus contributing to adolescents' negative self-narrative and often predicting future psychopathology as adults. Cooking as a therapeutic approach, referred to as cooking therapy, medical cooking therapy, and culinary therapy, has been shown to have beneficial physical and mental health effects, and an increasing number of treatment centers are already providing such cooking classes. However, despite the efficacy of cooking as an appropriate treatment approach to improve physical and mental health, there is minimal research regarding the application and

effectiveness of cooking specifically in the treatment of anxiety among adolescents, let alone when using a social construction approach of collaborative-dialogic practices as the orientation and offered in an easily accessible, safe, and natural living environment for adolescents, such as schools. In this dissertation, these questions will be answered.

1. Is there evidence to support the experience of adolescents who have been diagnosed with anxiety participating in a culinary arts program, executed from a collaborative-dialogic orientation in a school setting, as having therapeutic benefits from the perspectives of the adolescents, their parents, and their teachers?
    a. Did the adolescents experience a shift or change in their identity story?
    b. Did the adolescents experience an increase or decrease in their anxiety symptoms as measured by the Generalized Anxiety Disorder 7-item (GAD-7) Scale?

Chapter 2: Methods

2.1 Study Design

This qualitative study aimed to investigate the experience of anxious adolescents participating in a collaborative-dialogic, school-based culinary arts program from the perspectives of the adolescents, their parents, and their teachers to determine the program's therapeutic efficacy. The methodology used in this study was participatory action research (PAR). PAR tends to focus on research that aims to initiate action or change and pays particular attention to power relationships, advocating for power to be intentionally shared between the researcher and the researched (Baum et al., 2006; Feekery, 2023). Participatory action research is a proponent of those being researched becoming partners in the research process. This contrasts with other approaches that collect data and information about their research objects away from their contexts Baum et al., 2006). PAR collaboratively explores change and creates a flexible and practice-focused way of thinking about research-informed outcomes and promoting change (Baum et al., 2006).

Thematic analysis, consistent with Braun and Clarke (2006), was used as an open-ended way to explore adolescent, parent, and teacher perspectives on the program's efficacy and the adolescent participants' identity enrichment. Social construction informed the epistemological basis that guided the processes of this research by adopting a bidirectional understanding of the connection between language and experience (Byrne, 2021). Thus, the research design underscored the socially constructed nature of reality and meaning-making (Gergen & Gergen, 2008) where the focus was on the social interaction between researcher and participant, communicating agreed-upon meaning through language that generated a socially negotiated reality (Roy-Chowdhury, 2010).

2.2 Participants and Settings

Adolescent, Parent & Teacher Participants

Study participants were adolescent students, their parents, and teachers. Students were recruited via my private psychotherapy practice at Xavier Educational Academy in Houston, Texas. The criteria for participation in the study included being between the ages of 13 and 17 at the start of the study and either self-identifying or being diagnosed with anxiety by a professional provider. Parents (1 per student) were included through the students, who were also advised about selecting teachers (1 per student) from Xavier Educational Academy.

The study occurred between November 2020 and March 2021 and included 189 culinary sessions. The call to participate in the study was two-fold. First, an email with a description of the study and requirements for participation was sent to each adolescent client using an encrypted email server to guarantee professional privacy and security for voluntary participation. Using an encrypted email server for communication regarding private health information is required by law in the United States and is known as the Health Insurance Portability and Accountability Act (HIPAA). Secondly, a flier was posted on my office door, briefly describing the study and participation requirements. Interested adolescents could request more information regarding the study from my therapy offices or by calling or emailing me directly.

Well-informed students who were willing to participate in the study were then screened to fit the eligibility criteria for the study. If they met the criteria, parents were contacted and given research consent forms that detailed the research purpose, the methods used, and the participant's rights. Due to the sample population consisting of minors, student participants' assent was also obtained after parental consent was provided to confirm participation and to schedule the start of the culinary sessions (see Appendices B & C). (For more information on

how consent was obtained, see ethical considerations.)

The adolescent student participants were then asked to identify three current teachers at Xavier Academy, in no particular order, with whom they have a positive relationship and with whom they would feel comfortable sharing their culinary creations. The purpose of student participants naming three possible teacher participants was to enable a more balanced spread of teacher participation with less overlap and create variation due to the small teaching staff available at the school. I contacted, via HIPAA-compliant email, each of the teachers who were named by the student participants and provided them with information about the study along with an invitation for participation. The student participants named a combined total of 8 teachers (4 men and 4 women aged 23-72 years old), all of whom volunteered and completed the required informed consent (see Appendix D). Each teacher was assigned 1-3 student participants, who had selected them as teachers with whom they had a positive relationship. I completed this process of assignment and compiled a list of all teacher choices by student participants and used the list as a guide to make the selections, ensuring each student was paired with a teacher they had named. Lastly, one parent per adolescent was asked to participate in an interview with me at the conclusion of the student participants' culinary sessions. The student's participating parent was self-selected. Seventeen students (9 males and 8 females) participated in this study with their respective parents (17 mothers) and 8 teachers (see Table 4).

Table 4
Participant Demographics

AGE GROUP:

13 - 14	15-16	17-18

Student Name	Gender	Age Group	Parent Interviewed	Teacher Participant Interviewed
1	F	13-14	Mom	2
2	M	15-16	Mom	1
3	M	13-14	Mom	4
4	M	15-16	Mom	3
5	F	13-14	Mom	6
6	M	15-16	Mom	5
7	F	15-16	Mom	7
8	F	15-16	Mom	1
9	M	13-14	Mom	2
10	M	13-14	Mom	3
11	F	13-14	Mom	4
12	F	15-16	Mom	5
13	F	17-18	Mom	7
14	M	17-18	Mom	8
15	M	17-18	Mom	3
16	F	17-18	Mom	6
17	M	15-16	Mom	1

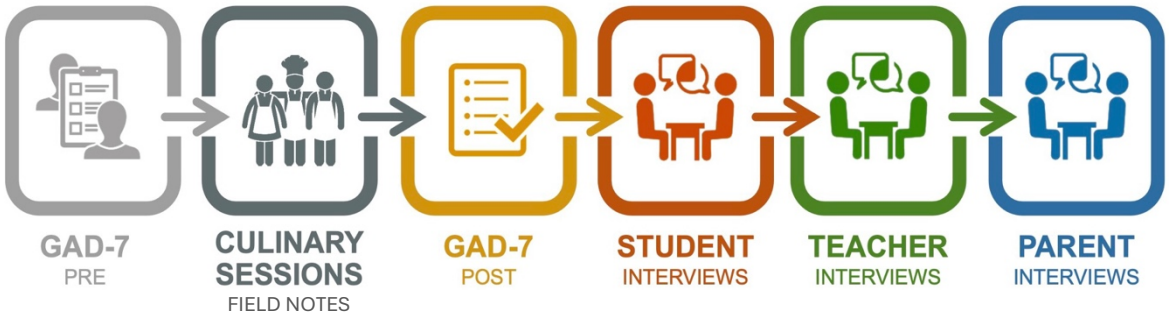
2.3 Data Collection

1. General Procedure

Student participants were required to complete 10-12 culinary sessions for this study. These sessions were conducted in a private kitchen at Xavier Educational Academy during regular school hours. Before and after completing all culinary sessions, I provided each student participant with the GAD-7, a seven-item anxiety scale for self-report on listed symptoms and the frequency of occurrence. After each culinary session, I completed field notes. At the

completion of all culinary sessions and the post-GAD-7, I audio-recorded the interviews conducted, first with the student participants, followed by the teacher participants, and lastly with the parent participants (see Figure 3).

Figure 3
Flow Chart for General Procedure



The research included field notes of significance from culinary sessions to use along with the student participants' individual interview guides, where specified. The final step in the data collection process involved interviews designed to gather qualitative data regarding the students' subjective experiences and observations from parents and teachers at the completion of the culinary sessions.

2. Measurements

Generalized Anxiety Disorder 7-Item Scale. The Generalized Anxiety Disorder 7-item Anxiety Scale (GAD-7) is a brief and efficient self-report scale and a commonly used tool for screening anxiety symptoms with the general public (Byrd-Bredbenner et al., 2021; Naeinian et al., 2001; Spitzer et al., 2006). It has good reliability, factorial validity, and procedural validity (Byrd-Bredbenner et al., 2021; Naeinian et al., 2001; Spritzer et al., 2006). However, my purpose of using the GAD-7 was not because it would reveal "the truth" but rather that it might provide a way for the student participants to make note of the symptoms they were experiencing during the

2 weeks before the start of the culinary sessions and during the last 2 weeks at the conclusion of the culinary sessions. Response options for each item are on a 4-point Likert scale that ranges from 0 (Not at all) to 3 (Nearly every day). The GAD-7 is a paper questionnaire that was completed by each student participant privately, in my school kitchen (lab) just before the start of the first culinary session and again immediately following the final culinary session. The pre and post GAD-7 compared the intensity of symptoms experienced by the adolescent participants before the start of culinary arts sessions with those at the completion of the culinary sessions. This symptom intensity comparison for anxiety allowed the adolescent to determine its accuracy, reflect on any implications, and to stimulate conversation.

3. Culinary Sessions

From a constructionist perspective, I conducted culinary sessions as a culinary co-creator with each student participant in a private kitchen (lab) located in a school setting Each student participant attended 10-12, 90-minute culinary sessions in which the participant chose a different pastry item each session to co-create with me. During the culinary arts sessions, the students were engaged in conversation using open-ended questions and the back-and-forth nature of conversational interactions as they unfolded organically per the philosophical stance of collaborative-dialogic practices (McNamee & Gergen, 1999). Through this approach, I focused on "talking with" (Anderson, 1999; Shotter, 2012) the student participants and being respectful of them and the thoughts and ideas that they bring with them. My genuine curiosity about their feelings and beliefs led to meaningful dialogue about the construction of realities and how those conceptions and the meaning given to them lead us to feel and act in certain ways (Anderson, 1999). Through dialogue, I engaged in a process to explore situations or problems introduced by the student participants. With the belief that our ideas and the meaning we give to them are co-

constructed through relationships, other possibilities or perspectives were explored together, creating new understandings, meanings, and possibilities (Anderson, 1999; Anderson & Gehart, 2022). This type of conversation was transformative and generative for the student participants and for me.

At the conclusion of each culinary session, I wrote field notes with relevant information about the participant's ability and competency, relational quality, emergent identities or topics the I might be curious to know more about. The specific contents of these field notes were created by the student participant and me together using broad, overarching and agreed-upon statements describing the culinary session such as: what knowledge was generated and skills were learned or practiced, or were they talkative, reflective, curious, or pensive and how they were feeling. If something of interest arose in the session that I was curious about, it was documented in the field notes for follow-up during the student interviews.

Student participants were allowed to share the pastry items they created with their peers at school and their families as compensation for their participation in this study.

4. Semi-Structured Interviews

Three interview guides were created for the interview process, with one set each for the students, parents, and teachers (see Appendices E-G). These interview guides were informed by the literature (Anderson, 2017; Farmer et al., 2018; Grant, 2013; Hsai, 2014; Locke et al., 2015; Maldinado, 2013; Shrobsdorff, 2016; Utter et al., 2015; Woodword, 2001) and with the use of pertinent clinical notes from the culinary sessions. I audio-recorded these interviews with the assent of the student participants and consent from parent and teacher participants.

With regard to the *student participants*, 15 students were interviewed face-to-face, and 2 students were interviewed via Zoom during the regular school day. The pre-planned question

guide used for the semi-structured interview was comprised of content pertaining to previous experiences when discussing the students' anxiety, their subjective experience before, during, and after the culinary sessions, curiosities from my field notes, and the student's opinions on any changes in their anxiety symptoms as noticed from the comparison of their GAD-7 scales. Each interview was approximately 1 hour in duration and all student interviews were completed prior to teacher and parent interviews.

Individual, in person interviews were conducted with *teacher participants* during their scheduled planning period, or after school, using the pre-planned question guide. The teachers were asked about their perspectives of a student's anxiety and any observed changes emotionally and/or behaviorally that they may have noticed in the classroom. In addition to these questions, teachers were asked if there were accommodations in place for the students and if so, their opinion of whether those were useful in managing their anxiety symptoms. The interviews with teachers varied from 25 minutes to 70 minutes as some teachers repeated the interview for up to three different student participants.

All *parent participants* were given a pre-planned semi-structured interview via Zoom for convenience of scheduling and to reduce contact during the COVID-19 pandemic. The interview, which was similar to that of the teachers, concentrated on the parents' perspectives with regard to their child's anxiety prior to the intervention and any noticeable changes in their child's emotional well-being or behavior both during and after the culinary sessions. I also explored previous experiences with medical or mental health providers as it related to their child's anxiety, as negative prior experiences with therapy were frequently conveyed by the student participants during culinary sessions. These interviews with the parent participants were approximately 30 minutes in length.

2.4 Data Analysis

To gain an understanding of study participants' experiences, thoughts, and behaviors, thematic analysis was utilized in this study as a method of analyzing qualitative data across the entire data set (Nowell et al., 2017; Kiger & Varpio, 2020). Thematic analysis is theoretically flexible, providing a systemic framework for logically identifying, classifying, and providing insight into collective or shared patterns of significance in relation to the research questions (Braun & Clarke, 2012). The research organically generated options for labels, organization, and classification that describe the data; however, interpretation and data transformation processes that construct themes that connect, reframe, and reinterpret the data (Nowell et al., 2017) were left up to me (Braun & Clarke, 2012). The constructionist epistemology also pays attention to the meaningfulness of the data, as it is imperative for the formation of codes and themes (Byrne, 2021). A common theme occurs within the data repetitively and is noteworthy but does not necessarily indicate it is significant or meaningful to the analysis (Byrne, 2021). Throughout this process I maintained that meaning and meaningfulness were the most important criteria in coding (Braun and Clarke, 2012) and that meaning and experience were socially produced through a relational process. Also present in social construction epistemology was the assumption that there are multiple perspectives or realities and that no one single or absolute truth exists.

My use of a constructionist orientation for the thematic analysis aligned with the constructionist-influenced collaborative-dialogue that allowed for varied contexts that influence individual experiences. Social construction further supports the notion that knowledge and meaning are constructed through relationships; this study was between the student research participants and me. As a result of our close relationship, the interview data is richer and more

accurate (Toma, 2000).

The analysis revealed underlying patterns that illustrate how a specific meaning develops (Braun & Clarke, 2017; Kiger & Varpio, 2020). From a constructionist's lens, this latent approach of looking for assumptions and exploring their implications invokes deeper themes to be explored (Grandy, 2019; Kiger & Varpio, 2020). Frequently, I circled back to revisit earlier steps in the analysis, given new data or newly generated themes that deserved further investigation, as thematic analysis is an iterative process (Braun & Clarke, 2017) of refining, improving, and revising until the researcher is satisfied with the results. The thematic analysis approach comprises six steps that produce a deliberate, reflective, and thorough process of analyzing data (Kiger & Varpio, 2020). The six steps of this process are as follows: (1) becoming familiar with the data, (2) generating initial codes, (3) creating themes, (4) reviewing themes, (5) defining and naming themes, and (6) writing the report (Kiger & Varpio, 2020) (see Figure 4).

Figure 4
Six Steps of Thematic Analysis

1. Thematic Analysis: A Six-Step Schema

Becoming Familiar with the Data. As a first step in the analysis process, I carefully reviewed the entirety of the data set by listening to all of the participants' recorded interviews. After becoming altogether immersed in the recorded interviews, I began the process of transcribing each of the participant interviews verbatim. The 51 transcribed interviews produced 468 pages of handwritten data. It was with intention that I handwrote the transcriptions as a way to decelerate the process allowing me to concentrate and listen more effectively. Once the

transcriptions were completed, each interview was listened to once again while following the transcript and checking for accuracy. Next, I met individually with the student participants to check for understanding and correctness of the meaning of certain parts of their interviews. This content confirmation (member checking) was only conducted with the adolescent participants as I sought to address the accuracy of the co-constructed nature of knowledge and meaning that developed over time during the culinary sessions by inviting student participants to review and clarify the interview data and my interpretations of it. This content confirmation was not conducted with the parent or teacher participants, as their interviews were specifically about their observations. The interview transcripts were maintained in three separate categories: student, teacher, and parent participants.

Generating Initial Codes. The coding process involved organizing the data in an orderly and significant way. When considering the research questions, this process takes small sections of the raw data that are relevant or denote something interesting or meaningful (Boyatzism, 1998). The code, which provided a label for identification (Braun and Clarke, 2017) was a "researcher-generated construct" (Saldana, 2014. P 5). Open coding, where no pre-set codes were determined (also known as an inductive approach) provided a more broad and expansive analysis of the complete body of data (Kiger & Varpio, 2020). Therefore, the codes were continually developed and adjusted during the entirety of the coding process according to relevant issues raised by the data.

The open coding process was conducted manually using individual file cards that included each data segment and its location along with an initial code. With each new data segment, either an existing code was applied, if relevant, or a new code was created. This process continued throughout the entire data set (Braun & Clarke, 2017). The coding process of labeling

data segments with relevant codes and making note of any potential patterns or connections that may inform theme development (Braun and Clarke, 2006) was recorded in my coding notebook, which helped guide the continuation of the coding process by both outlining and defining the codes applied and creating a record of interpretations and analysis (Lincoln & Guba, 1985; Nowell et al. 2017).

Two additional coding committee members, trained research scientists, independently reviewed the open coding that I completed to increase intercoder reliability. The coding committee discussed the data excerpts and coding, deliberating on any discrepancies until we reached consensus. The committee then modified the existing codes, combined some related coded data into a single category, and finally, identified the connections among the coded data and grouped them into categories that resemble one another (axial coding) (Braun & Clarke, 2006).

The then entered the coded and collated data into Trello, a web-based list-making application, creating a workspace or "board" to organize and create a visual system to facilitate collaboration virtually with the coding committee. Further, the coded data was identified with labels of "student," "parent," or "teacher" to facilitate review across the entire data set and ensure that all participant groups' voices and perspectives would be included in the data examples. All coding team members reviewed, made suggestions, and proposed minor edits to the coded data once it was available in a visual format on Trello. Very little modification was made in the coding and collating. The coding was then organized into a table that included the code name, a description of the code, and example quotes from across the entire data set and whether the quote was from a student, parent, or teacher participant. (See Table 4 in the results section.)

Creating Initial Themes. A theme is a pattern of interesting or meaningful responses (Braun and Clarke, 2006, p. 82) that informs the research question. I made note of all codes of potential significance, including a miscellaneous code for data that did not seem to fit into any other category. The coding committee sorted and re-sorted the codes into potential categories by identifying, comparing, and analyzing to determine those that had a unifying feature together or had a meaningful pattern or experience in the data (Braun and Clarke 2017). Once arranged, the coding committee created themes that reflected and described the categories, and these themes were then assigned to the coded data. The relationship between these themes would work together to tell the story of the data (Braun and Clarke, 2017). The initial themes were then organized into a table that included the newly grouped code names along with sample quotes from across the entire data set. (See Table 5 in the results section.)

Reviewing Themes. The coding committee members and I reviewed the coded data placed within each theme to determine if the individual themes fit meaningfully within the data set (Braun & Clarke, 2006). Re-reading codes and themes and making revisions was an anticipated part of the analysis process, and the coding committee agreed to some changes in coding (adding additional codes to some segments of the raw data) and an adjustment of themes during this stage of the analysis. This step in the analysis was complete once all items that appeared to be relevant to the research questions were incorporated into the coding scheme, themes were reasoned, and any further adjustments were not of extensive modification (Kiger & Varpio, 2020).

At this point in the process, I then read through the entirety of the data once again to re-evaluate if the generated themes represented the entirety of the data set accurately and included the most significant and applicable sections (Braun & Clarke, 2017) in an initial thematic map

(see Figure 5 in the results section.)

Defining and Naming Themes. Ultimately, I considered and refined the specifics of the thematic map by identifying areas of overlap between themes, developing sub-themes, and delineating each theme area I focused on, along with selecting particular data excerpts that will be used in the write-up of the report. By merging similar themes and sub-themes, re-arranging the themes and sub-themes on the map to establish a process, and providing clear names, definitions, and narrative explanations of each theme and sub-theme, I generated the story the analysis tells along with its importance to the broader research questions (Braun and Clarke, 2006). Illustrating the significant characteristics of themes and creating the narratives surrounding them provides the context that explains their importance to each theme's greater story (Braun and Clarke, 2006). (See Figure 6 in the results section.)

Writing the Report. The final stage of the analysis is writing a report with the results of the findings.

2.5 Ethical Considerations

This study was approved by the medical ethics committee of the Academic Hospital of Vrije Universiteit Brussel (B.U.N. 1432020000149).

Richard De La Cuadra, Founder and Head of schools for Xavier Educational Academy; David Garner, Director of Schools at Xavier Educational Academy, have reviewed, evaluated, and approved the proposed research to take place at Xavier Educational Academy (see Appendix H).

An individual meeting with me at my office was scheduled for each potential participant and parent at a mutually convenient time. The consent form for participation in the study was reviewed, concerns were addressed, and questions were answered. Participants and their parents

were encouraged to take adequate time for discussion and consideration amongst themselves before making a commitment. Participants were minors at the start of the study, and therefore, their assent, along with their parent's consent, must be obtained to participate in the study. The final date for submission of the consent and assent form was no earlier than two weeks (14 days) from the date of the last scheduled participant meeting to provide ample time for consideration. The involvement of the teacher participants was preceded by information about the study and informed consent.

Permission will be requested to voice record each of the participants', parents', and teachers' interviews prior to conducting the interview. Participation in this study is voluntary, and a participant may stop at any time without consequence.

I was careful to maintain the confidentiality of all data and records associated with the participants in this study. All written data was numbered for identification and stored in a locked file cabinet in my business office. Recordings of interviews with study participants were also numbered for identification and stored in a locked file cabinet in my business office. A separate list that identified each participant by his or her assigned number was stored in a separate locked file cabinet in my home office. The recordings were destroyed after they were transcribed, and all transcriptions will be destroyed at the close of the research.

I do not anticipate an accident, but in the event that one occurs, emergency first aid care is available. I am trained and certified in Pediatric First Aid and Child and Adult CPR/AED (see Appendix I). An insurance policy for Commercial General Liability Insurance is also in place in the event of an accident (see Appendix J). There is minimal risk that a participant may experience psychological or social distress; nevertheless, participants will be provided with pertinent contact information for counseling services and walk-in clinics for mental health care.

A Professional Liability insurance policy is in place (see Appendix J).

Chapter 3: Results

3.1 Introduction

To answer the first overarching research question, specifically, (1) Is there evidence to support the expectation that anxious adolescents experiencing a culinary arts program from a collaborative-dialogic orientation, within a school setting has therapeutic benefits from the perspectives of the adolescents, their parents, and their teachers, and subordinate research question (a) did the adolescents experience a shift or change in their identity story? the entire transcribed interview data was thoroughly thematically analyzed (see Chapter 2), resulting in codes, themes, and thematic maps. To answer the last subordinate research question (b), did the adolescents experience an increase or decrease in their anxiety symptoms? a comparison of the results of the GAD-7 inventories was used during the adolescents' individual interviews to invite conversation about their anxiety symptoms at the start and following the culinary sessions.

3.2 Coding and Searching for Themes

The transcribed interviews were inductively analyzed and labeled by open coding, generating initial concepts from the data, which resulted in 22 initial codes. Table 4 provides an overview of these initial codes, specifying the code name, the description assigned to the code, and excerpts from the participant's interviews, including identification of whether the particular excerpt originated from a student, parent, or teacher participant (see Table 5).

Table 5
Initial Coding Across the Entire Data Set

Code Name	Description	Who?	Examples from Interviews
Traditional therapy	Therapeutic experience with traditional psychotherapist	Student	When I go to other therapists, I feel nauseous. My regular therapist asks questions the whole time; it is definitely therapy.
		Student	When I am sitting in a therapist's office, it is very scary, and I feel worse. I feel forced to talk and have answers.
		Student	There's that smell in Doctors' offices and in the kitchen, it smells really good. I don't like going to Doctors' offices. I get particularly anxious.
		Student	Doctors' offices are completely different than the kitchen; they check my height and weight.

		Student	When I am sitting in a therapist's office, it is very scary, and I feel worse. I feel forced to talk and have answers.
		Student	I prefer [culinary arts] having something else to focus on. If I have to sit still and talk, I get kind of anxious, I get pretty anxious. (S2)
		Student	I'm kind of scared to talk in those (therapists) offices.
		Parent	Traditional therapy shuts him down.
Kitchen Conversation	Culinary Sessions	Student	Here I know you and I feel comfortable talking to you because our conversations were about all kinds of things, I got to get to know you as a person.
		Student	It is baking with a side of therapy. We only talk about something if I tell you I have a problem.
		Student	I would rather talk about my anxiety while I'm baking because I won't get worked up about it.
		Student	I was able to let you in because we shared passions (cooking/baking) and humor. Those similarities made it easier to talk to someone who liked the same stuff.
		Student	We only talk about the things I think are important when it is important for me. Here, I am in charge.
		Parent	I am so happy that she connected with you -that she feels she can reach out any time and talk with you. I think that is my favorite part.
		Parent	I think conversations about his anxiety come about so organically when he is baking that he can talk about it without it getting worse.
		Parent	You are not walking into a therapist's office with the expectation of "okay, tell me how you feel." It is just a conversation; it is much more natural feeling.
		Parent	I wonder if being in the kitchen gave students more tools than what they would have in a therapy room.
		Parent	The kitchen is a neutral environment, it is an okay place to fail.
		Parent	He loves culinary therapy; it has been helpful for him.
		Parent	She felt so special. I think with you and with all the time you've spent together, it allowed her to see you as a probably, right after me, her confident.
		Parent	Online therapy was not good for her during Covid. She loved coming to bake with you.
		Teacher	The baking program is so great. I have seen it change lives, especially two freshmen.
		Teacher	The focus is shifted.
		Teacher	They wanted to be the smartest person in class, a bit of a rivalry. We were learning together (about chess) the way the student was learning with you.
Relationship	The way two or more people behave towards one another.	Student	My social anxiety has gotten better over the year, but it was really bad before starting school here. It was hard. Making cookies and sharing them helped me meet other students and make friends.
		Student	The most important thing for me was making connections and a relationship with someone supportive of you, who gets you, who loves you.
		Parent	Taking desserts to teachers was a big power shift.
		Teacher	Food is vital. Making food is important. Sharing food is a beautiful and nurturing gesture.
		Teacher	After he shared the cookies, he had made with me, it was one of the first times we could just relax and have a conversation.
		Teacher	One thing I noticed is that I have a relationship with each of the students that brought baked goods to me.
		Teacher	I saw conversations that might not have otherwise happened as a result of baking and offering samples.
Connection	A social link between people	Student	When I cooked before in school, they gave us directions, then you'd have to go to your table and work independently.

		Teacher	He used baking to overcome his social anxiety limitations and met and made more friends.
		Teacher	I loved it! And I felt special because not all of the teachers were included, so I thought they liked me or wanted to have a connection.
		Teacher	Positive interactions helped one student ask for accommodations that he needed but for months hadn't been willing to talk about.
		Teacher	A safe way for students to connect and build relationship in a different way.
Skill building	Learning and developing new skills	Student	When people ask me what I like best about myself, it is not my eyes or smile, it is that I bake really well.
		Student	Every time I come here to bake; I learn something. It is helpful and I'm always learning.
		Student	I was surprised I could do it (French chocolates) even though I almost dropped them so many times.
		Parent	Just the other day, he taught his grandma something that he learned from you in the kitchen.
		Parent	Even just the sense of accomplishment when he came home, and he brought something really pretty and everybody in the house is excited.
Social Confidence	Belief in oneself in social settings	Student	I am more than just my mental health, there is a real me. I'm not wearing a label anymore. I'm becoming myself.
		Parent	He was displaying his Culinary Arts and interacting with guests. It was almost unbelievable.
		Teacher	The presentation and how they approached me as always polite and that they are proud of what they have done.
Confidence	Self-assurance; appreciating one's own abilities	Student	I always felt like the depressed girl, and I just kept being her because I didn't have anything to replace that with. I was only focused on the bad parts of me.
		Student	When I started baking and having normal conversations in the kitchen, I realized there was so much more to me.
		Student	The baking has helped me a lot. My communication skills have improved and I'm much more confident in them.
		Parent	She feels much safer in her world right now because of her experience, the whole experience of baking and therapy and sharing with others.
		Parent	He is far more open about new experiences – he looks forward to them.
		Teacher	Can make mistakes, start over, and achieve success and then capitalize on that success.
		Teacher	He is not afraid to be vulnerable with his feelings and thoughts.
		Teacher	He became more comfortable and confident that he could do the work and would be more social in class and then finish his work in the evenings at home.
		Teacher	One student's anxiety would get in his way and the irrational thoughts about his inability to do well in school kept him from being successful academically. Once his confidence grew, the irrational thoughts were replaced with rational thoughts that came from his self-confidence and belief that he can do things well, like
Identity	Characteristics that determine who or what a person is	Student	I loved when you told me, "You are the perfect version of you."
		Student	I think you have noticed, but I'm more me. I'm more comfortable in my own skin.
		Parent	I could see the shift in him when he came home.
		Parent	Opinion of himself, changed.
		Teacher	You are what you do, not what you say you do.
		Teacher	So many of them struggle with "who" they are.
		Teacher	Completely transformed one student in the classroom.
		Teacher	He made the most intense shift this year and baking was an integral part of this.
		Teacher	His transition this semester has been really wild for me to watch. This was a

			defining moment.
		Teacher	They were becoming happier overall. They were always serious with some sense of uncertainty. They became more comfortable in their own body as they baked.
		Teacher	We need to continue to expand these “fun” tings to capitalize on the success students have.
Self-esteem	Emergent Identities	Student	I feel proud of myself when I bake.
		Parent	After he learned to make chocolates, he was able to own it, he was so proud of himself. Perception of self, changed.
		Parent	She’s upbeat and happy after baking.
		Teacher	All of them were so proud of what they had made. A will now just ask questions in class when he doesn’t know or understand. There was a dramatic shift in his self-esteem.
		Teacher	Saw academic change and socially also.
		Teacher	Baking really helped their self-esteem. They did something really well and building that self-esteem made it easier to talk to me. It was like they saw themselves differently.
		Teacher	I remember one time walking down the hallway when I passed them carrying a cake they had made, and they had a big smile on their face. To be honest, that was the first time I had ever seen them smile.
Community	A group of people with shared attributes and a sense of belonging	Student	The first time I baked I made cookies and met 3 people at school by sharing them. I then had someone to eat lunch with instead of eating all alone.
		Student	It was a way to socialize.
		Student	I am easily able to share with people who share back with me. It was nice.
		Student	It’s nice to put time into something and then let others experience it and watch the expression on their face when they taste it.
		Student	I love sharing what I make with others. I share the love!
		Parent	He knows people humor him a lot of times with the facts he shares, but baking was different, people were genuinely interested.
		Parent	His sisters get home and run to the refrigerator to see what he made.
		Teacher	Most of them were very professional about sharing their baked goods. They brought them in and created an experience rather than just saying, “Here’s a cupcake.”
		Teacher	Teacher and staff are very supportive of culinary therapy.
		Teacher	When you send the extra baked goods to the lower grades (3-8) you are sending joy.
Safe Space	A place where a person feels safe from any physical or emotional harm	Student	I had PTSD and it was not treated when I was in foster homes. When I came to live with my adoptive parents, my mom would bake with me, and I really liked it. I knew it was something comforting and healing for me.
		Parent	He had someone else to share the blame if something didn’t work out, so it wasn’t as risky.
		Teacher	A lot of them came to class after baking and were just happier.
		Teacher	Baking has become a safe space for students.
Calming/Grounding	Not feeling nervousness or other strong emotions	Student	5-4-3-2-1 Grounding technique. 5 things you can see / 4 things you can feel / 3 things you can hear / 2 things you can smell / 1 thing you can taste. I found this online after a panic attack and it helps me to stay grounded.
		Parent	She feels grounded and secure and more comfortable talking about the deep things while baking.
		Teacher	Severe anxiety in class, would go bake and come back feeling better. It calmed her.
Flexible & Spontaneous	Ready and able to change or adapt to different situations and circumstances in an open, natural manner	Teacher	That was a great way to connect that experience – the failed then successful cookie – to real life situations. That what was really neat about it

Increase or Decrease in Anxiety	Feeling worried, nervous, or uneasy about something with an uncertain outcome	Student	I definitely felt less anxious after baking on the days when I did it.
		Student	When I am stressed out, it would help me to feel better to bake. I need to remember that I can bake.
		Student	My mom even noticed when I get in the car after baking that I was less anxious than usual. She said, "You're a lot less anxious right now."
		Student	Anxiety is lower in here (kitchen); it is fun. It stays that way for a while after.
		Parent	Some days he says he is anxious but doesn't know why.
		Student	Usually, I become immobilized when my anxiety is bad.
		Parent	He has generalized anxiety disorder and sometimes it is situational and he'll perverserate on a particular thought.
		Parent	Somewhat of an unpredictableness about anxiety and when it shows up.
		Teacher	He is a bundle of nerves. He talks a lot about perfectionism.
		Teacher	Nearly all of our students have discussed having anxiety or struggling with anxiety.
Baking lab	A dedicated private, sound proofed kitchen for therapy or research	Student	I think brioche was the favorite thing I made.
		Student	My favorite things to make were cheesecake, chocolate cake, and donuts.
		Student	Favorite item to make was French Chocolates.
		Student	May favorite thing to make was the hand molded white chocolate roses for my brother's wedding cake.
		Student	Soft, hot pretzels were my favorite. It was fun to shape them, and they tasted so good.
		Student	I think brioche was my favorite thing that I made.
		Student	White chocolate macadamia cookies were my favorite.
		Student	I really liked the Scarlett Empress and the one with the strawberry cloud cream.
		Teacher	My favorite item was the creative cookies that were made using all of my favorite ingredients.
		Teacher	The Scarlett Empress was unbelievable! But that lemon bar was a close second.
		Teacher	I told him that I am a chocolate chip cookie connoisseur and I always compare them to my favorite, so we would see if he can make the standard or not. His chocolate chip cookie was as good as my favorite.
		Teacher	A student brought me the best lemon bar I have ever had. She seemed really happy with that.
Anticipation & Disappointment	An expectation or prediction & feeling of sadness because expectation did not come to fruition.	Student	It is something to look forward to during the school day and helped me get to school.
		Student	Baking is helpful for me because when I'm depressed it motivates me to get out of bed. I want to get up and bake.
		Parent	For him, the anticipation was very positive.
		Parent	She doesn't complain if her regular therapist cancels but gets really upset if she can't go bake.
		Parent	She lit up when she got to bake with you, and she was so excited to share her creation.
		Teacher	She would always refuse my offers to create art, so I was surprised when I saw how exited she was to be baking.
		Teacher	There is talk around school about baking.
		Teacher	Those that were going to bake after my class were exited and looking forward to it.
Collaborative Dialogue	A meaning-making process with language as the medium – a particular type of conversation that is a generative pathway to possibilities	Student	The openness, the fact that I could talk to you, and you would talk about things, and I didn't feel like it was a one-way street where I was being asked a lot of personal questions.
		Student	Conversation with you can create new ideas and new thoughts while creating something physical as well.
		Student	We did a lot of talking and singing today and I had milk in my tea the way

			you like to drink tea. I like it quite a lot.
		Student	When I am baking, and we are talking it just feels like regular conversation. It just comes out. I don't cry or anything. I don't feel triggered. It is more comfortable.
		Teacher	When we are doing things we love, they happen so naturally. We feel it and our students do too.
		Teacher	One thing I noticed was hearing you laugh and having fun. I could hear laughter and joy happening in the kitchen.
		Parent	I love to see that curiosity and wonder and the ease with which they share with you, that which is so private.
		Teacher	She was unable to come to school during Covid but was allowed to come to school to bake once a week with you. You reciprocated by h ow much you went out of your way for her. Your mirrored her same level of commitment.
Risk Taking	Willing to take action that may result in failure	Student	Being successful in the kitchen helps me to try other new things.
		Student	Baking made it a safe place to fail and not feel overwhelmed.
		Parent	Safer than the specter of school.
		Parent	He wasn't able to ask for help. Prior to culinary therapy, he would not ask for help, he would suffer in silence.
		Teacher	Baking is a calculated risk, but safe, and builds confidence and self-esteem.
		Teacher	Baking doesn't have rights and wrongs; it is not a test.
		Teacher	He pushed himself to make things that didn't work for him at home, like croissants.
Academic performance	The measurement of a student's achievements across academic subjects	Student	Every time I come here to bake; I learn something. It is helpful, I am always learning.
		Parent	It is nice to recognize a student's success baking and put them on a pedestal for a second and applaud them. It is an easy way to get some work out of them.
		Teacher	She was once a nervous chatterer who was fearful to write without constant support, was now writing papers on her own.
		Teacher	Them bringing us baked goods gave us a way to encourage the relationship and they produced more and better-quality work.
		Teacher	Teachers support culinary therapy – it makes academic time more effective.
		Teacher	Shift began in February; he began coming to class and asking about assignments instead of avoiding.
		Teacher	Actually, I asked a student that was avoiding me if he would bring me something he baked and he did. I told him it was really good and from that point on he started coming to class more often.
Impact on trajectory	To have a strong effect on a student's current developmental path	Student	I really want to have my own baking business.
		Parent	He taught his grandmother something that you taught him the other day. It was fun to see the tables turned.
		Teacher	After 2-3 months of baking, his confidence really improved, and his grade went up an entire letter grade. He also became more autonomous.
		Teacher	Beginning of second semester, I noticed a shift in all of them, consistently and across the board.
		Teacher	The baking program is so great. I have seen it change lives, especially with two freshmen.
		Teacher	He wasn't able to ask for help. Prior to culinary therapy, he would not ask for help he would suffer in silence.
Learning Through Critique	Evaluating, deconstructing. and making sense of dominant discourses and truths.	Student	Finding the humor and absurdity in things and laughing about it instead of worrying.
		Student	The most helpful thing was your positive attitude, and we just have fun.
		Student	I've always been naturally funny. I like that we laugh a lot.
		Student	The most helpful thing is your positive attitude and your funny attitude, and we just have fun.

		Student	Your sense of humor is very helpful to me. It is very important; I appreciate it.
		Student	That is the space where I am the most able to sort of laugh things off that made me most uncomfortable or the things that worry me.
		Student	This is a pretty safe space and I like that you use humor.
		Parent	He enjoys the freedom that he can laugh at himself now. I think your sense of humor helped lighten his burden.
		Teacher	One thing I noticed was hearing you laugh and having fun. I could hear laughter and joy happening in the kitchen.
Orphan Data	Data of various types	Student	I have anxiety medicine, but I don't like to take it.
		Parent	A bit of surprise when baking.
		Parent	Kids baking is work study.

These initial codes were then categorized into *15 initial themes* based on comparing and linking codes into patterns of meaning. Table 5 shows these initial themes, specifying the name of each theme, the code names that were re-sorted into the categories of the themes, and again included interview excerpts specifying which participant type had commented (see Table 6).

Table 6
Initial Themes

Theme	Code Names	Who?	Examples from Interviews
Therapeutic Orientation	Traditional Therapy	Student	When I go to other therapists, I feel nauseous. My regular therapist asks questions the whole time; it is definitely therapy.
		Student	When I am sitting in a therapist's office, it is very scary, and I feel worse. I feel forced to talk and have answers.
		Student	There's that smell in Drs offices and in the kitchen, it smells really good.
		Student	I don't like going to Drs offices. I get particularly anxious.
		Student	Drs offices are completely different than the kitchen; they check my height and weight.
		Student	When I am sitting in a therapist's office, it is very scary, and I feel worse. I feel forced to talk and have answers.
		Student	I prefer [culinary arts], having something to do, something else to focus on. If I have to sit still and talk, I get kind of anxious: I get pretty anxious.
		Student	I'm kind of scared to talk in those (therapists) offices.
		Parent	Traditional therapy shuts him down.
	Kitchen Conversations	Student	Here I know you and I feel comfortable talking to you because our conversations were about all kinds of things, I got to get to know you as a person.
		Student	It is baking with a side of therapy. We only talk about something if I tell you I have a problem.
		Student	I would rather talk about my anxiety while I'm baking because I won't get worked up about it.
		Student	I was able to let you in because we shared passions (cooking/baking) and humor. Those similarities made it easier to talk to someone who liked the same stuff.
		Student	We only talk about the things I think are important when it is important for me. Here, I am in charge.

		Parent	I am so happy that she connected with you -that she feels she can reach out any time and talk with you. I think that is my favorite part.
		Parent	I think conversations about his anxiety come about so organically when he is baking that he can talk about it without it getting worse.
		Parent	You are not walking into a therapist's office with the expectation of "okay, tell me how you feel." It is just a conversation; it is much more natural feeling.
		Parent	I wonder if being in the kitchen gave students more tools than what they would have in a therapy room.
		Parent	The kitchen is a neutral environment, it is an okay place to fail.
		Parent	He loves culinary therapy; it has been helpful for him.
		Parent	She felt so special. I think with you and with all the time you've spent together, it allowed her to see you as a probably, right after me, her confident.
		Parent	Online therapy was not good for her during Covid. She loved coming to bake with you.
		Teacher	The baking program is so great. I have seen it change lives, especially two freshmen.
		Teacher	The focus is shifted.
		Teacher	They wanted to be the smartest person in class, a bit of a rivalry.
		Teacher	We were learning together (about chess) the way the student was learning with you
Relationship Engagement	Relationships	Student	My social anxiety has gotten better over the year, but it was really bad before starting school here. It was hard. Making cookies and sharing them helped me meet other students and make friends.
		Student	The most important thing for me was making connections and a relationship with someone supportive of you, who gets you, who loves you.
		Parent	Taking desserts to teachers was a big power shift.
		Parent	Food is vital. Making food is important. Sharing food is a beautiful and nurturing gesture.
		Teacher	After A shared the cookies, he had made with me, it was one of the first times we could just relax and have a conversation.
		Teacher	One thing I noticed is that I have a relationship with each of the students that brought baked goods to me.
		Teacher	I saw conversations that might not have otherwise happened as a result of baking and offering samples.
	Connections	Student	When I cooked before in school, they gave us directions, then you'd have to go to your table and work independently.
		Teacher	He used baking to overcome his social anxiety limitations and met and made more friends.
		Teacher	I loved it! And I felt special because not all of the teachers were included, so I thought they liked me or wanted to have a connection.
		Teacher	Positive interactions helped one student ask for accommodations that he needed but for months hadn't been willing to talk about.
		Parent	A safe way for students to connect and build relationship in a different way.
Efficacy in Action	Skill building	Student	When people ask me what I like best about myself, it is not my eyes or smile, it is that I bake really well.
		Student	I was surprised I could do it (French chocolates) even though I almost dropped them so many times.

		Parent	Just the other day, he taught his grandma something that he learned from you in the kitchen.
		Parent	Even just the sense of accomplishment when he came home, and he brought something really pretty and everybody in the house is excited.
	Social Confidence	Student	I am more than just my mental health, there is a real me. I'm not wearing a label anymore. I'm becoming myself.
		Parent	He was displaying his Culinary Arts and interacting with guests. It was almost unbelievable.
		Teacher	The presentation and how they approached me as always polite and that they are proud of what they have done.
Identity Enhancement	Confidence	Student	I always felt like the depressed girl, and I just kept being her because I didn't have anything to replace that with. I was only focused on the bad parts of me. When I started baking and having normal conversations in the kitchen, I realized there was so much more to me.
		Student	The baking has helped me a lot. My communication skills have improved and I'm much more confident in them.
		Parent	She feels much safer in her world right now because of her experience, the whole experience of baking and therapy and sharing with others.
		Parent	He is far more open about new experiences – he looks forward to them.
		Teacher	Can make mistakes, start over, and achieve success and then capitalize on that success.
		Teacher	He is not afraid to be vulnerable with his feelings and thoughts.
		Teacher	He became more comfortable and confident that he could do the work and would be more social in class and then finish his work in the evenings at home.
		Teacher	One student's anxiety would get in his way and the irrational thoughts about his inability to do well in school kept him from being successful academically. Once his confidence grew, the irrational thoughts were replaced with rational thoughts that came from his self-confidence and belief that he can do things well, like bake.
	Identity	Student	I loved when you told me, "You are the perfect version of you."
		Student	I think you have noticed, but I'm more me. I'm more comfortable in my own skin.
		Student	I could see the shift in him when he came home.
		Parent	Opinion of himself, changed.
		Parent	You are what you do, not what you say you do.
		Teacher	So many of them struggle with "who" they are.
		Teacher	Completely transformed one student in the classroom.
		Teacher	He made the most intense shift this year and baking was an integral part of this.
		Teacher	A's transition this semester has been really wild for me to watch.
		Teacher	This was a defining moment.
		Teacher	They were becoming happier overall. They were always serious with some sense of uncertainty. They became more comfortable in their own body as they baked.
		Parent	We need to continue to expand these "fun" tings to capitalize on the success students have.
	Self-esteem	Student	I feel proud of myself when I bake.
	(Emergent Identities)	Parent	After he learned to make chocolates, he was able to own it, he was

			so proud of himself. Perception of self, changed.
		Teacher	She's upbeat and happy after baking.
		Teacher	All of them were so proud of what they had made. A will now just ask questions in class when he doesn't know or understand. There was a dramatic shift in his self-esteem.
		Teacher	Saw academic change and socially also.
		Teacher	Baking really helped their self-esteem. They did something really well and building that self-esteem made it easier to talk to me. It was like they saw themselves differently.
		Teacher	I remember one time walking down the hallway when I passed them carrying a cake they had made, and they had a big smile on their face. To be honest, that was the first time I had ever seen them smile.
Connectivity	Community	Student	The first time I baked I made cookies and met 3 people at school by sharing them. I then had someone to eat lunch with instead of eating all alone.
		Student	It was a way to socialize.
		Student	I am easily able to share with people who share back with me. It was nice.
		Student	It's nice to put time into something and then let others experience it and watch the expression on their face when they taste it.
		Student	I love sharing what I make with others. I share the love!
		Parent	He knows people humor him a lot of times with the facts he shares, but baking was different, people were genuinely interested.
		Parent	His sisters get home and run to the refrigerator to see what he made.
		Teacher	Most of them were very professional about sharing their baked goods. They brought them in and created an experience rather than just saying, "Here's a cupcake."
		Teacher	Teacher and staff are very supportive of culinary therapy.
		Teacher	When you send the extra baked goods to the lower grades (3-8) you are sending joy.
Ability to Improvise	Creating Space	Student	I had PTSD and it was not treated when I was in foster homes.
		Student	When I came to live with my adoptive parents, my mom would bake with me, and I really liked it. I knew it was something comforting and healing for me.
		Parent	He had someone else to share the blame if something didn't work out, so it wasn't as risky.
		Teacher	A lot of them came to class after baking and were just happier.
		Teacher	Baking has become a safe space for students.
	Calming/Grounding	Student	5-4-3-2-1 Grounding technique. 5 things you can see / 4 things you can feel / 3 things you can hear / 2 things you can smell / 1 thing you can taste. I found this online after a panic attack and it helps me to stay grounded.
		Parent	She feels grounded and secure and more comfortable talking about the deep things while baking.
		Teacher	Severe anxiety in class, would go bake and come back feeling better. It calmed her.
	Flexibility/ Spontaneity	Teacher	That was a great way to connect that experience – the failed then successful cookie – to real life situations. That what was really neat about it.
Level of Anxiety	Increase or Decrease	Student	I definitely felt less anxious after baking on the days when I did it.
		Student	When I am stressed out, it would help me to feel better to bake. I need to remember that I can bake.

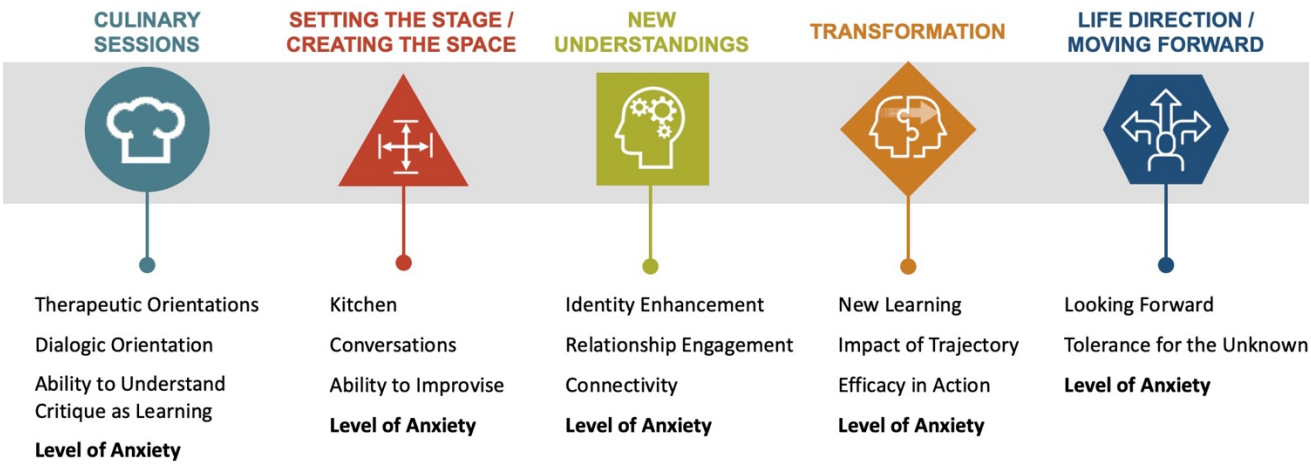
		Student	My mom even noticed when I get in the car after baking that I was less anxious than usual. She said, “You’re a lot less anxious right now.”
		Student	Anxiety is lower in here (kitchen); it is fun. It stays that way for a while after.
	Anxiety	Parent	Some days he says he is anxious but doesn’t know why.
		Parent	He has generalized anxiety disorder and sometimes it is situational and he’ll perverserating on a particular thought.
		Parent	Somewhat of an unpredictableness about anxiety and when it shows up.
		Teacher	He is a bundle of nerves. He talks a lot about perfectionism.
		Teacher	Nearly all of our students have discussed having anxiety or struggling with anxiety.
Culinary Arts	Baking Lab	Student	I think brioche was the favorite thing I made.
		Student	My favorite things to make were cheesecake, chocolate cake, and donuts.
		Student	Favorite item to make was French Chocolates.
		Student	May favorite thing to make was the hand molded white chocolate roses for my brother’s wedding cake.
		Student	Soft, hot pretzels were my favorite. It was fun to shape them, and they tasted so good.
		Student	I think brioche was my favorite thing that I made.
		Student	White chocolate macadamia cookies were my favorite.
		Student	I really liked the Scarlett Empress and the one with the strawberry cloud cream.
		Teacher	My favorite item was the creative cookies that were made using all of my favorite ingredients.
		Teacher	The Scarlett Empress was unbelievable! But that lemon bar was a close second.
		Teacher	I told him that I am a chocolate chip cookie connoisseur and I always compare them to my favorite, so we would see if he can make the standard or not. His chocolate chip cookie was as good as my favorite.
		Teacher	A student brought me the best lemon bar I have ever had. She seemed really happy with that.
Looking Forward	Anticipation & Disappointment	Student	It is something to look forward to during the school day and helped me get to school.
		Student	For him, the anticipation was very positive.
		Student	Baking is helpful for me because when I’m depressed it motivates me to get out of bed. I want to get up and bake.
		Parent	She doesn’t complain if her regular therapist cancels but gets really upset if she can’t go bake.
		Parent	She lit up when she got to bake with you, and she was so excited to share her creation.
		Teacher	She would always refuse my offers to create art, so I was surprised when I saw how exited she was to be baking.
		Teacher	There is talk around school about baking. It is something others are looking forward to.
		Teacher	Those that were going to bake after my class were exited and looking forward to it. So, I think it really helped them to be grounded.
Dialogic Orientation	Collaborative Dialogue	Student	The openness, the fact that I could talk to you, and you would talk about things, and I didn’t feel like it was a one-way street where I was being asked a lot of personal questions.

		Student	Conversation with you can create new ideas and new thoughts while creating something physical as well.
		Student	We did a lot of talking and singing today and I had milk in my tea the way you like to drink tea. I like it quite a lot.
		Student	When I am baking, and we are talking it just feels like regular conversation. It just comes out. I don't cry or anything. I don't feel triggered. It is more comfortable.
		Teacher	When we are doing things we love, they happen so naturally. We feel it and our students do too.
		Teacher	One thing I noticed was hearing you laugh and having fun. I could hear laughter and joy happening in the kitchen.
		Parent	I love to see that curiosity and wonder and the ease with which they share with you, that which is so private.
		Parent	She was unable to come to school during Covid but was allowed to come to school to bake once a week with you. You reciprocated by how much you went out of your way for her. Your mirrored her same level of commitment.
Tolerance for the Unknown	Risk Taking	Student	Being successful in the kitchen helps me to try other new things.
		Student	Baking made it a safe place to fail and not feel overwhelmed.
		Parent	Safer than the specter of school.
		Parent	He wasn't able to ask for help. Prior to culinary therapy, he would not ask for help, he would suffer in silence.
		Teacher	Baking is a calculated risk, but safe, and builds confidence and self-esteem.
		Teacher	Baking doesn't have rights and wrongs; it is not a test.
		Teacher	He pushed himself to make things that didn't work for him at home, like croissants.
New Learning	Academic Performance	Student	Every time I come here to bake; I learn something. It is helpful, I am always learning.
		Parent	It is nice to recognize a student's success baking and pput them on a pedestal for a second and applaud them. It is an easy way to get some work out of them.
		Teacher	She was once a nervous chatterer who was fearful to write without constant support, was now writing papers on her own.
		Teacher	Them bringing us baked goods gave us a way to encourage the relationship and they produced more and better-quality work.
		Teacher	Teachers support culinary therapy – it makes academic time more effective.
		Teacher	Shift began in February; he began coming to class and asking about assignments instead of avoiding.
		Teacher	Actually, I asked a student that was avoiding me if he would bring me something he baked and he did. I told him it was really good and from that point on he started coming to class more often.
Impact on Trajectory	Impact on Trajectory	Student	I really want to have my own baking business.
		Student	He wasn't able to ask for help. Prior to culinary therapy, he would not ask for help, he would suffer in silence.
		Parent	He taught his grandmother something that you taught him the other day. It was fun to see the tables turned.
		Teacher	After 2-3 months of baking, his confidence really improved, and his grade went up an entire letter grade. He also became more autonomous.
		Teacher	Beginning of second semester, I noticed a shift in all of them, consistently and across the board.
		Teacher	The baking program is so great. I have seen it change lives,

			especially with two freshmen.
Humor / Critique as Learning	Humor	Student	Finding the humor and absurdity in things and laughing about it instead of worrying.
		Student	The most helpful thing was your positive attitude, and we just have fun.
		Student	I've always been naturally funny. I like that we laugh a lot.
		Student	The most helpful thing is your positive attitude and your funny attitude, and we just have fun.
		Student	Your sense of humor is very helpful to me. It is very important; I appreciate it.
		Student	That is the space where I am the most able to sort of laugh things off that made me most uncomfortable or the things that worry me.
		Student	This is a pretty safe space and I like that you use humor.
		Parent	He enjoys the freedom that he can laugh at himself now. I think your sense of humor helped lighten his burden.
		Teacher	One thing I noticed was hearing you laugh and having fun. I could hear laughter and joy happening in the kitchen.
Miscellaneous	Orphan Data	Student	I have anxiety medicine, but I don't like to take it.
		Parent	A bit of surprise when baking.
		Parent	Kids baking is work study.

Next, I re-evaluated if the constructed themes represented the entirety of the data set accurately and included the most significant and applicable sections in an initial thematic map (see Figure 5).

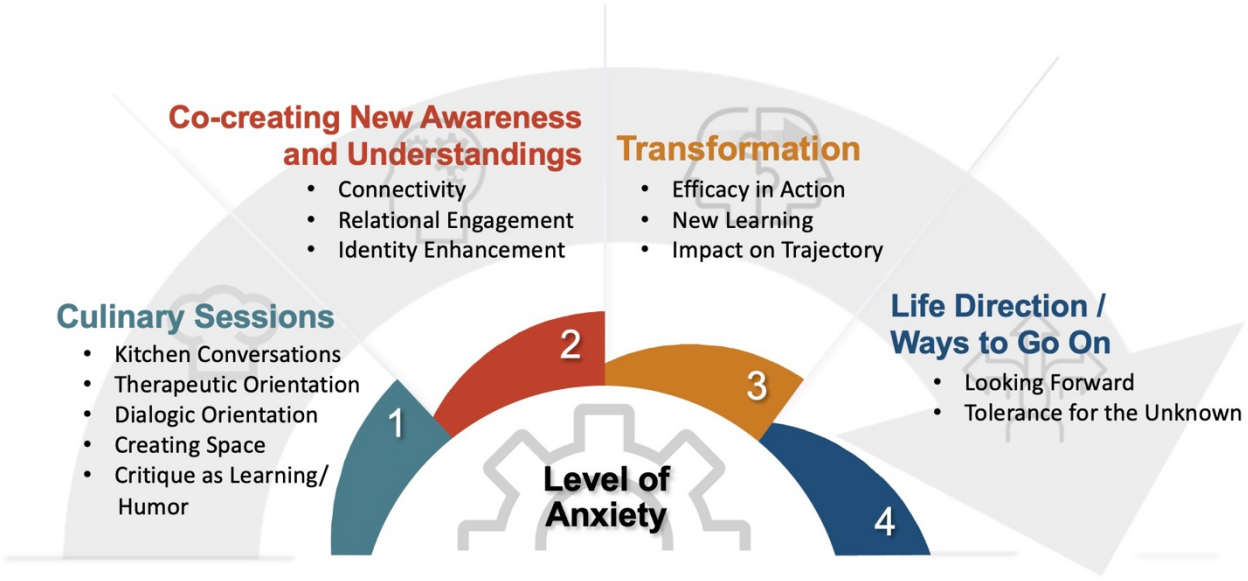
Figure 5
Initial Thematic Map



Ultimately, after refining the previous thematic map, a process of merging common themes and removing those that lack sufficient supportive data, four distinct, major themes with clear names providing definitions and narrative explanations were believed to appropriately categorize the

study findings: (1) culinary sessions, (2) co-creating new awareness and understandings, (3) transformation, and (4) life direction: ways to go on. A conceptual model was made based on these major themes (see Figure 6) with a final thematic map narrative. The subsequent sections describe the narratives around these major themes in more detail (see Figure 6).

Figure 6
Final Thematic Map



1. Final Thematic Map Narrative

The refinement of the initial thematic map included merging the sub-theme, kitchen conversations with sub-themes: therapeutic orientation, dialogic orientation, creating space, and the ability to understand critique as learning all under the major theme of Culinary Sessions as these were all aspects of what occurred or shaped the culinary sessions. The initial theme, Setting the Stage/Creating the Space, was changed to the sub-theme entitled, creating space (for a particular kind of conversation) as it is a dialogic component of culinary sessions, and the sub-theme, ability to improvise, was merged with the aforementioned, creating space, sub-theme. The sub-theme level of anxiety was removed from all themes as it was determined that the

responses regarding anxiety were accounted for within the included sub-themes. Anxiety was then placed centrally in the final map to indicate that it is affected by and affects all of the categories. The theme, New Understandings, was updated to Co-Creating New Awareness and Understanding as it was determined to encapsulate the sub-themes: relational engagement, identity enhancement, and connectivity more completely. Adding co-creating denotes that it was a relational process. No additional changes were made to the theme Transformation with sub-themes: impact on trajectory, efficacy in action, and new learning. The final theme was changed from Life Direction/Moving Forward to Life Direction/Ways to Go On as it illustrates more clearly the continual and fluid unfolding process of knowledge and the adolescents' ability to tolerate the unknown through newly developed resiliency.

The final thematic map also indicates a pattern of movement from theme to theme, with sub-themes creating the connections or influences that connect or lead a student's growth to the next theme. However, although indicative of a sequence of occurrences that often transpired as indicated, the experiences and moments of co-created meaning and knowledge were multi-directional and not necessarily accomplished in any specific order or regimented way.

3.3 Culinary Sessions

Within the theme of culinary sessions, five sub-themes were identified while considering the data: 1) kitchen conversations, 2) therapeutic orientation, 3) dialogic orientation, 4) creating space, and 5) critique as learning/humor.

The analysis confirmed that study participants indicated culinary sessions were more helpful than traditional therapy. The dialogic approach used in these culinary sessions was highly appreciated, leading to more feelings of comfort, calmness, ease of conversation, and being in charge among the student participants. Finally, critique as learning and humor that could be

present during the culinary therapy sessions enabled student participants to discover their own beliefs, perspectives, and reality in a way that was not intimidating or aggressive but instead was derived from a place of curiosity.

1. Therapeutic Orientation -- Traditional Therapy vs Culinary Sessions

The students' previous experiences with traditional therapy were not expressed as positive or as helpful concerning reducing their anxiety symptoms. Most of the student participants experienced an increase in anxiety symptoms when traveling to, waiting for, or attending traditional therapeutic sessions, subsequently exacerbating the very condition for which they were seeking help. The student participants sensed they were being examined, forced to sit still, answer questions, and talk in a certain way about anxiety. In their own words:

> *"When I am sitting in a therapist's office it is very scary and I feel worse. I feel forced to talk and have answers."* (S1)
>
> *"I prefer [culinary arts], having something to do, something else to focus on. If I have to sit still and talk, I get kind of anxious; I get pretty anxious."* (S2)

Moreover, they were negatively impacted by a perceived lack of privacy with others overhearing their conversations from outside the therapy room.

> *"The therapist's office feels like the walls are thin and closing in on me. It feels like everyone is listening in."* (S14)
>
> *"In the kitchen, there is so much stuff and noise that it feels comfortable. I can hear my own voice and I don't have to worry about someone listening through the door and walls."* (S15)

These outcomes were confirmed by the parent participants, including one who simply stated:

> *"Traditional therapy [in a therapy office] shuts him down."* (P3)

For two students, the stress of traditional therapy resulted in their lack of engagement and participation in the therapy session. Methods of avoidance used by these students were made-up stories and silence, which confirmed their incapacity to participate in the process as they explain:

> *"I have deep, dark thoughts all the time. I know what I deal with, and I don't openly share this [with a therapist]. I would make up stories to make them think I was being personal with them, but in reality, I don't let people in very much."* (S3)

> *"At the Drs. Office, I feel pressure to answer so I would have my mom talk for me because I didn't know them, so I wasn't expressing myself. In the kitchen my mom's not here and I am comfortable, and I talk for myself."* (S1)

Due to their negative opinions and anxiety-provoking experiences related to traditional therapy, fifteen of the seventeen student participants stopped attending traditional therapy entirely, and all of those student participants indicated that their anxiety symptoms were either at the same level or had increased in intensity from when they began traditional therapy.

2. Dialogic Orientation

At the heart of the culinary sessions was collaborative-dialogic practice; a particular way of communicating and being with another. The guiding assumptions of this philosophical stance were important to the student participants, most particularly, the shared inquiry of a two-way exchange where the student and I are equitable partners. This invitation for polyvocality challenged the hierarchical and expert role of traditional therapeutic modalities and invited a particular kind of relational process. This different way of thinking and responding to each other is oriented towards an ordinary, everyday conversation.

> *"When I am baking and we are talking, it just feels like regular conversation. It just comes out. I don't cry or anything. I don't feel triggered. It is more comfortable.* (S7)

"The most important thing for me was…making connections and relationships with someone supportive of you, who gets you, who loves you." (S1)

"Here, I know you and I feel comfortable talking to you, because our conversations were about all kinds of things; I got to get to know you as a person." (S3)

Equally as significant in collaborative dialogue is the belief that the student participant is the expert in their own life and brings their own ideas, knowledge, and resourcefulness to the conversation. As a way of setting the stage for this different kind of conversation, the I did not intervene in a specific area of a student's life or use certain therapeutic techniques, but rather remained focused on keeping the conversation flowing in a shared action. In this way, there was mutual inquiry, where genuine curiosity replaced any pre-knowing or assumptions. The student participant was free to share whatever they felt was important for the therapist to know, and I met them in the way they wanted to be known, for the very first time. This was powerful for the student participants as it allowed them to feel comfortable and have a sense of control as represented in the following interview excerpts:

"In the kitchen, I don't have to talk about anything unless I want to. But mostly, I am just more comfortable." (S11)

"We only talk about the things I think are important when it is important for me. Here, I am in charge." (S8)

"[Culinary sessions] feels different, less stressful, absence of pressure. Here, I am in charge of what we talk about." (S7)

The parent participants confirmed that their children had experienced a sense of comfort and agency in culinary sessions, adding that the organic and natural feeling of the conversations allowed for a different kind of dialogue.

"I think conversations about his anxiety come about so organically when he is baking that he can talk about it without it getting worse." (P16)

"They are not walking into a therapist's office with the expectation of 'okay, tell me how you feel.' [In the kitchen] it is just a conversation; it is a more natural feeling." (P17)

3. Creating Space, For a Particular Kind of Conversation

In this study, I communicated to the adolescents that they are valued, have knowledge and expertise, what they have to say is important, and are equals in the relationship. My way of positioning myself and my connection with the student participants built trust, safety, and a sense of calm that allowed them to feel comfortable and relaxed. The absence of nervousness or other strong emotions during their culinary therapy sessions allowed for the feeling of being grounded or settled. It was here, from within the student participant's feelings of calm and being grounded coupled with the my positioning or way of being, that a metaphorical space was created for a particular kind of conversation. This metaphorical space existed between the student participant and me and allowed each of us to bring our own expertise, thoughts, and curiosities into a conversation that was mindful of our individual sensitivities. Hence, it is here that possibility-generating conversations transpired, and new understandings and meanings were constructed.

The connection between student participants and me, where trust and safety are significant and student participants feel calm and relaxed, establishes an important, observable, early positive outcome and steps within the process.

"In the kitchen, I realize that I can easily do the 5-4-3-2-1 grounding technique. I found this online after I had an anxiety attack to help [me] stay calm. It is how I ground myself and I think it helps me with my mental health. Find 5 things you can see, 4 things you can feel, 3 things you can hear, 2 things you can smell, and 1 thing you can taste." (S7)

"…time to have a break at school and bake 'cause it is relaxing." (S4)

"I leave relaxed." (S8)

Teacher participants had a unique perspective as they observed the student participants in the natural setting of a school throughout the culinary sessions. They witnessed changes, in students becoming more grounded and relaxed, both immediate and those occurring over time. This was noticed as students were happier, more positive, and more confident when facing challenges. Other observations included the kitchen as a safe place and one of comfort for student participants and that overall, student participants were better-off after baking. From the teacher participants' perspectives:

"Baking has become a safe space for students." (T5)

"I noticed that the students that baked seemed more grounded and relaxed." (T3)

"A lot of them came to class after baking and were just happier." (T8)

"Baking gave students a break from the things that are challenging to comfort themselves and then come back and face the challenge more confident." (T4)

Parent participants echoed the sentiment that their children felt grounded, secure, and calm, during their culinary sessions.

"She was so much calmer and more grounded after baking." (P11)

"She came away feeling loved and grounded. It was enough to carry her through." (P1)

However, it was also clear from the data that from within the safety of the culinary partnership or relationship, that student participants struggling with anxiety were able to respond to different situations and circumstances in a more open and natural manner.

More specifically, the student participants risked sharing with me their most personal inner thoughts and feelings that emerged as fragments of narratives that freely wove their way into an

ordinary, everyday conversation.

> *"She feels grounded and secure and more comfortable talking about the deep things while baking."* (P1)
>
> *"I've never really let someone so far in, but you are the exception because we've gotten pretty deep in our conversations. I let you in…more than I have let anyone. I've experienced too much being taken advantage of by letting people in. [I] just don't want to do it."* (S3)

4. Critique as Learning/Humor

I was light-hearted with the student participants, often looking with them for the comicalness within even the most difficult situation or problem, including a recipe gone very wrong. Being curious about and deconstructing a truth or situation together, the student participant and I often times reduced that truth or situation to its most absurd level, and then laughed together as they discovered that, from a different perspective, or perspectives, it wasn't a truth or a problem at all, and new knowledge was created and meaning was made. These interactions, evaluating and critiquing together an imposed belief, label, or value system, determining its meaning and relevance, along with the ability to have fun together, supported the student participants' social and emotional learning and encouraged them to not take things, or themselves, quite so seriously. The importance for the student participants to be able to laugh, to question, to consider, and to make sense of their world is expressed in the following data extracts:

> "*I feel like sometimes talking about it [anxiety], others can make a big deal about it, like "You're so brave" or "that must be really tough." I guess it is their attempt at validation, but being able to make a joke about it, umm, helps me a lot."* (S2)

"Your sense of humor is very helpful… and very important to me. I appreciate it." (S15)

"Finding the humor and absurdity in things and laughing about it instead of always worrying." (S1)

"That is the space where I am the most able to sort of laugh things off that made me most uncomfortable or the things that worry me." (S2)

"It [baking] is a nice experience here because I walk into a kitchen, and we bake and joke around and there is no pressure; no need for perfection." (S6)

"This is a pretty safe space and I like that you use humor." (S3)

"The most helpful thing is your positive…. funny attitude, and we just have fun." (S13)

"He enjoys the freedom that he can laugh at himself now. I think your sense of humor helped lighten his burden." (P15)

It was notable that one teacher responded to the interview question, "What do you think helped (S2) most to stop criticizing themself?"

"Deconstructing things [people] said to them and being able to laugh about it." (T8)

3.4 Co-Creating New Awareness and Understandings

Three sub-themes for co-creating new awareness and understandings were identified when considering the study data: 1) connectivity, 2) relational engagement, and 3) identity enhancement.

Student participants in this study learned, during their culinary sessions, that together, they had co-created the possibility of meeting peers at school in a low-stress and inviting way that was previously unknown to them. As they became more comfortable, this way of connecting continued to expand and grow to include student participants' families and teachers. The student participants benefited by a control or power shift, perhaps unknowingly, within their connections

to others, which encouraged positive interactions. Coupled with the responsibility of continued nurturing and consistency, the student participants developed, together with others, genuine relational engagement, and a sense of belonging.

The relationship between the student participants and me, was built on trust, safety, and value of the other, and allowed the student participants to be vulnerable and take risks, as they were confident in the shared relational responsibility. The student participants developed new awareness and understanding of themselves, their value, and their social capabilities through the process of co-creating relational engagement with others. As a result of this newly constructed knowledge, the student participants identities were enhanced.

1. Connectivity

During their culinary sessions, the student participants in this study discovered that together with me, they had generated the possibility to meet their peers at school in a low-stress and inviting way that was previously unknown to them. Baking and sharing what they had made was an easy approach to connect with other students and staff members in a very positive way. This was vital for the student participants, as students facing anxiety often isolate and avoid activities where they would be required to meet others, despite a longing to connect and make friends. Offering culinary sessions in the school setting provides students with a unique and valuable opportunity to engage with their peers in a natural living environment while being supported by their culinary partner and school staff. This reinforces the therapeutic process by setting up the student participant for success.

> *"The first time I baked, I made cookies and met 3 people at school by sharing them. I then had someone to eat lunch with instead of eating all alone."* (S10)
>
> *"It was a way to socialize."* (S11)

"I am easily able to share with people who share back with me. It was nice". (S2)

One parent indicated that baking provided a way for her child, who was struggling with anxiety and also on the autism spectrum, who desperately wanted to engage in meaningful conversation to connect with those that had previously been inaccessible to him.

"He knows people humor him a lot of times with the facts he shares, but baking was different; people were genuinely interested." (P15)

Once student participants experienced meeting people in a different way, it became something they really enjoyed, looked forward to, and even felt comfortable with. This ultimately allowed for their focus to shift from themselves to the experience of the people they were meeting.

"It's nice to put time into something and then let others experience it and watch the expression on their face when they taste it." (S1)

"I love sharing what I make with others. I share the love!" (S13)

"Most of them were very professional about sharing their baked goods. They brought them in and created an experience rather than just saying, "Here's a cupcake." (T4)

"When you send the extra baked goods to the lower grades (3-8) you are really sending joy." (T2)

One student began a ritual of surprising his family each week with something extraordinary that he chose to make for them based on his knowledge of their preferred flavor profiles. This connected him in a positive way to his younger siblings and created a special weekly family occasion where he was celebrated. His parent shared:

"His sisters get home and run to the refrigerator to see what he made." (P15)

2. Relational Engagement

Connecting is a way to meet others, but building friendships is based on relational engagement; how two or more people interact with and treat each other. It is a reciprocal investment over time with another that deepens trust, support, and acceptance. Student participants capitalized on their newly discovered ways to connect and continued to share of themselves through baking, which strengthened their current friendships and allowed them to meet new students.

"The most important thing for me was making connections and a relationship with someone who is supportive of you, who gets you, who loves you." (S1)

"My social anxiety has gotten better over the year, but it was really bad before starting school here. It was hard. Making cookies and sharing them helped me meet other students and make friends". (S10)

"A safe way for students to connect and build relationships in a different way." (T7)

"He used baking to overcome his social anxiety limitations and met and made more friends." (T1)

The transformative power of culinary sessions through the relationships students created with their teachers and the inspiring dynamic of power or control for the student in these interactions was evident from the observations of the teacher participants through these interview excerpts:

"Taking desserts to teachers was a big power shift." (T7)

"I saw conversations that might not have otherwise happened [between student and teacher] as a result of baking and offering samples." (T3)

"After (S11) *shared the cookies, he had made with me, it was one of the first times we could just relax and have a conversation."* (T3)

"Positive interactions helped one student ask for accommodations that he needed but for months hadn't been willing to talk about." (T6)

"One thing I noticed is that I have a relationship with each of the students that brought baked goods to me." (T7)

"I loved it! And I felt special because not all of the teachers were included, so I thought they liked me or wanted to have a connection." (T2)

Another advantage of relational engagement for the student participant was a result of the shift from the main focus being on the individual to the relational process and construction of knowledge together with a partner. Student participants benefitted through the shared responsibility of creating the baked items, allowing them to stretch themselves and grow by taking on difficult recipes requiring skills outside of their comfort zone. The added vulnerability of them sharing these baked goods publicly with their families, peers, and staff was mitigated by the knowledge that this was a joint effort of student participants and me. Thus, the student participants experienced successful, measured, risk-taking through relational responsibility.

"He didn't have much anxiety in the buildup because it wasn't all on him if something didn't turn out. There was safety in it for him." (P15)

"He had someone else to share the blame with if something didn't work out, so it wasn't so risky." (P17)

3. Identity Enhancement

Adolescents' emergent identities were positively influenced by collaborative dialogue through the co-construction of new knowledge and meaning during culinary sessions. As student participants continued their sessions and conversations, they began to see aspects of themselves they had not noticed before, such as capable, resourceful, creative and having value rather than

identifying as any previous identity or labels they had been given. By intentionally not focusing on or drawing attention to anxiety, other, more nuanced or hidden aspects of the students' personalities began to shine through, generating new possibilities and influencing a new reality and preferred identities. With this shift in perspective, student participants capitalized on their relational competencies. They began engaging more often with other students, in the classroom setting, and with their families, which was a generative process, opening up more possibilities to continue to construct new knowledge and meaning, which enriched their preferred identity stories in several different contexts. As the student participants' identities were enhanced through their relational interactions, they experienced feelings of being authentic, comfortable with themselves, happy, and liking who they were and were becoming.

Students expressed this in the following responses:

> *"I always felt like the depressed girl, and I just kept being her because I didn't have anything to replace that with. I was only focused on the bad parts of me. When I started baking and having normal conversations in the kitchen, I realized there was so much more to me."* (S7)
>
> *"I am more than just my mental health, there is a real me. I'm not wearing a label anymore. I'm becoming myself".* (S12)
>
> *"I think you have noticed, but I'm more me. I'm more comfortable in my own skin."* (S7)

Teacher participants echoed these sentiments adding that the transformation or shift in students was observable and profound:

> *"They were becoming happier overall. They were always serious with some sense of uncertainty. They became more comfortable in their own body as they baked."* (T7)
>
> *"Completely transformed one student in the classroom".* (T3)

"He made the most intense shift this year and baking was an integral part of this." (T5)

"(S10)*'s transition this semester has been really wild for me to watch. This was a defining moment."* (T3)

"So many of them struggle with "who" they are." (T1)

The effect was also observed and mentioned by parents:

"I could see the shift in him when he came home." (P17)

"Opinion of himself, changed." (P16)

With the emergence of new identities, many students began feeling more confident in themselves, and their symptoms of anxiety decreased, no longer preventing them from success in academics or in social settings.

"The baking has helped me a lot. My communication skills have improved and I'm much more confident in them." (S2)

"He became more comfortable and confident that he could do the work and would be more social in class and then finish his work in the evenings at home." (T6)

"One student's anxiety would get in his way and the irrational thoughts about his inability to do well in school kept him from being successful academically. Once his confidence grew, the irrational thoughts were replaced with rational thoughts that came from his self-confidence and belief that he can do things well, like bake." (T3)

"I loved when you told me, "You are the perfect version of you." (S7)

"He is far more open about new experiences – he looks forward to them." (P6)

"We need to continue to expand these "fun" things to capitalize on the success students have." (T7)

From their growing confidence, student participants' attitudes about themselves were improved.

They were constructing a preferred personal narrative of success and possibility where they were no longer hiding, but front and center in their own lives.

"I feel proud of myself when I bake." (S5)

"After he learned to make chocolates, he was able to own it, and he was so proud of himself." (P16)

"Perception of self, changed." (P2)

"She's upbeat and happy after baking." (P5)

"All of them were so proud of what they had made." (T8)

"(S10) *will now just ask questions in class when he doesn't know or understand. There was a dramatic shift in his self-esteem."* (T3)

"Saw academic change and socially also." (P10)

"Baking really helped their self-esteem. They did something really well and building that self-esteem made it easier to talk to me. It was like they saw themselves differently." (T3)

"I remember one time walking down the hallway when I passed them carrying a cake they had made, and they had a big smile on their face. To be honest, that was the first time I had ever seen them smile." (T1)

"Can make mistakes, start over, and achieve success and then capitalize on that success." (T5)

Identity enhancement was profoundly significant in this study as it represented a successful outcome of positive social interactions for student participants. Adolescents with anxiety generally avoid social settings and social interactions, that can isolate them and perpetuatete their negative personal narratives. Since identity develops over time and through social interactions in diverse contexts, successfully navigating social interactions is critical to an

adolescent's preferred identity formation.

Most of the adolescents in this study experienced creating knowledge and meaning during culinary sessions from within the relationship of the student and me. As the adolescents became more confident in their relational competency, they began initiating and engaging in conversations with students, teachers, and family members that would not have seemed possible before. By actively participating in social interactions, the student participants chose to create new understandings and construct their own preferred identity stories while developing an internal sense of control. While constructing their preferred identities was of great consequence and satisfaction, the adolescents were alleviating their own symptoms of anxiety related to social interactions by shifting their focus away from anxiety to finding ways to go on, illustrating the ongoing, unfolding nature of collaborative-dialogic practices.

3.5 Transformation

Student participants experienced a sense of belonging and relational competency with improved confidence, which served as the foundation for transformation. Within the theme of transformation, three sub-themes were identified: 1) efficacy in action, 2) new learning, and 3) impact on trajectory.

Within the sub-theme of efficacy in action, there were two distinct areas of acquired skill building. First, specific abilities, capabilities, and skill sets acquired through education and experience that are measurable (known as hard skills), and second, non-technical skills that describe how you work and interact with others, such as communicating effectively, teamwork, and problem-solving (known as soft-skills). Data indicated that student participants learned new skills and developed mastery while increasing their social and emotional learning.

The acquisition of specific abilities and capabilities translated into the successful

production of baked goods. Student participants recognized and appreciated their own ability and determination to produce a desired or intended result in the kitchen. They also learned how to work as a team and communicate more effectively, which made classroom participation more comfortable. During the culinary sessions, when they had reached a particular level of comfort in their newly obtained skills, the student participants began attending class more often, participated in classroom discussions, and completed better quality and a higher volume of class work. Through these actions, they began a parallel process to culinary sessions– they prepared, focused on one process at a time, adjusted as needed, and though uncertain of the eventual outcome, they trusted themselves, took the risk, and submitted their work. Their improved identity story and belief in themselves and their abilities supported their academic success. In tandem, these two processes, culinary sessions, and academics, served as catalysts for further transformation through continual confidence-building and emergent identities. Data showed that student participants with positive emergent identities felt good about themselves and about life in general.

1. Efficacy in Action

Supported by the data, learning new skills in the kitchen provided student participants with frequent opportunities to feel good about themselves. Most student participants continued practicing their new skills and developing mastery, the ability to perform the skills unconsciously. Students found themselves sharing their knowledge by teaching others. Student participants expressed this through the following excerpts:

> *"When people ask me what I like best about myself, it is not my eyes or smile, it is that I bake really well."* (S7)
>
> *"I was surprised I could do it (French chocolates) even though I almost dropped them so*

many times." (S2)

"Every time I come here to bake; I learn something. It is helpful and I am always learning." (S6)

These skills, mastery, and competence the student participants demonstrated were witnessed by parents as noted in the following comments:

"Even just the sense of accomplishment when he came home, and he brought something he made." (P3)

"Just the other day, he taught his grandma something that he learned from you in the kitchen." (P15)

Student participants also improved their social competency by interacting through verbal and non-verbal communication, making connections, and appropriately navigating diverse social settings. These important social skills were specified in the following comments:

"He was displaying his Culinary Arts and interacting with guests. It was almost unbelievable." (P16)

"The presentation and how they approached me as always polite and that they are proud of what they have done." (T4)

2. New Learning

From the teacher participants' perspective, culinary therapy had a big impact on the student participants' academic success. The data suggested that the teachers were able to improve their relationships with the student participants by showing genuine interest in their baking skills and complimenting their products. As a result, students attended class more often, were more productive, and the quality of their work improved.

"Them bringing us baked goods gave us a way to encourage the relationship and they

produced more and better-quality work." (T6)

"It is nice to recognize a student's success baking and put them on a pedestal for a second and applaud them. It is an easy way to get some work out of them." (T3)

"She was once a nervous chatterer who was fearful to write without constant support, was now writing papers on her own." (T3)

"Teachers support culinary therapy – it makes academic time more effective." (T8)

"Shift began in February; he began coming to class and asking about assignments instead of avoiding." (T7)

"Actually, I asked a student that was avoiding me if he would bring me something he baked and he did. I told him it was really good and from that point on he started coming to class more often." (T3)

3. Impact on Trajectory

The impact of culinary therapy on students struggling with anxiety is demonstrated through the data to have had a strong effect on the student participants. One student developed enough confidence in herself that she decided that she would like to have her own baking business one day and began taking orders for cakes from neighbors. For others, academic grades and school attendance improved along with the ability to be assertive and ask for help when needed as their attitude about themselves improved. As a result, this opened doors to possibilities for their futures that did not exist before. Notably, the data showed that improved self-esteem and confidence were experienced by all of the student participants.

"I really want to have my own baking business." (S7)

"After 2-3 months of baking, his confidence really improved, and his grade went up an entire letter grade. He also became more autonomous." (T8)

"He wasn't able to ask for help. Prior to culinary therapy, he would not ask for help, he would suffer in silence." (T8)

"Beginning of second semester, I noticed a shift in all of them, consistently and across the board." (T5)

"The baking program is so great. I have seen it change lives, especially with two freshmen." (T5)

3.6 Life Direction: Ways to Go On

When contemplating the data, life direction: ways to go on, was identified as a theme that indicated how students would continue to progress as they moved forward in life. According to the data, two sub-themes, 1) looking forward and 2) tolerance for the unknown, represented the student participants' ability to manage both anticipation and disappointment as well as participate in new experiences, which for an anxious adolescent, is frightful risk-taking.

1. Looking Forward

For the student participants facing anxiety, who presented with low distress tolerance, feelings of anticipation and disappointment amplified their anxiety symptoms. Anticipation, the exhilaration felt while waiting for something you know will happen, becomes anticipatory anxiety when the adolescent becomes so fearful that what they are waiting for to happen might not happen or they will be unable to participate. Disappointment occurs when thoughts and expectations are inconsistent with what will or has happened. For the student participants unable to reconcile their feelings of disappointment, stay positive, and choose hope, their anxiety symptoms increased. However, through failed then salvaged and successful baking experiences and discovering new possibilities that didn't previously exist for continuing on when faced with disappointment, the student participants increased their distress tolerance or resiliency. The

student participants experienced that disappointment is often an opportunity for problem-solving and creativity.

Over the course of the study, as the trust between student participants and I was formed, the student participants began to anticipate the culinary sessions, allowing themselves to let go of fear and look forward to their culinary sessions with positivity and confidence, which lessened their anxiety and further increased their development of resiliency. This is demonstrated in the following students' comments:

"It is something to look forward to during the school day and helped me get to school." (S2)

"Baking is helpful for me because when I'm depressed it motivates me to get out of bed, I want to get up and bake." (S7)

Parents also noticed the student participants' anticipation and excitement as it emerged:

"For him, the anticipation was very positive." (P15)

"She lit up when she got to bake with you, she was so excited to share her creation." (P5)

The teacher participants noticed students looking forward to and excited about participating in therapy – culinary therapy – at school.

"She would always refuse my offers to create art, so I was surprised when I saw how exited she was to be baking." (T3)

"There is talk around school about baking. It is something others are looking forward to." (T3)

"Those that were going to bake after my class were excited and looking forward to it." (T8)

2. Tolerance for the Unknown

Culinary sessions provided a considerable opportunity for active learning, one where student participants are fully immersed and engaged in the baking process and learn through both their successes and failures. There is some uneasiness for participants as the result of their efforts is usually unknown until the end of the baking session when the item is removed from the oven or when finishing touches are added to a product. There is an unpredictable nature (risk) in the creation of baked goods that holds in suspense the possibility of great success or an upsetting or embarrassing disaster. This was highlighted by one parent participant's comment:

"There's a bit of surprise when baking." (P16)

Adolescent participants found culinary sessions or baking to be a safer experience than school academics as it was not perceived as a test or as having a right or wrong answer, but rather as a place where all actions help open doors to new experiences and opportunities. Regardless, of the possibility of failure, the kitchen was identified by students, parents, and teachers as a safe place to take risks, to fail, to try new things, to be successful, and all while building positive and preferred identities, in no small part because it was a joint venture, an activity done *with* a culinary partner. This shared experience allowed the adolescent and I to work as a team, make meaning together, and create new knowledge about taking risks and managing the emotions that accompany them. As a result of the adolescents' new understandings and enriched identity stories, they were more confident, capable, and inspired, which generated new possibilities, specifically ones where they can better navigate life's ups and downs as they now embrace them as successes and opportunities. In their own words, the students stated:

"Being successful in the kitchen helps me to try other new things." (S9)

"Baking made it a safe place to fail and not feel overwhelmed." (S15)

Parents acknowledged their student's new willingness to challenge themselves instead of

yielding to their fear of failure:

> *"He pushed himself to make things that didn't work for him at home by himself, like croissants."* (P6)
>
> *"Baking doesn't have rights and wrongs; it is not a test."* (P5)
>
> *"Safer than the specter of school."* (P16)

And lastly, teachers noticed the improved confidence and self-esteem in students who were taking risks.

> *"Baking is a calculated risk, but safe, and builds confidence and self-esteem."* (T1)

The student participants increased their resiliency (their ability to withstand or recover quickly from difficulties) by remaining positive and learning to navigate anticipation and disappointment and the emotions they evoke. By considering previous challenges as opportunities for generating new possibilities, problem-solving, and creativity, the student participants learned important skills for overcoming past limitations. Feeling safe taking risks and understanding that failure is merely an opportunity to develop knowledge and for personal growth, the student participants continued to benefit from the ongoing unfolding nature of culinary sessions and collaborative dialogue and its influence in their life direction as the student participants continued on in life.

3.7 Level of Anxiety

At the start of the study, all student participants completed the GAD-7 inventory as a way to make note of their level of anxiety before the start of the culinary sessions. Eleven of the 17 student participants were rated as having severe anxiety, five with moderate anxiety, and one with mild anxiety (See Table 6). My field notes and interview transcripts included data that indicated that student participants presented with symptoms of anxiety consistent with

generalized anxiety disorder, social anxiety disorder, agoraphobia, and panic disorder. All of the participants had comorbidities of more than one anxiety disorder or another mental health disorder and self-reported as major depressive disorder, attention deficit hyperactivity disorder, bipolar disorder, selective mutism, specific learning disorders, gender dysphoria, post-traumatic stress disorder, or an eating disorder. Two participants were battling school refusal, missing more days than they attended, and ten of the 17 student participants were struggling with suicidal ideation or had a history of attempted suicide.

According to the data, nearly all of the student participants had high levels of functional impairment, used avoidance as a coping mechanism, had little insight into recognizing their own anxiety, and though they had received treatment through traditional therapy before the start of this study, student participants and their parents lacked understanding of the cause(s) of their anxiety or how to help. This is expressed in the following statements:

"Somewhat of an unpredictableness about anxiety and when it shows up." (P2)

"Some days he says he is anxious but doesn't know why." (P5)

"He has generalized anxiety disorder and sometimes it is situational, and he will perverserate on a particular thought." (P15)

"Usually, I become immobilized when my anxiety is bad." (S7)

Teacher participants noticed perfectionism as a prevalent symptom of anxiety and that anxiety is experienced and discussed by most of the students that attend Xavier Educational Academy.

"He is a bundle of nerves. He talks a lot about perfectionism." (T6)

"Nearly all of our students have discussed having or struggling with anxiety." (T5)

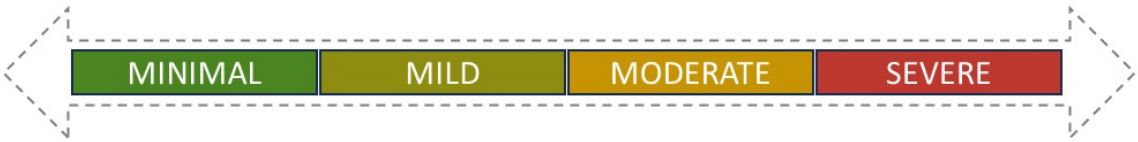
At the conclusion of the culinary sessions the student participants were given the GAD-7

inventory to again note their level of anxiety symptoms. Of the 17 student participants, five students rated themselves as having severe anxiety, four with moderate anxiety, seven with mild anxiety, and one with minimal anxiety. While all of the student participants noted that they continued to struggle with symptoms of anxiety, they all reported that their anxiety problems had decreased. Three student participants indicated that their symptoms had decreased by more than one-half (see Table 7).

While most of the student participants were unable to identify underlying causes or triggers for their anxiety, they were conclusive in recognizing a decrease in their anxious symptoms, as expressed below:

> *"I definitely felt less anxious after baking on the days when I did it."* (S7)
>
> *"Anxiety is lower in here [the kitchen]; it is fun. It stays that way for a while after."* (S3)
>
> *"When I am stressed out, it would help me to feel better to bake. I need to remember that I can bake."* (S11)
>
> *"My mom even noticed when I get in the car after baking that I was less anxious than usual. She said, 'You're a lot less anxious right now.'"* (S15)

Table 7
GAD – 7 Anxiety Inventory



Student Name	Pre-test	Post-Test	Increase or Decrease	Level Change
1	21	13	⇩	8
2	21	17	⇩	4
3	14	10	⇩	4
4	21	7	⇩	14
5	12	7	⇩	5
6	7	4	⇩	3
7	21	18	⇩	3
8	21	16	⇩	5
9	14	7	⇩	7
10	21	9	⇩	12
11	17	10	⇩	7
12	14	8	⇩	6
13	13	7	⇩	6
14	19	11	⇩	8
15	21	9	⇩	12
16	21	15	⇩	6
17	21	18	⇩	3

Scoring for GAD-7 Anxiety Severity

0-4: minimal anxiety
5-9: mild anxiety
10-14: moderate anxiety
15-21: severe anxiety

Chapter 4: Discussion

4.1 Introduction

The overall goal of this research was to explore an alternative treatment approach for anxiety in adolescents as it is an epidemic that continues to surge, negatively affecting vulnerable adolescents despite current best practices treatment. My interest isn't in trying to understand why current best practices treatment doesn't work, but rather given that the data indicates that current treatment practices are ineffective for adolescents, what could we do as an alternative? Culinary therapy is one alternative approach that has been shown to have positive mental health benefits. However, nominal research exists about its effectiveness as a treatment for mental healthcare and specifically for the treatment of anxiety in adolescents.

There were three specific areas of importance for this study: (1) to establish if there is evidence to support therapeutic benefits for adolescents with anxiety participating in a culinary arts program, from a collaborative-dialogic orientation, and within a school setting from the perspectives of the adolescents, their parents, and their teachers; (2) to determine whether they felt a shift or change in their identity story, and (3) to decern whether the adolescent participants experienced a change in their level of anxiety symptoms from the start of the study as compared to after the study. The results chapter identified the research outcomes, but I will extrapolate and summarize the key takeaways in what follows.

4.2 Summary of Findings

1. Culinary Arts Program Experiences at School for Anxious Adolescents

This study identified a culinary arts program in the school setting as providing student participants with the opportunity to immediately engage in social situations that are accessible within a school environment (but which students had not previously taken advantage of), such as

inviting peers and teachers to sample the delicious baked goods they had just created. When the student participants entered the classroom with the results of their daily culinary efforts, they were met with attention and admiration by their peers hoping to be invited to taste their delicacies. This event permitted the student participant to safely bid for connection while publicly displaying the results of their new skills. It similarly positioned the student participants as candidates for social-emotional growth in a protected, natural, and nurturing environment where words of praise and gratitude for a job well done by peers and staff served to recognize and reinforce their newly learned skills. For 15 out of 17 student participants who had terminated traditional therapy due to their negative experiences, school-based culinary arts provided them with easy access to activity-based, adolescent-centered mental health care.

Culinary sessions in a school setting integrated the three domains of development - socio-emotional, cognitive, and physical – and offered opportunities for building confidence and emergent identities. Social-emotional development in adolescents refers to initiating, cultivating, and responding to others, emphasizing forming relationships. This includes relating to others and expressing feelings, empathy, and compassion for others (Cassel, 2022). Cognitive processes explicate how thinking develops. More specifically, it is the development of knowledge, problem-solving, and logical operations that include the ability to think, reason, and consider many points of view (Casel, 2022). Cognitive processes also include the development of abstract thinking and the ability to think about possibilities (Frasier-Thill, 2010). Lastly, physical development signifies growth and changes in the body, brain, senses, and motor skills, or in other words, an adolescent's ability to use and control their body (National et al. on the Developing Child, 2010).

The findings highlight the student participants' preference for polyvocality, the diversity

of viewpoints welcomed by collaborative-dialogic practices used in this culinary arts program, as compared to mono-vocality, the singular view by an expert of traditional treatment. The results strongly implied that mono-vocality was negatively experienced by student participants who claimed to feel intimidated and forced to answer questions with the expectation of producing the "right" answer and that they were being judged. The student participants described having been diagnosed by a traditional therapist (expert) with functional impairment due to anxiety disorder symptoms such as difficulty concentrating, irritability, restlessness, worry about school performance, or school refusal, which reinforced their feelings of failure. Ultimately, this significantly raised their anxiety level. Student participants terminated traditional therapy sessions as they were experiencing markedly increasing anxiety symptoms in anticipation of their sessions, during their sessions, and following their sessions.

Conversely, collaborative dialogue, used in this culinary arts program, emphasized working together as partners in a relationship, emphasizing polyvocality (multiple voices and perspectives) rather than a single truth; the adolescents felt that their voices and perspectives were heard and valued. This multiplicity of voices was central to communicating with others, creating understanding, producing new knowledge, and making meaning together. The conversations were motivated out of genuine curiosity about each other and a desire to explore different perspectives, especially that of the student participant, and the flexible and spontaneous nature of the relational process, allowing for the generativity of new possibilities where none may have existed before. For example, one student participant's conversations with teachers had been uncomfortable and negative interactions focused on what the student got wrong or what assignments were missing, reinforcing the anxious adolescent's narrative of failure. As a result, this student participant avoided teachers, classes, and ultimately, school altogether. As partners

in the relationship, the student participant and I explored various hypothetical perspectives or viewpoints, including potential thoughts the teacher may have about them that could influence the pattern of their interactions. This process generated new ideas and possibilities, including one where the student could initiate a different kind of conversation with their teacher. Intending to change the focus of their interaction from negative to positive, the student participant brought their teacher freshly baked lemon bars, showcasing their skills while allowing the teacher to observe and appreciate a different aspect of the student participant, this time where skills and success were present. In this way, the student participant actively shifted the relational narrative from deficit and failure to capability and success. The student and teacher created a new understanding that included a more desired and positive perception, giving new meaning to the student's identity story.

2. Change in Identity Story

The results of this research provide additional supporting evidence that the study participants experienced a transformational change that enriched their identity story through improved confidence and emergent relational competency. The data indicates that the development of these resources was supported by the unique experiences presented through culinary arts sessions in a school setting. These experiences include, for example, student participant #10, who sat alone, isolated, and virtually invisible while he ate lunch on those few rare days when he managed to attend school. That changed the day he entered the lunchroom with a tray of warm red velvet cookies he had baked during his culinary session. He was instantly noticed, receiving several positive acknowledgments, including invitations to join different student groups for lunch. From that day forward, student participant #10's attendance improved significantly; classroom participation increased, he made friends, and he enjoyed lunch

with other students daily.

The data further indicated that collaborative dialogue during culinary sessions was a way of communicating in a distinctive, more equitable, and inviting way and supported the development of positive changes in confidence and relational competency. An example of this would be the experience of participant #7. When she began her culinary sessions, I asked about her favorite desserts, what she thought was important for her to learn and create together, and how she would like to begin. As the culinary sessions and the mutual inquiry continued, the adolescent participant and I learned more about each other and ourselves, in the same way, any two people would, through everyday activity, sharing thoughts, likes, and dislikes, exploring ideas, listening, and questioning each other's beliefs as well as their own. Through this relational process, they noticed what was unique and special about the other and created new understandings, knowledge, and meaning. Through this process, participant #7 could see herself differently, and her identity story shifted from a negative failure narrative to a positive, capable, and hopeful success narrative by noticing, exploring, and highlighting other, more preferred parts of her identity together. She no longer identified as "the depressed girl" as depression was simply a feature, not her identity.

Student participants preferred being a conversational partner and talking with me about what was essential for them at the moment, rather than being spoken to, with a focus on their pathologized maladaptive thoughts and behaviors and what they must do (or do better) to fix their problems. This preference in communication style was symbolic of the mutual respect of the student participant and therapist's egalitarian relationship. It gave the student participant a sense of control in the conversation and relationship. The relational process of "being with" is rooted in collaborative dialogue and how the student participant was shown genuine respect and

value and that their thoughts and words mattered. This kind of conversation was very natural, organic, and free-flowing, as opposed to an intervention that included an assessment, a list of questions, or a scripted set of techniques. Through collaborative-dialogue, attributes of the student participants that were encouraging, exceptional, and virtuous, such as courage, honesty, and loyalty, were emphasized.

Additionally, the student participants' thoughts, ideas, hopes, dreams, and goals were invited into the conversation, and it was there that new meanings and understandings transpired, creating a narrative of positivity and possibility. The student participants acknowledged and celebrated the good in themselves rather than conceding to a previously harmful, negative view of who they were. They were empowered to take steps toward what they desired and how they wanted to be and be known, with better confidence.

These findings strongly suggest that student participants became more comfortable and confident as they engaged in ordinary conversation in an ordinary setting, doing ordinary things together, just one human being with another human being. The absence of their previously experienced pathologizing, labeling, and shame resulted in the student participants' newly emerging narratives of being capable, creative, resourceful, and whole. Their improved and positive narrative was generative, giving them a sense of hopefulness that further enriched their identity stories.

3. Anxiety: Increase or Decrease?

A key finding in this study was that all student participants experienced a decrease in anxiety symptoms after the culinary arts sessions when compared to their level of anxiety symptoms at the start. The data supported the finding that anxiety for student participants was lower during the culinary sessions in the kitchen. After baking, they felt less anxious, with

decreased symptoms that continued for some time afterward. The findings highlighted student participants' positive experiences during culinary sessions and that they felt better throughout the day, before, during, and after their scheduled baking session. Culinary arts was something that they enjoyed; it was important to them, and they looked forward to it.

Through my research, the data, both in the anxiety measure and in the quotes from students, parents, and teachers, clearly show a genuine shift in how these students were constructing who they are. Parents begin to notice the shift, and then they, along with the teachers, become part of continuing the co-construction of identity stories, thereby reinforcing it. In this way, a new and preferred identity emerges creating more possibilities.

4. Anxiety Disorders and Comorbidity

Over the course of the culinary sessions, student participants voluntarily shared information about additional diagnoses they were given. These comorbidities included Major Depressive Disorder, Attention Deficit Disorder, Bi-Polar Disorder, Selective Mutism, Specific Learning Disability, Gender Dysphoria, Suicidal Ideation, Suicide Attempt, Eating Disorders, Post Traumatic Stress Disorder, Social Anxiety Disorder, Agoraphobia, and Panic Disorder. Of the 17 adolescent participants, only one student identified with a single diagnosis of anxiety. The other 16 student participants had diagnoses, in addition to anxiety, that ranged in number from two to six. No two student participants shared the same list of diagnoses, therefore making it difficult to draw specific conclusions about the types or numbers of overlapping diagnoses and changes in symptoms of anxiety.

It is worth noting that indicated that the coexistence or overlap of disorders increases the complexities of treatment but according to Fried et al. (2014) it does not impact the effectiveness of treatment. In this study the student participant with the single anxiety diagnosis did show the

greatest decrease in the level of anxiety symptoms after the study based on self-report. However, consistent with the literature, all student participants with overlapping diagnoses experienced reduced anxiety symptoms.

5. Collaborative-Dialogic Practices Take the Cake

The findings in this study convincingly demonstrated that culinary arts sessions, using a collaborative-dialogic perspective, were efficacious in reducing adolescents' symptoms of anxiety. As I began this research, I had many curiosities centered around baking and learning skills in the kitchen and what contributed to a kitchen being powerful and transformative. In considering my childhood experience and connection to my research, I began writing as a way to reflect on my own kitchen experiences, attempting to organize them in a way that would make sense and give me insight. As my process continued, I recognized that the defining moment in my life was the shift from a negative deficit-filled identity to a preferred identity story that provided possibilities and a way to move forward. I became a baker and could share my creations with others and reinforce my preferred identity of being skilled and talented. I can remember considering, "Maybe that's it. If they all become bakers, learning skills and demonstrating talent they will become empowered to create change in their lives." That seemed simple enough "change through the power of baking." I further reflected that perhaps it didn't have to be baking and could be any skill as it would provide a way to shift identity.

As the student participants continued their culinary sessions, I began noticing that some shifts seemed to be occurring. The student participants were coming to the kitchen with their aprons on and hands washed, eager to begin, or would show up excitedly with their own recipe they wanted to show me and then co-create it in the kitchen. They were demonstrating initiative and taking ownership of their experiences. Most student participants appeared happier and more

at ease. It was working, I thought, whatever it is.

I was looking forward to the interviews with the students, their parents and teachers as now I would be able to hear about their experiences and perhaps how baking changed their lives as it did mine. I was only about 6 interviews in when I began recognizing that while they had learned skills, developed mastery, and increased their social competencies, becoming a baker was not what created change for them. I continued the interviews, and there were indications that, indeed, the student's identity stories had shifted to ones that were more positive. But it wasn't until I was sorting and coding the data that it became apparent, that while the kitchen offered some wonderful opportunities and benefits, learning to bake was *not* the key to the adolescents' improved narratives and identity stories. What was abundantly clear was that collaborative dialogic practices, the way in which we communicated "with" each other, was the powerful change agent. Culinary arts simply provided a promising context for collaborative-dialogic conversations that are therapeutic.

Over time, and with this new interpretation and understanding, I returned to my earlier reflections and writings about my childhood experience. Could my story be understood or retold in another way? What was I missing, or perhaps more importantly, whose voice was missing? It was over a period of time of contemplation and reflection that I came to realize the positive impact that my grandfather, Papa, had on me as a young child while making soup together. It was his interactions and conversations with me, those that resembled the perspective-orienting assumptions of collaborative-dialogic practices, that made a difference. It was through these meaning-making conversations that I learned I had value and that I mattered. This knowledge and the emergent identity that was generated from our interactions so long ago re-appeared in my adolescence and provided a different "truth" or perspective of who I was. What Papa and I

created was much more than soup; it was a life-changing conversation that continued unfolding over time and became, quite possibly, my greatest resource during adolescence. This amalgamation of reflections and writings now appears as my personal narrative as the forward in my dissertation.

4.3 Discussion

1. *Previous Research*

Whereas earlier researchers have found that culinary therapy is successful in helping patients learn about nutrition and developing a healthy relationship with food (Clark et al., 2015) and that culinary therapy is successful in improving adolescents' health habits (D'Adamo et al., 2015), mental health benefits previously were secondary to the participant's physical health (Whalen, 2014). The present study results are consistent with the claims of Haley and McKay (2004) that participants in an in-patient baking class gained improved confidence, concentration, reasoning, self-connection, and coordination and that they had better self-image by focusing on more positive experiences. This is highlighted in two emergent themes: “co-creating new awareness and understandings” and “transformation.”This idea is supported by Ohana (2022), who notes that the likely benefits of culinary therapy include insight, mindfulness, social skills, and stress management, which is evident in the data contained in the sub-themes “connectivity” and “relational engagement.” The literature also proposes that learning new skills and developing mastery. Both are highlighted in the study’s sub-theme “efficacy in action” data and supports positive self-image, self-efficacy (Mainwaring et al., 2010) and emergent identities. A substantial part of culinary therapy is learning skills and techniques and mastering cooking or baking (Farmer, 2017). The information from previous research is significant as it demonstrates what has been known: culinary therapy helps adolescents improve confidence, self-connection, social

skills, and positive self-image, thereby improving their emergent identities.

Prior research purports the benefits of culinary therapy are directly related to positive change in one's identity and that developing mastery of skills positively affects one's attitude toward oneself and reduces anxiety symptoms (Maldonado et al., 2013; Fernandes et al., 2021). However, culinary therapy has not been studied explicitly for mental health care treatment for anxiety symptoms in adolescents. The study results reported here represent the first direct demonstration of a culinary arts program, utilizing collaborative- dialogue – made available in a school setting – for mental healthcare treatment of adolescents struggling with anxiety.

2. From Pathology and Deficiency to Possibility and Empowerment

In Chapter 1, it was established that current treatments for adolescent anxiety had very low success rates, was not more successful than other therapies or the usual care at clinics, and did not show positive long-term remission rates. Anxiety was also discussed as something that exists in infancy, childhood, adolescence, and throughout adulthood, and the occurrence of symptoms is not typically pathological as it is often good information used in avoiding perceived danger (Beesdo et al., 2009). This makes it difficult to determine whether an adolescent's symptoms of anxiety are pathological or if their worries and fears are appropriate (Cresswell et al., 2014).

From a constructionist perspective, anxiety is not a quality of a person but a cultural label used when certain social norms are violated. It is a contextual, cultural problem. For example, an established conceptualization is that anxiety is maladaptive when it interrupts normal functioning, as in avoidance behavior or an extreme presentation of normal events (Beesdo et al., 2009). But, who decides what is normal? If an adolescent is anticipating a school event, such as school travel or graduation, and has trouble staying focused in class, completing work, or even

attending class, which disrupts normal functioning, would this be considered pathological behavior? Or perhaps an adolescent is spending all their time studying for final exams and not bathing, engaging in regularly enjoyed activities, or socializing, causing disruptions to normal functioning, is this an appropriate response or would this be considered pathological behavior? For many, the answer is "yes," and they seek help to relieve the feelings they are experiencing to fix the "problem" of distraction, avoidance, isolation, or hyper-focus. However, we should consider that an adolescent may merely be reacting naturally to their situation, feeling excitement and anticipation for an eagerly awaited upcoming event. Or they may be capitalizing on their executive function skills by planning and preparing themselves through intentional, focused study to be successful on final exams. Our contemporary cultures, social media, constant comparison to others, an educational system that is all about grades and success, and constructed standards and expectations have all led to constructed beliefs that if something is uncomfortable or difficult, it is problematic or pathological and should be fixed. I would assert that humans experience a continuum of responses and feelings ranging from joy and elation to despair. To numb or avoid those feelings would be to minimize the full experience of life.

For this study, I designed a program that unites culinary arts with a collaborative-dialogic perspective in a school setting to examine its therapeutic efficacy for adolescents diagnosed with anxiety. As a child, I felt challenged by my identity. I did not want to be known in a particular way. As an adolescent, facing day-to-day family interactions left me feeling deficient. However, winning prizes and being written up in the newspaper for my baking, helped me construct a new identity. Fortunately, I had other, positive, interactions so I knew there were different possibilities for a more preferred identity as a human. I learned that identity shifts and changes in different contexts and relationships, which allowed me to perform a preferred identity

continually. I was doing more and more on my own and less under someone's thumb. Once I was old enough to make that choice, it didn't mean the other identity went away; it was still there, but my new emergent identities, which were the relational byproducts constructed in relationships with other bakers and pastry chefs, were my preferred identities.

Our identity can be, and often is, different in every context. We are not the same all the time, and if we think we are truly the same all the time, we are not paying attention. The only way to truly be the same is to continually seek out relationships that allow us to maintain a singular preferred constructed identity. This would be very difficult and limiting. The problem for all of us is that when a dis-preferred identity remains in place and we have no power or ability to leave the relationship or context, the dis-preferred identity is being reinforced. For an adolescent who has been diagnosed with anxiety, it often becomes the explanation for their failure narrative.

Anxiety is often offered as the explanation by parents, coaches, the adolescents themselves, their friends and teammates, etc., whenever the adolescent is confronted with a challenging situation. An anxiety diagnosis is often welcomed by adolescents and their families as being helpful for them in assisting them in understanding the adolescents' problems. However, this often emphasizes a deficit narrative where the adolescent is viewed as a victim. Over time, because of its frequent reinforcement, it may become their identity in many different contexts, as we are known by the identities most frequently reinforced by ourselves and others. This begs the question of whether or not a diagnosis is helpful. Might diagnosis be perpetuating the problem or potentially making it worse by frequently referencing it? Are families who are attempting to find help and support for their children unknowingly perpetuating this dominant discourse or common wisdom about anxiety through their actions?

How might this look different if anxiety were described in a way that suggests possibility, such as an adolescent being compassionate and intuitive, keenly observant, motivated and excited about life, capable of unique perceptual awareness of their environment and situation, purposely attuned to others and their expectations, self-observing, reflective, deep-thinking, reserved, and cautious decision makers and good problem solvers? These attributes are not the adolescents' identities, but action resources that the adolescent has access to. Discovering possibilities for how to utilize them positively could be empowering and generative and could be facilitated by parents and teachers as relational learning.

How would the conversation change within families and schools if they defined anxiety symptoms in ways that identified them as strengths? Would this shift the focus from deficit-based to what is possible and how a child can succeed and excel using these strengths? Would this improve the relationships within the family, specifically between parents and the child with anxiety symptoms?

Many parents and teachers back-off from interacting with their anxious children being cautious that they might "trigger" their child's anxiety and increase the severity of their symptoms. For a child who has already developed a negative personal narrative, this (well-intentioned) distancing or avoidance by parents or teachers increases the child's failure narrative by feeling rejected or that they are an embarrassment, disappointment, or a failure in their eyes. The result is often that the child becomes further isolated. At a time when adolescents need social interaction and relationships most to learn and grow and to develop their identity story, they are suffering in silence. If the symptoms of anxiety were described as strengths and parents and teachers called upon these anxious children to help them in ways that demonstrated the positive attributes of these symptoms, the child would more likely than not, develop a positive

personal narrative and would continue building a preferred identity through their relationship with their parents and teachers as co-creating knowledge and understanding about the strengths and gifts of the child and how they can use them.

An example of this might be asking a student to help prepare for and co-lead a classroom discussion with the teacher looking for possibilities to solve a classroom problem. For instance, tardiness or disruption in class. The student could prepare by observing the phenomena occurring, use their awareness of the environment and situation to develop an understanding of when this occurs, consider the teacher's expectations, reflect, and because of their careful decision-making process, offer some tentative ideas for possible solutions. In the group discussion, the student is reserved, not imposing, attuned to others, empathic, sensitive, and accepting. Because students with these action resources also consider the possibility of multiple outcomes, they support others and their ideas, which allows for a collaborative process for those involved, the classroom's students, to be heard. This could empower the student and positively influence their emergent identities by acknowledging their leadership capabilities and sensitivities, while also impacting the narratives of the other classroom students in the process.

By challenging the way we think about anxiety and its treatment for adolescents, by changing how we define the symptoms currently associated with anxiety from a perspective of deficit to one of possibility, and from pathological to empowering, adolescents could capitalize on their attributes in a way that is generative and helps to develop their preferred emergent identities.

3. What is Happening in Schools in the U.S.?

Schools play an important role in the lives of children and their families and are thought to provide education, the acquisition of knowledge, and socialization (Anderson et al., 2004),

which is an important factor in identity formation. However, for many students, school is a chore, something they are required to do, and an additional source of labeling or pathologizing that often becomes part of a child's identity.

Most educators' goals, or, in some cases, requirements, are to teach an efficiently pre-planned curriculum so that students can produce correct answers on demand in class or on exams (Lam, 2019). Students can learn passively, where teachers give information through lectures or by providing reading materials, and students internalize or memorize it (Chi & Wylie, 2014). This method does not encourage reflection or engagement with the material. Instead, it is likely accepted as truth. At worst, students do not even stop to consider whether or not they agree or disagree with the information. They are simply expected to "learn it" without personal or critical evaluation of the content. The students for whom this type of educational structure works are successful in answering questions about the material correctly (Lam, 2019). School settings of this kind measure students' success by the "correctness" of homework, class assignments, and exams (Lam, 2013). A student is considered to have successfully learned the information based on the number of correct answers; the higher the scores, the more knowledge they gained.

However, there are those who would question how much learning and knowledge was truly gained without a student actively engaging with the material and really thinking critically about it (Chi & Wylie, 2014). For many students, passive learning doesn't suit them. They are within the normal range of development, but this educational format doesn't engage them or pique their curiosity. Consequently, they do not perform well in class or on exams and are not comfortable answering out loud in class when called on for fear of embarrassment or looking dumb.

Education is not developmentally oriented; instead, it was developed in a one-size-fits-all

system. If you are 13 years old, then you are enrolled in the 8th grade and will take specific courses designed for 13-year-olds. However, some 13-year-olds will not be ready for those specific courses at that time, and there will be some who will never be ready for those courses taught in their usual manner. However, the U.S. educational system continues to teach in a way that encourages sameness and penalizes or excludes differences, exceptionality, individuality, and what may be special or unique about an adolescent. This oftentimes leads to pathologizing (she's slow, or he's very ADHD) and casts negativity on the adolescent that is frequently internalized as failure or not being good enough and increases symptoms of anxiety. This prevents the healthy development of self-esteem as the focus is on negatives, such as what has not been accomplished. This would be particularly damaging during vulnerable adolescent years when young people are forming their identities. The impact of the negative narrative surrounding them is even more disparaging and difficult to dismiss as it came from an "expert." Psychosocial development during adolescence will occur within the school setting for all students (James, 2009). Understanding the importance and impact of this developmental process for adolescents suggests that a conscious effort should be made by schools to create the best possible environment to support this critical period of growth rather than ignore its importance and, perchance, allow for a mediocre or repressive setting (James, 2009). The current school system in the United States, with its passive teaching methods, lack of relational engagement, and focus on answer correctness (Lam, 2019), is failing youth both cognitively and social-emotionally. Without engaging students in the process of collaborative-dialogue or mutual inquiry, both relational activities, the opportunity for creating new knowledge and meaning and further developing social competency, critical thinking, and emergent identities is lost. Margaret Meade, an American Cultural Anthropologist, said it best when she stated, "Children should be

taught how to think, not what to think" (Rawson, 2022).

The research data identified what was most important was creating identity through relationships and that the development of preferred identities mediates symptoms of anxiety. Our current school system does not support students in this relational way and may unintentionally have become part of the problem or unwittingly be maintaining the problem of anxiety symptoms in adolescents. As we rethink how we approach anxiety and its treatment for adolescents, we could create some necessary change in schools by removing barriers of negative labels for adolescents with anxiety by shifting the narrative to their unique strengths and talents. This could be the impetus in realigning an educational system to support the behavioral, cognitive, and social, and emotional evolution of the whole child.

Xavier Academy, a private school, is one that uses a collaborative-dialogic orientation in education with a focus on collaborative learning from within the relationship. Each student has their own individual educational plan that takes into consideration the student's strengths and unique qualities along with the areas in which the student would benefit most from an innovative instructional design. These innovative designs or ways of learning are crafted together with the student. Class sizes are small (10:1) and students are seated in a way that resembles sitting at a large dining room table. This creates a sense of belonging and a community of learners, each as important as the other. The teacher is also seated at the large table, not at a desk in a corner of the room separate from the students. The teacher's position at the table is a way of being "with" the students as a partner on their educational journey. Conversation and discussion are prioritized in this learning environment. The collaborative-dialogic model for Xavier welcomes the multiplicity of thoughts and ideas, which helps reduce the fear of being "wrong" if speaking up as there is no single truth.

Students, staff, and parents address all staff at Xavier Academy by their first names. This helps to remove barriers to connection and encourages relationship engagement in several different contexts. Xavier Academy has prioritized relationships as the most important part of the student's education, as relationships are where all knowledge and learning are constructed. This school is an exceptional example of what education could look like, but sadly, it is one-of-a-kind and not the usual educational experience in the United States.

4. It Is Quite Different in The Kitchen

A culinary arts program, through a collaborative-dialogic perspective, provides a unique environment and way of communicating that dramatically supports the cognitive, behavioral, and social-emotional development of adolescents. It invites adolescents to engage in social situations, share what they have made with others, and receive praise for a job well done. As the research reported in this dissertation illustrates, this positive reinforcement served as motivation to learn more skills, bake more, and share more treats with others. This process also helped to build social competence as adolescents were willing to take social risks while feeling valued, respected, and supported.

The culinary arts program is activity-based, and adolescents were eager to participate. Together, the participant and I are partners in the relational process, communicating in an equitable and mutually respectful way about what is important for the adolescent at that particular moment while co-creating a product. By inviting different voices or perspectives along with the adolescents' thoughts, hopes, ideas, and goals into the conversation, new meanings, understandings, and knowledge were created that further supported their process of identity construction. Adolescents felt safe from judgment and became comfortable, relaxed, and confident in themselves as conversations felt unforced, natural, and ordinary. The transformation

in adolescents was noticeable when their negative self-narrative shifted to one of positivity, highlighting their accomplishments, what they can do, and what is unique and special about them. This was an observable step in the development of the self and identity development.

Baking during culinary arts sessions was challenging and encouraged skill-building, mastery, and increased self-esteem and confidence. An important part of this process was for the adolescent to learn how to learn, how to acknowledge their own success, and conversely, how to embrace failure as an opportunity to study and discover something new. For adolescents fighting a failure self-narrative, it is less risky to "fail" when the responsibility is shared, especially with a mentor. In the kitchen with the me, failure is a joint action. Failure is something that cannot be avoided, and it will happen; it is a sign of perfect imperfection and humanness. Failure provides an important opportunity to be still, to notice, to query our own thoughts and actions, and to persevere and overcome. Recent research has indicated that students learn more deeply from failure-based learning, and it is a precursor to deeper and transformational learning (Lam, 2019 & Mueller & Shephard, 2016).

Adolescents learn many other things in culinary arts sessions, including academic subjects. For example (1) English (recipes are precise technical documents), (2) mathematics (increasing or decreasing recipes, food cost, converting grams to ounces and ml to teaspoons), (3) history (learning about food origins, different cultural food themes and traditions), (4) geography (discovering regional recipes and what ingredients are indigenous to those regions), (5) chemistry (tempering chocolate, leavening agents, chemical reactions), and (6) biology (bread making includes yeast, a living microorganism).

The kitchen provides a safe and collaborative learning environment with active learning, where the adolescent is engaged "cognitively and meaningfully" (Chi & Wylie, 2014) and builds

on positive experiences, focusing on what they can do. Acknowledging the adolescent's efforts and accomplishments improves their emergent identities. The adolescent develops more social competence through the ordinary, everyday conversations that transpire with the collaborative therapist and through sharing what they have created in the kitchen with others. The power of inviting other voices into the conversation brings added perspectives and possibilities while exploring their own beliefs and perspectives. Different points of view may also highlight unique or hidden features of the adolescent that hadn't been noticed previously. A culinary arts program in a school setting provides a safe, nurturing environment where adolescents feel respected, supported, and valued, giving way to their willingness to try new things and take emotional risks, such as initiating positive social interactions. The relational process of constructing knowledge and meaning-making, a continual, unfolding process, influenced the adolescents' reality and improved their personal narrative and emergent identities (see Table 7).

Table 7

Culinary Therapy vs. U.S. Educational System

CULINARY ARTS PROGRAM	VS	U.S. EDUCATIONAL SYSTEM
Collaborative and creates an environment that doesn't induce anxiety.	**Anxiety**	Hierarchical system where teacher is the expert. Fear of failing invites more anxiety.
Encourages, focuses, and builds on positive experiences.	**Experiences**	Focus is on what was wrong, creates negative experiences.
The focus is on what adolescents can do and what is unique and exceptional about them.	**Abilities**	The focus is on failure or categorizing and pathologizing them.
Increases social competence.	**Socialization**	Discourages social involvement of those fearful of failure.
Emergent Identities with focus on accomplishments.	**Identity Story**	Prevents positive emergent identities by focusing on what was not accomplished.
Positive reinforcement. Desire to repeat those actions and recreate those feelings.	**Conditioning**	Negative punishment. Removing a pleasant stimulus to deter a behavior.
Adolescents are more open to trying something new when they feel respected, valued, and supported.	**Confidence**	Adolescents are not willing to take risks for fear of failure, embarrassment, shame, or looking dumb.
Invites many other voices or perspectives to conversations.	**Collaboration**	Teacher is the only voice, the expert.
Certain aspects, especially more nuanced or positive traits of the adolescent, are not visible from a single point of view.	**Assessment**	Students' traits are made public according to the teacher: lazy, slow, trouble-maker, difficult, stupid, etc.
Relational process. Unfolding and continual process.	**Pedagogy**	Individual process.

5. Dual Role of Practitioner and Researcher

In participatory action research, acting in the dual role of practitioner and researcher can benefit the production of knowledge in both professional and organizational settings, using information that an outsider would not have gained otherwise (Baum et al., 2006). The dual role of the researcher and practitioner provides a unique opportunity to capture the participants' lived experiences and explore the social and cultural contexts of the problem (Baum et al., 2006). However, the dual role requires I question and scrutinize my position in the complex and changing social context in which the study is conducted (Bordeau, 2000).

One important reflection area for me was the role of power and empowerment within the relationship with co-participants (Baum et al., 2006). Shifting the dynamic quality of power transactions between two or more people creates equity in the relationship, thereby decreasing disparities and power inequalities, theorized as empowerment by Herr & Anderson, (2005). PAR aims to shift the power relations between the researcher and the researched by creating local knowledge from within the relationship, thus empowering those being researched or the local participants directly impacted by it (Bordeau, 2000; Feekery, 2023). Bordeau (2000) suggests areas of power that are influenced by the level of the participants' vulnerability and the influence maintained by the researcher participant. It is thought that the more the relationship falls into intense realms of high-power differential and long duration, the greater the possibility of harm to the study participants (Bordeau, 2000). As the director of mental health services for Xavier Academy, I am an independent contractor and, therefore, have no formal role in the school administration. I work within the school setting in offices located in a private area of the school. All mental health sessions are confidential services provided separately from any direct school resources, and the school does not have access to any records indicating which students have

utilized my services nor access to confidential clinical files. However, as a department head, I can be perceived as holding a position of power within the research setting.

To attend to the first likely power imbalance I strove to create an environment where co-participants would be more likely to consider themselves like peers and referred to my study as a project we were working on. With the adolescent participants, I referred to our roles in the project as "partners" and "culinary co-creators" rather than as mentor and mentee or therapist and client, as those would likely have created a relationship that had more influence, and they were more vulnerable. This study occurred at Xavier Academy, where I had provided mental health services for students for more than 5 years. At the start of the study, teacher participants were colleagues with whom I had established relationships of mutual respect and trust. Their participation in this project was more like mutual collaborators as their observations offered unique and important perspectives of the students' experiences, contributing invaluable data for my research. My position with parent participants was the same as I have continually and sincerely purported my role to be as a mental health clinician providing services to adolescents. I partner with parents in supporting their children's healthy growth and development as they mature towards their adult lives. I intend that by being a partner, I am not in charge or the expert, but I am "with" them in this process together for a period of time that they determine is helpful for themselves and their child.

The second area of power imbalance Bordeau (2000) proposes is the duration of the relationship, from brief to intermediate to long, and extending along a continuum from a few contacts over a brief amount of time to continuous contact over a long period of time. It is proposed that the longer the continuous contact period, the more vulnerable those being researched may become. To attend to this potential power imbalance I established a specific

period of time during which each of the adolescent participants would attend 10-12 culinary sessions and participate in an interview to limit the time of continuous contact. I would have preferred a shorter window of time; however, since these sessions took place during the pandemic, I felt it was necessary to provide enough scheduling flexibility for the adolescent participants to complete the sessions, given that they may become infected and would need to isolate for an adequate period of time before continuing. The study also had an established period of time for participation for teacher and parent participants, extending 2-4 weeks beyond the adolescents' time period to allow adequate time for the interviews to be completed.

6. Researcher Positionality

According to Herr and Anderson (2005), researcher positionality is important in all research and requires that we ask the question, "Who am I in relation to my participants and setting?" (p 37). They point out that for action researchers, their relationship with participants and the setting is a significant quandary (Herr & Anderson, 2005). Action researchers may identify as insiders or outsiders to the setting or the participants, but the distinction between the two carries varying implications as does the fluid nature of insider or outsider as it can fluctuate throughout the course of the study (Herr. & Anderson, 2005).

Determining my positionality presented me with challenges regarding the complexities of the insider or outsider designation. I began by locating myself as an insider in collaboration with other insiders. The study participants were students, the students' parents, and teachers at the school where I provide mental health services. I thought of them all as insiders, especially since Xavier Academy promotes a family-type atmosphere at the school. I also considered that although all participants were related through the setting for the study, there were other nuances to our positions as insiders or outsiders that needed to be reflected on. For instance, the student

participants were all adolescents in high school, and I was an adult with a higher education degree, making me an outsider to the adolescent participants. All of the teacher participants work at Xavier Academy, just as I did. I too am a credentialed teacher, but I do not work in that capacity at the school and am, therefore, an outsider of that group. The parent participants were included as insiders in this research as they are closely involved with the school and their children. I, too, am a parent and can identify with the challenges of raising adolescents, but I am in a different phase of my life as an empty nester with no minor children that I am responsible for. Once again, I am outside the study participant group. After reflecting for quite some time on the nuanced insider or outsider position debate, I settled on my position as an insider within the research because of the family-like atmosphere of the school.

As I continued to locate myself on the positionality continuum, I considered that I had two outside research scientists who independently reviewed my research data throughout the thematic analysis process and offered alternative explanations and suggestions for categories, codes, and names for themes and sub-themes. They offered a critical assessment or peer review regarding my study. I also recruited two critical friends with knowledge of Xavier Academy and my practice to play devil's advocate and help expose potential problems or taken-for-granted aspects of my research setting (Herr & Anderson, 2005). This would shift my researcher positionality to insider(s) collaborating with outsiders. I believed that this closely resembled my position. However, as I progressed through the study, I recognized several times where I was an insider while simultaneously an outsider, highlighting the confusing nature and complexities of positionality.

A goal of this study was to deepen my own reflection on practice toward problem-solving and professional development and to generate knowledge from the inside out. Participatory

action research provided a way to get close to finding out what might produce new understanding of the culinary arts program. The cyclical process of developing a plan of action, implementing the action, observing the effects, and reflecting for further planning and subsequent action was an important process in helping me to maintain a collaborative position and not put "a positive spin" on my data or findings. I developed the culinary arts program for this study and had focused on baking, pastry, or chocolate work as those are my specific areas of expertise. Toward the end of one student participant's sessions, he asked if we could make pasta and bolognese from scratch in our next session. I responded that we were only making pastry-type items during our sessions. He appeared disappointed but didn't challenge my response. Later that week as I was reflecting on the effects of the sessions for further planning, I thought about the request to make pasta and my response. After processing this encounter, I realized that I was imposing my agenda and my own comfort level and not collaborating with my co-researcher.

The culinary arts program wasn't about baking, it was about the relationship and the knowledge and possibilities we created together in the kitchen while working together. With this in mind, I devised a plan of action and acted to implement it as Herr & Anderson (2005) would say, it was folding the action research immediately back into the program. To implement the plan, I informed the young man who requested to make pasta and bolognese that I had reflected on his request and found absolutely no reason why we couldn't make that together. During our next session, I discussed my reflection process with him and recognized I wasn't allowing his voice to be part of the decision-making process. I thanked him for speaking up and making his voice heard. We also made pasta and bolognese that he proudly took home to serve to his family for dinner. Still, more importantly, our relationship shifted in an important way, which he later

described as “trust” in me, and our conversations deepened, allowing for new learning, understanding, and transformation. While his experience and transformational moments are documented in the interview data, mine are not, so I will share them here.

In further reflection, after our pasta-making session, I was acutely aware that while my initial intentions may have been good or neutral (or not well thought out), my inflexibility and desire to control the process created a power imbalance and the potential to damage the relationship. The process, the action research spiral, provided a way for me to check myself and recognize the misstep, determine corrective action, implement the action, and observe the effects. This incident and the experience described earlier in the discussion of findings relating to my personal narrative made explicit just how critical and valuable the spiral of self-reflective cycles is in the participatory action research process.

4.4 Strengths and Limitations

This section will consider the possible strengths and limitations that may influence this study. It will include a look at thematic analysis as an approach, social construction as an epistemology, additional constructionist research scientists, adolescent study participants' voices in the study, study participant rates of completion, participatory action research as a methodology, and the study’s relevance as strengths. The consequences of COVID-19 on participants, possible selection and respondent bias as well as researcher bias as potential limitations.

One strength of this study was the use of thematic analysis, an approach that is theoretically flexible and versatile with fewer restrictions yet provides a general framework for carefully detecting, organizing, and highlighting shared patterns of significance to the research questions (Braun & Clarke, 2012). The process of thematic analysis identifies new beliefs, can

help consider the diverse perspectives of different study participants, and reveals both connections and disparities (Nowell et al., 2017). For this study, thematic analysis provided an appropriate and necessary qualitative method of analysis that can be used successfully when analyzing large sets of data (Braun & Clarke, 2006; Braun & Clarke, 2012; Nowell et al., 2017).

Another study strength, in particular, was the use of a social construction-informed epistemology that adopts the understanding of the connection between language and experience as a reciprocal process (Byrne, 2021) and carries with it research design decisions that highlight the socially constructed nature of reality and meaning-making (Gergen & Gergen, 2008). Utilizing an inductive approach, themes that are identified are closely associated with the data (Braun & Clarke, 2012). The themes created to represent clusters of meaningful data I determined on a latent or interpretive level (Braun & Clarke, 2006). Believing that meaning and experience are socially produced, I focused on the sociocultural context and its influence on the study participants' interpretations and experiences (Braun & Clarke, 2012).

Further strengthening the study was the social interaction between the study participant and me, a process of shared and agreed-upon meaning making through language (Roy-Chowdhury, 2010). This socially negotiated reality increased the authenticity, accuracy, and richness of the study's data (Roy-Chowdhury, 2010). It allowed me to be more immersed in the research with the ability to examine it in more detail and depth (Nowell, 2017).

Two additional research scientists participated in creating codes across the entire data set, using a social constructionist approach until saturation was reached. This process could also be considered *data-meaning-making* (Camargo-Borges & McNamee, 2022). These two research scientists also played an essential role in generating themes in a "dynamic and fluid way" (Camargo-Borges & McNamee, 2022), which helped to expand ideas and possibilities during the

process and was an added strength in this study.

The participant completion rate also added additional strength to this study. Seventeen student volunteers were recruited to participate in the study, with the aim of having 12 completers. I anticipated that due to the length of commitment to the study and potential infection—this research took place during the COVID-19 epidemic—it was likely there would be student volunteers who would withdraw from the study. However, all 17 student participants completed the requirements of the study, thereby providing a more robust data set.

Further strengthening the study was using participatory action research as a methodology. The social interaction between the study participant and me is a process of shared and agreed-upon meaning-making through language (Roy-Chowdhury, 2010). This socially negotiated reality increased the study's data's authenticity, accuracy, and richness (Roy-Chowdhury, 2010). It allowed me to be more immersed in the research with the ability to examine it in more detail and depth (Nowell, 2017) and allowed deep access that would be difficult from an outsider role (Herr & Anderson, 2005).

Adolescents with anxiety were the group researched, and their included voices were a large part of the research process. This research provided a significant description of the experience of anxious adolescents in this culinary arts program and allowed the adolescents involved to have their voices heard in and a say in their own health care.

This research focused on a group of 17 adolescents in school in one area of the United States. While anxiety in children and adolescents is ranked number one in the United States for diagnosed mental health disorders, it is ranked number six globally, making this research relevant worldwide.

There were limitations in this study. One limitation was that the culinary sessions took

place during the COVID-19 pandemic, which may have affected the adolescents who participated in the study. Students with a compromised immune system or living with someone who has a compromised immune system were likely not able to participate due to the high risk of contracting COVID-19.

Another limitation of the study was the requirement to wear masks to minimize exposure or spread of infection during the pandemic. Recognizing that most communication is non-verbal, the researcher could not read facial clues and likely missed more nuanced expressive communication.

There also may have been selection bias as student participants who volunteered to participate in the study may have previously enjoyed cooking and baking, making them more likely to be committed to the study protocol, complete all required sessions, and have a positive experience.

It is possible that participants answered interview questions in a way that would be socially acceptable or to please me by saying what they think I am looking for in a response, which could have impacted the study's data.

My dual role of participant and researcher requires critical examination of my own bias while keeping any pre-existing assumptions at bay. I questioned myself in relation to the inquiries under study and participated in an ongoing circular process of reflection, research, and action as a way to mitigate my own ideas or perspectives. As an insider, I truly believe in my practice and may have unintentionally put my data in a positive light or not been able to interpret the data from a position of neutrality, which would be a limitation on this study.

4.5 Implications

Currently, in the United States, there is a surging epidemic of adolescents struggling with

symptoms attributed to anxiety that include high levels of functional impairment. This has produced a substantial public health issue. This crisis continues because the prescribed treatment for adolescents facing anxiety isn't effective (Higa-McMillan, 2015). While adolescents languish, falling farther and farther behind their counterparts, further increasing the likelihood of more severe mental health struggles during their adulthood, those in the medical community involved in the diagnosis and treatment of anxiety in adolescents continue to modify current low-success treatment modalities or create new variations of the same ineffective therapeutic interventions. It seems an absurd bandage on a growing wound. There is an urgent priority to develop safe and effective treatments for adolescents with anxiety (Baker er al., 2021; Walter et al., 2020, Hill et al., 2016).

What is known about adolescents is that they thrive when they receive positive reinforcement, which encourages them to repeat the same positive behavior and decreases anxiety (Lim et al., 2019). Noticing and expanding on a child's strengths builds resiliency and also decreases anxiety (Gasparovich, 2008). Young people prefer activities that are engaging and thrive in active learning environments where it is safe to take risks, fail, try something new, succeed, and improve confidence and emergent identities. These are environments that are challenging and developmentally appropriate for adolescents who are in their most vulnerable phase of life, at high risk for anxiety, and, at the same time, trying to develop their identities, and determine their values and belief systems.

This study demonstrates that culinary therapy provides a unique activity-based, interactional, and client-centered environment that offers skill-building, mastery, and social-emotional learning while emphasizing the relationship and working as partners in baking. Through the relational creation of meaning and knowledge, multiple perspectives and truths are

challenged, new possibilities emerge, and opportunities to grow and become are generated. Adolescent participants in the culinary arts program like it; it is effective, and it can be made accessible in a safe and natural environment.

1. What is Going on in the Kitchen?

So, what is really happening during culinary therapy that makes it a successful mental health intervention? The collaborative-dialogic way of being "with" is how I position myself both in the therapy room and in the kitchen when I offer culinary sessions. I enter each session with a measure of uncertainty and am not too quick to "know," but rather, I am very curious. Each adolescent participant can choose an item they would like to co-create in the kitchen. In this way, I am honoring the adolescents' knowledge of themselves, their situations, and, in particular, their preferences and tastes.

Withness relationships (Shotter, 2011) in culinary therapy encourage a culinary process that is more egalitarian. Importantly, this fosters more involvement as participants view themselves as more equitable. My attitude, way of being, and relationship with the adolescents in culinary therapy affect how and what we create. Each culinary session is unique, and that which I might have thought to be familiar is created in a whole new and novel way.

In the culinary sessions, I regard adolescents as experts on themselves, their experiences, their particular tastes, and their world. My responsibility, having expertise in baking, pastry, and chocolate work and facilitating relationally responsible conversation, involves preparing an appropriate space. A space that is safe and comfortable and that invites the adolescent into the process of culinary creativity and meaningful, bi-directional conversation. My knowledge is not more important than the resources the adolescent brings, and it is through our interactive process of dialogic responses, along with mutual teaching and learning, that together we develop our

relational expertise, create new knowledge and meaning, and create our delicious product.

During culinary sessions, I only provide direction or teach if an adolescent communicates a need for it in some way. I do not assume to know how much the adolescent knows, what they are thinking, or what experience they may have regarding culinary skills or transference of skills. If I were to "know" an adolescent had very few or no culinary skills, I would run the risk of "doing for" instead of "doing with" and potentially limit the adolescent's confidence, resourcefulness, and creativity.

A culinary arts program offers a unique opportunity to be spontaneous and embrace uncertainty for the adolescent and for me. Baking, pastry, or chocolate work involves a specific sequence of steps, procedures, calculations, and chemical reactions to occur at precise moments in a particular way. Sometimes the process does not go as planned, and we must act spontaneously to adjust the process or salvage a product. As conversational partners and co-creators, we coordinate our actions as we respond to each other to negotiate our next steps. Uncertainty is a constant in in culinary arts sessions. When products are baking, cooling, curing, or solidifying in the refrigerator, there is always the apprehensive thought, "I hope this turns out right." The element of uncertainty and surprise remains throughout nearly the entire course of the culinary therapy session. Over time, the fear associated with this uncertainty is replaced with the confidence that together, we can adjust or do whatever the situation calls for.

As a partner in these culinary sessions, I am using my culinary expertise to model skills and confidence, inspire, and co-create with the adolescent participants the products they choose. However, the most fundamental and authentic aspect of culinary therapy is not a praline, a cake, a cookie, or a pastry; rather, it is our way of communicating, our dialogic interaction with the other, our relationship, and the meaning we create together. The kitchen represents an

ordinary, everyday environment and generates conversations and connections in the same way that they would occur in everyday life. In culinary sessions, we enjoy ordinary language and conversation in an ordinary setting while doing ordinary things together. In sum, we could say that the collaborative-dialogic approach is a humanizing practice and given the observed results of this study, could be considered a therapeutic modality with culinary arts providing a unique way to utilize it.

2. Other Ways to Offer Humanizing Practices

Other types of collaborative, action-oriented or activity-based approaches that offer a skill-building component, as well as social-emotional learning from a social-construction context where new knowledge and meaning are created relationally, could be successful in the treatment of adolescents with anxiety and easily accessible if designed for implementation in a school setting. Art, woodworking, auto shop, sewing and textiles, fashion design, cosmetology, and therapy with animals are just a few possibilities. Through these experiences, authentic learning can occur cognitively, physically, emotionally, and tangibly (Alanazi, 2015).

The activity itself is not the catalyst for transformation or change but provides an incomparable environment for meaningful social engagement and opportunities to try new things, to take risks, to fail, to problem solve and try again, to fail better, to learn by doing, to create, to explore wide-ranging perspectives and possibilities, and to apply what they have learned. What is transformational is the collaborative-dialogic approach, the equitable partnership between therapist and adolescent that invites a different way of listening, reflecting, and responding to the other that communicates respect, value, and that what you have to say is important and matters (Anderson 2012).

3. What is Therapy?

The Cambridge Dictionary (2024) defines therapy as "a treatment that helps someone feel better, grow stronger, etc." The National Institute of Mental Health (2024) refers to the general goal of therapy to "improve quality of life."

What does therapy look like? Traditional therapy occurs in a therapist's office, usually one-on-one, with the adolescent and therapist sitting across from each other. In this environment, the therapist, who is the expert, asks the non-expert adolescent who needs help questions to identify their maladaptive behaviors and thoughts and then explains to the adolescent what is wrong and what to do to fix it. Adolescents do not like this type of therapy. It is negative, deficit-based, pathologizing, reinforces the same thoughts and behaviors, and a failure narrative. These offices are usually located in medical centers or buildings; for many, it is stigmatizing and embarrassing and often brings shame.

What should therapy look like? Therapy should look like usual, every day, ordinary activities with others. Meaningful conversations about what the adolescent is concerned about are discussed bi-directionally, encouraging new ideas and understandings. New possibilities are generated by inviting more voices and perspectives to the conversation, and adolescents are supported in learning and critical thinking. If therapy is to help an adolescent feel better, grow stronger, and improve their quality of life (Cambridge Dictionary, 2024; NIMH, 2024) then therapy would be best if it were a positive experience, one where adolescents value what they are gaining and strive to continue and do more to recreate the positive feelings. It should be a place that adolescents want to go to because they feel better about themselves and their process of becoming.

What is therapeutic, who decides, and who establishes what is helpful? Currently, a medical community has created the criteria for diagnosing and classifying mental disorders.

Physicians, psychiatrists, psychotherapists, etc., determine the treatment type for a particular diagnosis, that is, they determine the best therapeutic intervention or therapy. Where different treatments are offered for a similar diagnosis, the adolescent's parent then chooses on their minor child's behalf. The treating professional and the parent(s) of the adolescent determine if a particular treatment is therapeutic by their own observations of the adolescent's behavior. What is most apparent is that the adolescent's voice is not included in either of these critical questions. From social construction and collaborative-dialogic perspectives, adolescents are experts on themselves, their feelings, thoughts, what they prefer, and what is helpful to them. Generally speaking, adolescents have a good understanding of what they are experiencing and how it affects them, yet their voice is absent in decisions made about them, and for them, or worse, it is expressed but ignored by those who "know better."

If it works, is it therapy? For this study, I created a culinary arts program and invited adolescents to participate in a research project with me. I did not refer to the culinary arts program as therapy or to myself as a therapist engaging in therapy. Instead, I took the position of a culinary co-creator, a partner in the kitchen who brought some culinary expertise to our relationship. Given the observed results of this study, the culinary arts program was therapeutic for the adolescent participants as it had a good effect on their body or mind or contributed to their sense of well-being. The data also indicated that adolescents not only preferred culinary sessions over traditional therapy, but they also enjoyed our time together in the kitchen, felt better and had less anxious symptoms. Does this make it therapy?

Is therapy as we know it an outdated idea? Diagnoses have been socially constructed by the dominant medical culture as a way of naming and describing behavior. From a constructionist view, it is noted that diagnoses are deficit-based (Gergen et al., 1996). In

addition, it is noted that in naming a behavior, we bring it into being. It is worth questioning whether a diagnosis might be re-languaged in a way that offers the possibility to the person being diagnosed. For many, but especially adolescents, diagnosis and labels become part of their identity. Even if the diagnosis or label isn't accurate, adolescents (and others) accept it as truth and have a way of "growing into it" or adopting it as part of their identity. Diagnosing or fitting adolescents into categories may, at times, have value, but it also can be detrimental and is not necessary to provide help (Gergen et al., 1996).

In the United States, a diagnosis is required to see a mental health care provider so that they can bill and receive payment for services rendered from insurance companies. In other words, you cannot use your insurance benefits to have a conversation with a therapist unless you are labeled with a diagnosis that then becomes part of your permanent health record. Each diagnosis also carries with it a preferred treatment method and a specific number of sessions determined by the insurance company, not by the treating therapist.

Perhaps reimagining the entire system for therapy is in order. As suggested by Gergen et al. (1996), imaginably a system could be developed that provided a sort of "no-fault" coverage for mental health care. One where each person is entitled to a certain number of sessions yearly that can be utilized as preferred without a diagnosis. Possibly, this would help to destigmatize therapy, reduce the amount of negativity and failure narratives that accompany diagnosis, therefore encouraging a culture of positivity and self-care. Therapy could then be known as a place that invites meaningful conversation and transformation.

A culinary arts program in schools could do just that, with the added benefit that it provides these benefits to *all* children, not just those with the benefit of health insurance. An adolescent does not need to have a diagnosis or deficit to participate in culinary arts, just a desire

to learn something new, improve the quality of their life, feel better, and grow stronger. Recognizing and celebrating developing adolescents as their unique selves, as having value and importance, invites them into generative conversation and is beneficial or therapeutic. Without the additional burden of removing labels placed on them, their emotional growth and well-being, which are critical to healthy child development and academic success (Djambazova-Popordanoska, 2016; Eisenberg et al., 2005), are likely to come to fruition more quickly and easily.

The takeaway from this research is not that collaborative-dialogic programs should be mandated for all youth. The takeaway is that such programs offer the possibility of an alternative to traditional talk therapy or medication for adolescents with anxiety symptoms. It is an activity or experience that is found to have the potential to shift ‘adolescents' identity stories in generative ways and can be delivered in the school setting, increasing access, especially for those who might not have other options for mental health care available to them. Anxiety, whatever that is, was changed.

4.6 Suggestions for Future Research

Although this study supports a culinary arts program in a school setting as an effective intervention for adolescents struggling with anxiety, future research could help broaden the possibilities of activity-based relational learning and provide insight into the possible long-term benefits of such activities.

How would adolescents experience participating in a culinary arts program in a school setting in groups of 4 - 6 students? Would they experience a noticeable shift in their identity stories?

Could this study's results be replicated using a different activity-based learning program

delivered through a collaborative-dialogic perspective in a school setting? For example: auto-mechanics, textiles and design, woodworking, or art.

How did the lives of the 17 adolescent participants in this study unfold over time, and how did they utilize the resources they acquired in adolescence in their adult lives?

How would adopting new language, from a social constructionist perspective, around the diagnosis of anxiety and its treatment, which shifted it from deficit-based and pathological to strengths-based and empowering, impact the lives of adolescents, their parents, and their families? Suppose anxiety was re-named "qualities of exceptional leadership" or "emergent executive skills," and its symptoms were reframed as action resources of powerful motivation and energy, being observant and carefully considering multiple possible outcomes, and paying particular attention to detail while being supportive of others. Would it change the landscape of adolescent mental health from one of an adolescent anxiety epidemic to a surge in future problem solvers or exceptional youth governance?

4.7 Significance of Study

1. Significance to Theory

This approach, collaborative-dialogic practices delivered in a culinary setting, offers an activity-based treatment modality as an alternative to traditional talk therapy or medication for adolescents struggling with symptoms of anxiety. An intervention specifically for mental health care in the kitchen is novel in the therapeutic domain and expands collaborative-dialogic practices as a way of conversing with people outside the realm of traditional language systems in different contexts.

2. Significance to Practice

Current research utilizes culinary education to improve physical health outcomes. While

there is growing evidence for the emotional benefits of cooking, scientific inquiry is limited in the study of adolescents participating in culinary arts sessions specifically for mental health care. This analysis will be the first to explore the experience and efficacy of anxious adolescents participating in a culinary arts program within a school setting, specifically for mental health care. It will thus fill an existing gap in the literature.

Culinary arts sessions provide practitioners with a unique opportunity to invite dialogic conversation in an environment that is comfortable, natural, and nurturing. Client and practitioner are partners and culinary co-creators, and from within the relationship, they jointly create and transform meanings and understandings concerning their dilemmas and create possibilities (McNamee et al., 2023) about what they can do about them while creating a tangible product together.

3. Significance to Social Change

A culinary arts program offers clients an opportunity to receive mental health care in a natural environment, the kitchen. The space could be a therapist's designated office kitchen or a kitchen at a residential facility, school, church, or even the client's home. This therapy can also be utilized for individuals, couples, families, or groups. The impacts of culinary arts sessions, including metaphors that make sense of plurality of meaning, create a powerful, mutually transformative experience. This current study builds on my previous research, which suggests that culinary arts sessions are a non-stigmatizing, educational, and effective way of treating participants (Paul, 2012).

This study empowered adolescents in the research process, allowing them to have a voice and ownership in a process for change in mental healthcare that could impact their futures.

4. Significance to Policy

The culinary arts program for mental healthcare located within a school setting was quite successful as a treatment option for adolescents with symptoms of anxiety. It could be an important contribution to the further development of healthcare services. Providing activity-based treatment options, using a collaborative-dialogic perspective in schools, may offer a possible solution for promoting mental healthcare with a potentially effective way to provide access for low socio-economic status adolescents and others not covered by health insurance.

4.8 Conclusion

Increasing numbers of vulnerable adolescents are facing disabling symptoms of anxiety, which has now become the most frequently diagnosed childhood mental health disorder in the United States. Current treatment protocols are ineffective, and many adolescents continue to live in distress. Offering an alternative to medication or traditional talk therapy, a collaborative-dialogic treatment approach, made available through a culinary arts program, has shown promising results in reducing symptoms of anxiety in adolescents.

This culinary arts program offers an innovative way to deliver collaborative-dialogic practices. This relational, generative, and social process created new understandings and possibilities (Anderson, 2012a) for the adolescent participants. Two main constructionist topics were frequently referred to and discussed. First, was the constructed nature of reality, which encourages challenging taken-for-granted assumptions, and second, was polyvocality, the power of many voices. The processes of questioning the dominant discourses or "truths" and welcoming multiple perspectives were pivotal in supporting the adolescents' development. As the adolescents began questioning the oppressive and devalued labels they had been assigned, other narratives and perspectives, including their own, entered the conversation, and a noticeable shift or transformation began. The shift in student participants can also be considered the

creation of their preferred emergent identities.

Identity formation is a collaborative process, as people create, rather than discover, themselves through relational processes with others. Collaborative-dialogue provides a humanizing, relational approach that complements identity formation, supports adolescents' developmental processes and has transformational potential.

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Appendix A

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Brussel, 26-11-2020

Ons Kenmerk: 2020/234

This is an English translation of the original Dutch Text, received from the Ethical Committee

OPINION FROM THE MEDICAL ETHICS COMMITTEE

Regarding:
Kitchen Conversations: Anxious Adolescents and Collaborative Dialogue in a Culinary Setting
Protocol nr 1
B1432020000149
After taking note of the documents concerning the aforementioned project, including the answers to the committee's questions, the accompanying letter dated 16-07-20 and the adjustments to Appendix 5 and Appendix 9, the addition of Appendix 10 and protocol v2 dated 16-07-20, and after an additional evaluation, the Medical Ethics Committee has decided that there are no ethical objections to the conducting of this study, on the condition that all the legal permissions are obtained as determined in the local regulations on scientific research, including the condition that participants must be appropriately insured.

The committee wishes to comment that, since vulnerable young people are involved, it is the responsibility of the promotors to provide sufficient monitoring/supervision of this study.

The committee wishes to receive an annual overview of the project's progress. The results of the study must be transmitted to the committee when the study ends. It reminds the person responsible for the experiment that this experiment will be conducted under his personal responsibility. The committee's advice does not mean in any way that the committee takes responsibility upon itself for the experiment. The Medical Ethics committee works and is organised according to the ICH-GCP guidelines.

With the greatest regards,

[signature]

Prof. A. Van Scharen, ondervoorzitter

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Ons kenmerk: 2020/234

MEMBERS OF THE MEDICAL ETHICS COMMITTEE UZ BRUSSEL - VUB (since 04-03-2020)

Name	Function	Gender
Prof. Dr. D. Michielsen, MD, PhD	CHAIRMAN Urology UZ BRUSSEL	M
Mrs. A. Van Scharen, LLM	VICE- CHAIRMAN Legal Expert UZ Brussel	F
Dr. Y. Adriaenssens, MD	General Practitioner Mechelen	M
Mrs. B. Blommaert	Nurse UZ BRUSSEL	F
Dr. A. Bretz, MD	Medical Oncology /Radiotherapy UZ BRUSSEL	F
Prof. Dr. F. Cools, MD, PhD	Neonatology UZ BRUSSEL	M
Mrs. R. Cools	Nurse UZ BRUSSEL	F
Dr. Apr. P.-J. Cortoos, PhD	Pharmacist UZ BRUSSEL	M
Dr. P. Flamee, MD	Anesthesiology UZ BRUSSEL	M
Mr. B. Humblet	Patient representative External Member	F
Prof. Dr. P. Lacor, MD	Internal Medicine UZ BRUSSEL	M
Prof. Dr. C. Schotte, PhD	Clinical Psychology UZ BRUSSEL	M
Prof. B. Bravenboer, PhD	Pharmacology - Faculty of Medicine and Pharmacy VUB	F
Dr. K. Vergaelen, MD	Intensive Care UZ BRUSSEL	F
Prof. Dr. I. Willekens, MD, PhD	Radiology UZ BRUSSEL	F

Appendix B

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the day	Nearly every day
1. Feeling nervous, anxious, or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4, Trouble relaxing				
5. Being so restless that it is hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid, as if something awful might happen				

COLUMN TOTALS _____+_____+_____+_____

Total score_____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult____

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of O, 1, 2, and 3 to fie response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day." GAD-7 total score for the seven items ranges from O to 21.

0—4: minimal anxiety 5-9: mild anxiety 10-14: moderate anxiety 15-21: severe anxiety

Appendix C

INFORMED CONSENT FORM FOR PARTICIPATION IN A RESEARCH STUDY

Adolescent Participants

RESEARCHER AND TITLE OF STUDY

My name is Josephine (Josie) Paul and I am a doctoral student at the Taos Institute and Vrije Universiteit, Brussels. I will be conducting a study titled: Kitchen Conversations: Exploring How Collaborative and Dialogic Space Enriches the Identity Stories of Adolescents

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to better understand how "Kitchen Conversations" enrich the identity stories of adolescents who find themselves in challenging social situations.

WHAT DOES YOUR PARTICIPATION IN THIS STUDY INVOLVE?

If you choose to participate in this study, you will be asked to attend 10-12 baking sessions with the researcher. This will take place over a period of 6-12 months. During these sessions, you will choose among a range of recipes and learn how to create "professional quality" baked goods. The Generalized Anxiety Disorder 7-item scale (GAD-7) will be given before the first baking session and again at the conclusion of the last baking session. You will also be asked to participate in an interview with the researcher after the final GAD-7 has been completed.

WHAT ARE THE POSSIBLE RISKS FOR PARTICIPATING IN THIS STUDY?

Participants will be provided full instruction on kitchen safety and sanitation, but there is always a small risk of injury, as there is for anyone who works in a kitchen (i.e., knife cut, oven burn, steam burn, etc.).

WHAT ARE THE POSSIBLE BENEFITS TO PARTICIPATING IN THIS STUDY?

Participants will learn practical kitchen skills and baking techniques. The participant will take the item they have created to share with family/friends. Participants may earn an elective credit for school if they complete a minimum of 10 sessions and create a portfolio of their work.

DO YOU HAVE TO PARTICIPATE IN THIS STUDY?

Taking part in this research is voluntary.

CAN YOU WITHDRAW FROM THIS STUDY?

You do not have to participate, and you can withdraw at any time.

HOW WILL THE CONFIDENTIALITY OF YOUR RECORDS BE PROTECTED?

I seek to maintain the confidentiality of all data and records associated with your participation in this research.

There are, however, rare instances when I am required to share personally identifiable information according to Marriage and Family Therapists ethical standards and Texas state laws. For example, law requires me to report child abuse or threatened violence against self or others to the parents or guardians of minors, and/or law enforcement officials and Child Protective Services. All written data will be numbered for identification and stored in a locked file cabinet in the researcher's business office. Recordings of interviews with study participants will also be numbered for identification and stored in a locked file cabinet in the researcher's business office. A separate list, that identifies each participant by his or her assigned number, will be stored in a separate locked file cabinet in the researcher's home office. The recordings will be destroyed after they are transcribed, and all transcriptions will be destroyed at the close of the research.

WHOM TO CONTACT IF YOU HAVE QUESTIONS ABOUT THIS STUDY?
If you have any questions pertaining to the research, you can contact and discuss them with:

*Researcher: Josephine Annette Paul; Josephine.Annette.Paul@vub.be tel.+1(210)464-4556
*Promotor Vrije Universiteit Brussel: Prof. Dr. Johan Bilsen; johan.bilsen@vub.be
*Taos Institute Advisor: Dr. Sheila McNamee; sheila.mcnamee@unh.edu

This research has been reviewed and approved by the Ethical Committee of the Vrije University Brussel in Belgium, whose task it is to make sure that research participants are protected from harm.

General Data Protection Regulation (GDPR), which has been in force since 25/02/2018

1. "The data will be processed in accordance with the principles imposed by the new European General Data Protection Regulation (GDPR), which came into effect on 25 May 2018.";

2. "Personal data belonging to you will be collected in the context of the research you are participating in. We are responsible for proper processing and the obligation to provide information that this entails.

3. "Clearly we are only allowed to use your personal data for the scientific research purposes described on the informed consent form.";

4. "It is possible that your data will be seen by persons in countries that do not apply the same legal standards for data protection as those in the EU. In that case, we are committed to ensuring that the conditions of European and Belgian legislation concerning the protection of personal data are enforced.";

5. "Consequently, we would like to inform you that, in accordance with the relevant legislation, the data collected as part of this research will be stored for at least 5 years in a locked file cabinet in the researcher's business office."

6. “According to the GDPR, you have a number of rights relating to the processing of your data. If you have further questions about these rights, you are always welcome to contact the data protection official at the VUB: dpo@vub.be.”;

7. “Finally, you also have the right to file a complaint about the way your information is treated. You can submit this complaint to the Belgian supervisory authority that is responsible for enforcing the data protection legislation:

Data Protection Authority (DPA)

Rue de la presse 35,

1000 Brussels

Tel. +32 2 274 48 00

e-mail: contact@apd-gba.be

website: www.gegevensbeschermingsautoriteit.be.”

I, _____, agree to participate in this research study.

_____ _____

Signature of Adolescent Participant Date

I, _____, CONSENT/AGREE to allow my

child, _____, to participate in this research study.

_____ _____

Signature of Parent or Guardian Date

I confirm that the individual giving consent has done so freely and voluntarily.

A copy of this Consent for Participation has been provided to the participant(s).

_____ _____

Signature of Researcher/Person gaining consent Date

Appendix D

INFORMED CONSENT FORM FOR PARTICIPATION IN A RESEARCH STUDY

Parent/Guardian Participants

RESEARCHER AND TITLE OF STUDY

My name is Josephine (Josie) Paul and I am a doctoral student at the Taos Institute and Vrije Universiteit, Brussels. I will be conducting a study titled: Kitchen Conversations: Exploring How Collaborative and Dialogic Space Enriches the Identity Stories of Adolescents

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to better understand how "Kitchen Conversations" enrich the identity stories of adolescents who find themselves in challenging social situations.

WHAT DOES YOUR PARTICIPATION IN THIS STUDY INVOLVE?

If you choose to participate in this study, you will be asked to participate in an interview with the researcher at the conclusion of your child's 10-12 baking sessions and their post culinary therapy interview. The researcher will ask you to share your observations of any behavioral and/or emotional changes that you noticed during the time you child was participating in the baking sessions.

WHAT ARE THE POSSIBLE RISKS FOR PARTICIPATING IN THIS STUDY?

Minimal risk from participating in this research may occur through changes in thought processes and emotions. Stress and feelings of guilt or embarrassment may arise simply from thinking or talking about one's own behavior or attitudes on sensitive topics related to their children**.**

WHAT ARE THE POSSIBLE BENEFITS TO PARTICIPATING IN THIS STUDY?

Parent/Guardian participants may benefit from catharsis, self-acknowledgment, sense of purpose, self-awareness, healing, and the validation of being understood and of having one's story heard in full without judgement. They may also benefit from the chance to have one's story joined with others in such a way as to create a 'voice' on a topic of shared experiences and the knowledge that findings will be published and communicated to other mental health providers.

DO YOU HAVE TO PARTICIPATE IN THIS STUDY?

Taking part in this research is voluntary.

CAN YOU WITHDRAW FROM THIS STUDY?

You do not have to participate, and you can withdraw at any time.

HOW WILL THE CONFIDENTIALITY OF YOUR RECORDS BE PROTECTED?

I seek to maintain the confidentiality of all data and records associated with your participation in this research.

There are, however, rare instances when I am required to share personally identifiable information according to Marriage and Family Therapists ethical standards and Texas state laws. For example, law requires me to report child abuse or threatened violence against self or others to the parents or guardians of minors, and/or law enforcement officials and Child Protective Services. All written data will be numbered for identification and stored in a locked file cabinet in the researcher's business office. Recordings of interviews with study participants will also be numbered for identification and stored in a locked file cabinet in the researcher's business office. A separate list, that identifies each participant by his or her assigned number, will be stored in a separate locked file cabinet in the researcher's home office. The recordings will be destroyed after they are transcribed, and all transcriptions will be destroyed at the close of the research.

WHOM TO CONTACT IF YOU HAVE QUESTIONS ABOUT THIS STUDY?
If you have any questions pertaining to the research, you can contact and discuss them with:

*Researcher: Josephine Annette Paul ; Josephine.Annette.Paul@vub.be; tel. +1(210)4644556
*Promotor Vrije Universiteit Brussel: Prof. Dr. Johan Bilsen; johan.bilsen@vub.be
*Taos Institute Advisor: Dr. Sheila McNamee; sheila.mcnamee@unh.edu

This research has been reviewed and approved by the Ethical Committee of the Vrije University Brussel in Belgium, whose task it is to make sure that research participants are protected from harm.

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3. "Clearly we are only allowed to use your personal data for the scientific research purposes described on the informed consent form.";

4. "It is possible that your data will be seen by persons in countries that do not apply the same legal standards for data protection as those in the EU. In that case, we are

committed to ensuring that the conditions of European and Belgian legislation concerning the protection of personal data are enforced.";

5. "Consequently, we would like to inform you that, in accordance with the relevant legislation, the data collected as part of this research will be stored for at least 5 years in a locked file cabinet in the researcher's business office."

6. "According to the GDPR, you have a number of rights relating to the processing of your data. If you have further questions about these rights, you are always welcome to contact the data protection official at the VUB: dpo@vub.be.".

7. "Finally, you also have the right to file a complaint about the way your information is treated. You can submit this complaint to the Belgian supervisory authority that is responsible for enforcing the data protection legislation:

Data Protection Authority (DPA)

Rue de la presse 35,

1000 Brussels

Tel. +32 2 274 48 00

e-mail: contact@apd-gba.be

website: www.gegevensbeschermingsautoriteit.be."

I, _____, agree to participate in this

research study.

_____ _____ Signature of

Participant Date

I confirm that the individual giving consent has done so freely and voluntarily.

A copy of this Consent for Participation has been provided to the participant(s).

_____ _____

Signature of Researcher/Person gaining consent Date

Appendix E

INFORMED CONSENT FORM FOR PARTICIPATION IN A RESEARCH STUDY

Teacher Participant

RESEARCHER AND TITLE OF STUDY

My name is Josephine (Josie) Paul and I am a doctoral student at the Taos Institute and Vrije Universiteit, Brussels. I will be conducting a study titled: Kitchen Conversations: Exploring How Collaborative and Dialogic Space Enriches the Identity Stories of Adolescents

WHAT IS THE PURPOSE OF THIS STUDY?

The purpose of this study is to better understand how "Kitchen Conversations" enrich the identity stories of adolescents who find themselves in challenging social situations.

WHAT DOES YOUR PARTICIPATION IN THIS STUDY INVOLVE?

If one of your students chooses to participate in this study, he/she will be asked to attend 10-12 baking sessions with the researcher. This will take place over a period of 3-4 months. At the conclusion of the baking sessions and following your student's interview, the researcher will interview you and ask about observed behavioral and emotional changes.

WHAT ARE THE POSSIBLE RISKS FOR PARTICIPATING IN THIS STUDY?

Teacher participants may risk alterations in relationships with others by labeling a student in a way that will have negative consequences or cause them embarrassment or to feel less than.

WHAT ARE THE POSSIBLE BENEFITS TO PARTICIPATING IN THIS STUDY?

Teacher participants may benefit from a sense of purpose, empowerment, and providing a voice for the student participant.

DO YOU HAVE TO PARTICIPATE IN THIS STUDY?

Taking part in this research is voluntary.

CAN YOU WITHDRAW FROM THIS STUDY?

You do not have to participate, and you may withdraw at any time.

HOW WILL THE CONFIDENTIALITY OF YOUR RECORDS BE PROTECTED?

I seek to maintain the confidentiality of all data and records associated with your participation in this research.

All written data will be numbered for identification and stored in a locked file cabinet in the researcher's business office. Recordings of interviews with study participants will also be numbered for identification and stored in a locked file cabinet in the researcher's business office. A separate list, that identifies each participant by his or her assigned

number, will be stored in a separate locked file cabinet in the researcher's home office. The recordings will be destroyed after they are transcribed, and all transcriptions will be destroyed at the close of the research.

WHOM TO CONTACT IF YOU HAVE QUESTIONS ABOUT THIS STUDY?
If you have any questions pertaining to the research, you can contact and discuss them with:
*Researcher: Josephine Annette Paul ; Josephine.Annette.Paul@vub.be; tel. +1(210)4644556
*Promotor Vrije Universiteit Brussel: Prof. Dr. Johan Bilsen; johan.bilsen@vub.be
*Taos Institute Advisor: Dr. Sheila McNamee; sheila.mcnamee@unh.edu

General Data Protection Regulation (GDPR), which has been in force since 25/02/2018

1. "The data will be processed in accordance with the principles imposed by the new European General Data Protection Regulation (GDPR), which came into effect on 25 May 2018.";

2. "Personal data belonging to you will be collected in the context of the research you are participating in. We are responsible for proper processing and the obligation to provide information that this entails.

3. "Clearly we are only allowed to use your personal data for the scientific research purposes described on the informed consent form.".

4. "It is possible that your data will be seen by persons in countries that do not apply the same legal standards for data protection as those in the EU. In that case, we are committed to ensuring that the conditions of European and Belgian legislation concerning the protection of personal data are enforced.".

5. "Consequently, we would like to inform you that, in accordance with the relevant legislation, the data collected as part of this research will be stored for at least 5 years in a locked file cabinet in the researcher's business office."

6. "According to the GDPR, you have a number of rights relating to the processing of your data. If you have further questions about these rights, you are always welcome to contact the data protection official at the VUB: dpo@vub.be.".

7. "Finally, you also have the right to file a complaint about the way your information is treated. You can submit this complaint to the Belgian supervisory authority that is responsible for enforcing the data protection legislation:

Data Protection Authority (DPA)

Rue de la presse 35,

1000 Brussels

Tel. +32 2 274 48 00

e-mail: contact@apd-gba.be

website: www.gegevensbeschermingsautoriteit.be."

I, _____, agree to participate in this research study.

_____ _____

Signature of Participant Date

I confirm that the individual giving consent has done so freely and voluntarily.

A copy of this Consent for Participation has been provided to the participant.

_____ _____

Signature of Researcher/person obtaining consent Date

Appendix F

The following are the guiding questions that will be asked of the **adolescent study participant**:

1. What can you tell me about our last session?
2. What was helpful or different for you?
3. What was helpful if anything?
4. Is there anything that was not helpful or that you wish could have been different?
5. Can you think of a way or time when that would be useful?
6. What do you need to keep this going?
7. What makes this a unique experience?
8. Can you describe that or give an example?
9. Have you ever discussed your anxiety with a medical mental health provider?
10. What was that setting?
11. How would you compare settings? What was similar? What was different?
12. Was it helpful? What was most helpful? What was least helpful?

The following are the guiding questions that will be asked of the study participant after introducing the results of the GAD-7 scale pre and post study comparison:

13. What do you think about these results?
14. As you reflect back, is there anything you would choose more of? Less of?
15. How did the environment effect you? How did it effect your experience?
16. What was most important for you?
17. What was meaningful for you?
18. Did you notice a change or shift?
19. What was your favorite item to create together?
20. What do you think would surprise me?
21. Is there anything you've noticed that I haven't noticed?

Appendix G

The following are the guiding questions that will be asked of the **parent study participants**:

1. What can you tell me about your child's struggle with anxiety?
2. Have you ever discussed anxiety with a medical mental health provider?
3. What was that setting like?
4. Was it helpful? What was most helpful? What was least helpful?
5. Reflecting on your child's culinary sessions, what did you notice?
6. Was there anything that was helpful or different?
7. Was there anything that was not useful?
8. How would you compare the settings? What was similar? What was different?
9. What made this a unique experience?
10. Can you describe that or give an example?
11. Did you notice a shift or change in your child?
12. Can you describe that or give an example?
13. When did you first notice this shirt or change?
14. How did you experience the results of your child's sessions?
15. What do you think would surprise me?
16. Is there anything you've notice that I haven't noticed?

Appendix H

The following are the guiding questions that will be asked of the **teacher study participants**:

1. What can you tell me about your student's struggle with anxiety?
2. Have you ever discussed anxiety with your student?
3. When you think back to that time, do you remember what accommodations they suggested would be helpful in the classroom?
4. Were these accommodations helpful? What was most helpful? What was least helpful?
5. Reflecting on your student's culinary therapy sessions, what did you notice?
6. Can you describe that or give an example?
7. Did you notice a shift or change in your student?
8. Can you describe that or give an example?
9. When did you first notice this shift or change?
10. Has there been a change in classroom behaviors?
11. Can you describe that or give an example?
12. How did you experience the results of your student's sessions?
13. What do you think would surprise me?
14. Is there anything you've noticed that I haven't noticed?

Appendix I

July 19, 2020

Josephine Paul
Josie@josiepaul.com

Protocol Title: Kitchen Conversations: Anxious Adolescents and Collaborative Dialogue in a Culinary Setting
Protocol #: 1
Effective Date: 8/25/2020
Expiration Date: 8/24/2021
Review Action: Approved

Dear Josephine Paul:

This letter will serve as confirmation that your research project entitled, "Kitchen Conversations: Anxious Adolescents and Collaborative Dialogue in a Culinary Setting" has been approved by the Executive Administration at Xavier Educational Academy.

This approval includes the following:

- Study Protocol: version 2
- Recruitment and enrollment of participants
- Disclosures/Informed Consent (Consent Materials)
    1. Adolescent Participants: version2
    2. Parent Participants: version 2
    3. Teacher Participants: version 2
- Generalized Anxiety Disorder 7-Item Scale (GAD-7) (Study Instrument): version 2
- Culinary Therapy (Baking) Sessions at Xavier Educational Academy
- Guiding Questions Documents
    1. Adolescent Participants: version 2
    2. Parent Participants: version 2
    3. Teacher Participants: version 2
- Paul First Aid/CPR certification (Researcher Information): version 2
- Paul CV (Researcher Information): version 2
- Professional Liability and Commercial General Liability Insurance: version 2

Please note that you may **only** conduct this research exactly in the form it was approved. You must seek approval for any changes in this study. You must also seek reapproval if the study extends beyond the termination date, which is one year from the first day of classes in the 2020-2021 academic school year.

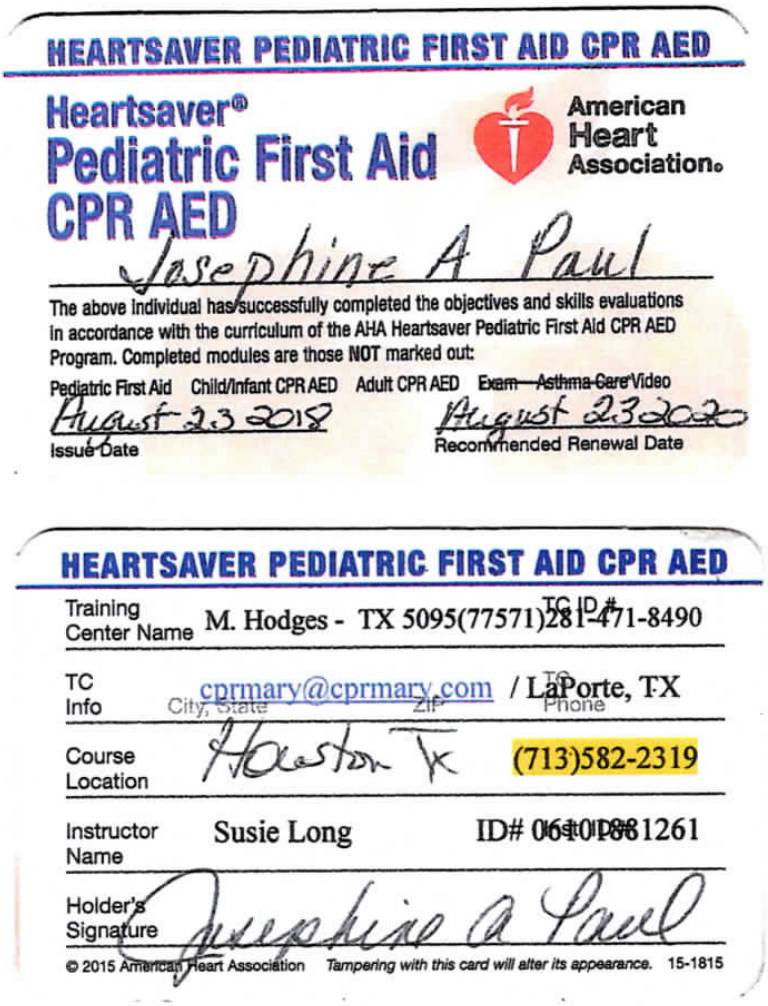
We wish you success in the pursuit of your research goals.

Sincerely,

Richard De La Cuadra
Founder and Head of Schools

David Garner, MAT, MBA
Managing Director of Schools

Appendix J



HEARTSAVER PEDIATRIC FIRST AID CPR AED

Heartsaver®
Pediatric First Aid
CPR AED

American Heart Association.

Josephine A Paul

The above individual has successfully completed the objectives and skills evaluations in accordance with the curriculum of the AHA Heartsaver Pediatric First Aid CPR AED Program. Completed modules are those **NOT** marked out:

Pediatric First Aid Child/Infant CPR AED Adult CPR AED ~~Exam~~ ~~Asthma Care Video~~

August 23 2018
Issue Date

August 23 2020
Recommended Renewal Date

HEARTSAVER PEDIATRIC FIRST AID CPR AED

Training Center Name: M. Hodges - TX 5095(77571) TC ID # 281-471-8490

TC Info: cprmary@cprmary.com / LaPorte, TX
City, State Zip TC Phone

Course Location: Houston Tx (713)582-2319

Instructor Name: Susie Long ID# 06101881261

Holder's Signature: Josephine a Paul

© 2015 American Heart Association *Tampering with this card will alter its appearance.* 15-1815

Appendix K

CPH & ASSOCIATES

PHILADELPHIA INSURANCE COMPANIES
A Member of the Tokio Marine Group

Certificate of Liability Insurance

Date Issued: 07/05/2020

Underwritten by: Philadelphia Indemnity Insurance Company · One Bala Plaza, Suite 100 · Bala Cynwyd, PA 19004 · NAIC #: 18058
Administered by: CPH & Associates · 711 S. Dearborn St. Ste 205 · Chicago, IL 60605 · P 800.875.1911 · F 312.987.0902 · info@cphins.com

DISCLAIMER: This certificate is issued as a matter of information only and confers no rights upon the certificate holder. The Certificate of Insurance does not constitute a contract between the issuing insurer(s), authorized representative or producer, and the certificate holder, nor does it affirmatively or negatively amend, extend, or alter the coverage afforded by the policies listed thereon.

Insured: Josephine Paul, LMFT, PLLC
Josephine Paul
1425 Thompson Street
Houston, TX 77007

Policy Number: E138415
Policy Term: 04/25/2020 to 04/25/2021

Covered Locations
Professional Liability: Portable coverage, not location specific
General Liability Insured Location(s):
3100 Wesleyan, Houston, TX 77027

Coverage Type (Occurrence Form)	Per Incident (Per individual claim)	Aggregate (Total amount per year)
Professional Liability	**$ 1,000,000**	**$ 5,000,000**
Supplemental Liability	**$ 1,000,000**	**$ 5,000,000**
Licensing Board Defense	**$ 35,000**	**$ 35,000**
Commercial General Liability ▫ *Fire/Water Legal Liability*	**$ 1,000,000** **$ 250,000**	**$ 3,000,000** **$ 250,000**
Business Personal Property	**N/A**	**N/A**

Comments/Special Descriptions:

Certificate Holder

PROOF OF COVERAGE

If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s). **Notice of Cancellation** will only be provided to the first named insured in accordance with policy provisions, who shall act on behalf of all additional insureds with respect to giving notice of cancellation.

C. Philip Hodson

Authorized Representative
C. Philip Hodson

Appendix L

This appendix is based on:

Paul, J. (2022). Kitchen conversations: Dialogic space in a culinary setting for adolescents facing anxiety. *International journal of collaborative practices, issue 12,* 28-36.

Kitchen Conversations:

Dialogic Space in a Culinary Setting for Adolescents Facing Anxiety

Josephine Paul

Houston, Texas, United States

Abstract

This article chronicles how a culinary setting co-creates a collaborative-dialogic space that enriches the identity stories of adolescents who struggle with anxiety; often seeing themselves as failures with little self-worth. Adolescence brings extraordinary cognitive and physical growth; however, it's also a high-risk time for the onset of mental health disorders (Grant, 2013). Anxiety is among the most prevalent psychological disorders among adolescents ("World Mental Health Day," 2017). The number of adolescents facing anxiety has drastically increased as the Covid-19 pandemic negatively impacts their psychological well-being (Guessoum, 2020). We must reverse this trend by finding new, effective ways of providing treatment to this vulnerable population. Emerging data indicates that cooking, as therapy, is successful in disease prevention and for benefitting adolescents' nutritional profiles (D'Adamo, et al., 2015). Drawing on nine years of experience using culinary arts therapy for mental health care, culinary arts therapy, while novel in the therapeutic domain, provides practitioners a unique and effective way to invite collaborative dialogue in an environment that is natural and nurturing for adolescents whose identity stories may be imperiled.

Key Words: *culinary arts therapy, collaborative-dialogic practices, adolescence, anxiety*

Kitchen Conversations: From Memories to Realization

My earliest and most precious memory as a child is as a three-year-old sitting atop my grandfather's kitchen table that had been pulled over close to the stove, while together we made potato soup. I looked forward to each Tuesday when my mother went to work and I would spend the whole day, all by myself, with my Papa, "helping" him cook. While my only tasks were to add potatoes and stir the soup, my Papa had a way of communicating the importance of my contribution, my inherent value, and his gratefulness for me; He said he just couldn't make soup without me! When finished, we would sit down together, and each enjoy a bowl of our potato soup. It was the best soup. The connection we shared in these private moments, the way Papa and I were "with" each other, had a profound effect on me. Though my Papa passed away when I was just four years old, the relationship we shared left an indelible impression on me as well as a longing for more of those special kinds of conversations and connection. This established the foundation for my future relationships and set the stage for a kitchen to become the setting and cooking together to be the channel through which these conversations would flow.

Finding Connection Again

Having worked as a cake decorator during my teenage years and as a European trained pastry chef for 30 years, the kitchen became a place where I spent much of my time and where I noticed that in this particular space, relational and conversational processes were often occurring. These conversations took place in bakeshops during the very early morning hours when the world around us was asleep and those of us who worked in that quiet stillness enjoyed an unhurried, peaceful, and significant amount of time daily to engage with the other about our curiosities and to reflect on thoughts, dreams, ideas, the world, and our place in it. The uniqueness and the intimacy of this space invited conversations and connections that likely would otherwise not have

occurred. These were the conversations I had longed for, and it was there that many of the most important conversations in my life, those that created change and those that created space for other perspectives and possibilities, took place. I refer to these significant dialogues and those with my Papa, as “Kitchen Conversations.”

The Impact of Kitchen Conversations

When I was 16 years old, I experienced a significant, positive, change in my own identity story as a result of conversations with the bakery owner and head baker. From his spoken words of confidence in me and his encouragement while teaching me new recipes and skills, to conveying the value and importance of my work ethic and integrity, I began to see myself as capable, creative, and became confident in my own self-worth. There is no doubt that my life was improved and that this shift helped to create the very foundation on which I have built my career.

The most profound conversation I can remember throughout the years happened early one morning, about half-way through my shift, while working alone with a much older German-Swiss pastry chef, who had been my mentor years earlier. Our conversation had led to relationships when I asked him when he would marry his live-in girlfriend of 20+ years. At that moment, and without changing his gaze to look up, he froze, his rolling pin suddenly coming to complete halt on the dough he was rolling. Recognizing that something significant had just happened, I too stopped what I was doing and looked at him for some sign that everything was okay, that I had not offended him. After a moment of quiet reflection and with his un-moved downward gaze, he quietly, in a near whisper, said, “I can’t, I was a Nazi.” Neither of us moved or uttered another word. Though it was only seconds, it felt like an eternity and the silence was deafening. In that moment, my previous known truth about Nazis as being immoral, evil people was being challenged. My mentor was neither immoral or evil, but rather was a gentle and generous man who had taken me under

his wing very early on in my career; he was my friend. While I don't remember what I asked or said next, I do know that I was the first to break the uncomfortable silence. With tears running down his face, he recounted the story of when the SS stormed his family home when he was just 15 years old. As the oldest sibling, and with his father not home at the time, they asked him to join their ranks. Because he did not agree, they raped his mother at gunpoint in front of all the children. They then asked him that fateful question again, this time advising him that they would rape all his sisters if he refused. He did not refuse again. He said that he decided during that time, while baking bread for the SS soldiers 16 hours a day, that he would never marry or have children of his own to prevent something like this from ever happening to him again.

From this conversation I was forever changed. I understood that there were many perspectives for even the most difficult situations and discourses and that a single, absolute truth did not exist. From that moment on, my life was not as simple or easy as I began questioning all that I thought I knew. I started de-constructing previously known "truths," searching for missing voices, and holding lightly my knowing to leave room for multiplicity of perspectives. In recognizing how little I "knew" and loosening my grip on "truths" I freed myself to learn so much more from so many others. For my mentor and I, our relationship deepened, and we were mutually transformed. For him, sharing his story filled with trauma and shame, and being understood and shown compassion, helped to lift the burden and fear around this long-held secret. He no longer had to carry this secret alone. For me, it firmly established my social constructionist views and expanded my world as I knew it.

Dialogic Similarities

In my later training as a Marriage and Family Therapist, I noticed the similarity between those particular Kitchen Conversations and Collaborative-Dialogic Practices. At the center of

collaborative-dialogue is the practioner's philosophical stance or "way of being" (Anderson, 1997). It is a way of relating and "being with" another that communicates their importance and that they are recognized, valued, and appreciated (Anderson, 2012a). This philosophical stance invites a particular kind of relational and conversational process (Shotter, 2011), one that leads to the potential for transformation and generative change. As I reflected on the most important Kitchen Conversations in my life, I recognized that in those particular moments of connection and conversation, were "being with" each other. The mutual respect and care that we showed for each other, our ability to be vulnerable and trust the other, and the capacity to respond or pause in the moment, invited intimate dialogue that otherwise might not have occurred. As I noticed more similarities, I began to think about the possibility of merging these disciplines; mental healthcare, through a collaborative-dialogic lens, and culinary arts.

Collaborative-Dialogic Practices

Collaborative-dialogic practices are informed by a set of guiding assumptions that are drawn from social construction, post-modern philosophy, and dialogue. These assumptions: maintaining skepticism; avoiding generalization; and privileging local knowledge, invite us to consider language and knowledge in different ways. The way we think about and relate to ourselves, others, and our world, in a spontaneous way, is referred to as "perspective-orienting" and reflects an attitude that differs from theoretical assumption, techniques, and devised methods from pre-knowing modalities (Anderson, 2012a). These perspective-orienting assumptions invite critical reflection on our current ways of thinking and categorizing and encourage a different way of hearing and seeing, which becomes our "way of being". These assumptions support a distinctive attitude regarding our clients, our relationship with them, and how and what we want to accomplish.

The philosophical stance for collaborative-dialogic practices includes seven interconnected features (Anderson, 2012b) serving as action-orienting characteristics that jointly create a particular kind of philosophical stance, one that underscores a specific kind of sensitivity from which a therapist's words and actions become known in response to the other and highlight a move away from the concept of "guiding". The philosophical position of collaborative-dialogic practices conveys a way of being that includes an attitude toward others, namely, that they are special, unique, recognized, and appreciated as having something worthy of saying and hearing (Anderson, 2012b). It is a way of thinking with, talking with, acting with, and responding with the other instead of talking at them, to them, for them, or about them (Shotter, 2012). Witness is a way of positioning oneself with another person as a participant within the therapy system rather than observering and interpreting from the outside. Withness is a dialogical activity in which we are spontaneously and relationally responsive to the other as an alternative to only thinking, seeing, and responding in terms of what is already familiar: that which we already think we know (Shotter, 2011). This philosophical stance, as well as withness relationships and conversations, invites a therapy process, and therapeutic relationship that is less hierarchical (Anderson, 2012b). People participate on a more equitable basis and therapy becomes more participatory and mutual (Anderson, 2012a, 2012b).

This philosophical stance becomes an example of values and beliefs. This way of being offers a congruency as a person, a way of integrating the professional and personal. This allows us to be fully present with the other and to respond and interact in the moment and do what the occasion calls for (Anderson, 2012a, 2012b). The seven interconnected features of the philosophical stance (Anderson, 2012 b) include: the therapist and client becoming conversational partners through a common activity or mutual inquiry; recognizing that the expert on the client

and their world is the client themselves; having an unassuming attitude with regard to what the therapist thinks he or she may know; being open and generous with our internal thoughts; being spontaneous and comfortable with uncertainty; understanding and accepting that both therapist and client are vulnerable to change due to their relational and dialogic practice; and that collaborative-dialogic conversations resemble the way we talk and interact in our everyday ordinary lives.

Culinary Arts Therapy

Culinary arts therapy is therapy that focuses on cooking to teach and communicate as well as a way for a client to express themselves. It has been used for mindfulness cooking, to explore client creativity, and could also help discover more about a client's culture, rituals, and relationship with food. Culinary arts therapy has been shown to be effective in the prevention of metabolic disease and obesity and is also beneficial for the adolescents' nutritional profile (Gatto, et al., 2015; D'Adamo, et al., 2015). However, culinary arts therapy specifically for mental healthcare is novel in the therapeutic domain and in the culinary domain. I wondered if merging these two disciplines, therapy and culinary arts, would foster the potential to produce important change in different ways. I had a belief that the process of teaching and learning skills in the kitchen would offer a unique environment for transformative dialogue and that the focus of our shared experience of baking together as a common activity would serve to invite connection, collaboration, and conversation.

Participants, Adolescence, and Anxiety

The most recent population that I chose to focus on in culinary arts therapy is adolescents facing anxiety. Adolescence is a developmental stage that transitions an individual from childhood into adulthood, but it is also a time of unprecedented cognitive and physical growth and of new thoughts, feelings, and ambitions (Chaudhary & Jain, 2014). This period of

concentrated learning and development creates a high-risk period for adolescents impulsive, reactive behavior and, due to the vulnerability of the adolescent, the onset of mental health disorders. The adolescent period is one of significant changes that occurs at the physiological and psychological level and where the adolescent is increasingly vulnerable to the development of anxiety disorder symptoms (Grant, 2013).

Anxiety is among the most prevalent psychological disorders among school age children and adolescents and affects more than 260 million youths globally and is the sixth leading cause of disability ("World Mental Health Day," 2017; Olofsdotter, et al., 2016). Anxiety has recently become the most common form of mental illness in the United States (Anxiety and Depression Association of America, 2019; National Alliance on Mental Illness, 2017). The phenomenon of anxiety in adolescents is a rising epidemic that deserves alternate therapeutic approaches or strategies for efficacious treatment of vulnerable, developing adolescents. Many adolescents that struggle with anxiety experience feelings of failure or fear of failure and low self-worth preventing them from success in school or attending at all. Common amongst these adolescents is irrational thought, which keeps their negative identity story intact and perpetuates the anxious symptoms. In addition, as the Covid-19 pandemic negatively impacts the psychological well-being of adolescents there has been a remarkable increase in anxiety symptoms amongst adolescents. While their symptoms are an emotional and physical response to a very real occurrence and their fears well-founded, it in no way diminishes the severity of their struggle. Due to their vulnerability, adolescents need careful consideration and healthcare adaptations to allow for mental health services during the pandemic and lockdown or social distancing practices (Selim, et al., 2020).

Drew's Experience

The first adolescent to participate in culinary arts therapy with me was Drew, a 16-year-

old male who had paralyzing anxiety that rendered him homebound for a year and a half. Though Drew had been in therapy for more than a year, he was not progressing and remained unable to attend school. Initially, the plan was for me to meet Drew on his high school campus, but I recommended that since school was a stressful place to be, that we might consider meeting somewhere else where his anxiety level would likely not be increased. I suggested to Drew that some of the people I am talking with enjoy having conversations in the kitchen while we work together to create a product of their choosing. Drew, who had some previous experience baking, decided he would like to move our conversations to the kitchen while learning how to temper chocolate and create hand-molded French chocolates.

The process of teaching and learning about chocolate in the kitchen offered a unique environment that was both natural and nurturing. Our focus was not on "the problem" but on the "doing together", the co-creating of chocolates and possibilities. During the first two to three sessions together, we learned our way around the kitchen, locating ingredients and tools, bumping into each other, and finding ourselves in each other's way, discovering our individual working styles as we negotiated our particular kitchen processes. There is a keen focus on proper measuring, knife skills, sanitation, and safety. Our conversations are centered around favorite flavors, foods, textures, restaurants, best desserts ever, milk chocolate or dark chocolate, and other important culinary curiosities. As I learned about Drew's preferred flavor profiles, I also learned about where, when, and with whom he shares these culinary experiences. This knowledge further helps determine what products I might propose we co-create in future sessions. Following this initial time of getting to know each other and ourselves in this context, our movements in the kitchen became more like that of a well-choreographed dance. Our relationship was improved by the way we oriented ourselves to be and the way we responded to and acted toward the other person, both

in dialogue and in co-creating a tangible product. Drew took the lead while I tentatively followed, quietly, assisting the process by organizing the necessary equipment, offering instruction when it was requested, and keeping our workspace clean, while actively listening and observing. There were many times when no words were spoken, but our communication continued. As we worked together creating, Drew and I responded to each other through movement, gestures, and expressions. There was a certain synchronicity, not planned or prescribed that communicated a spontaneous, attentive, and genuine connection. These moments of meditative self-expression and resonance created a pause, a way to enter the space between us.

The focus of our shared experience of doing together invited connection, collaboration, and unique communication. During our sessions, our individual thoughts and curiosities would weave their way into the conversation naturally and organically, like the threads in a beautiful tapestry. There were no prescribed lists of questions or techniques, just two ordinary people in ordinary conversation "with" each other, sharing their thoughts and inner conversations. Often once a product was baking or cooling and the focus was relaxed, we would just chat, unhurriedly and mindfully about our day, upcoming plans, what he's been reading, and his favorite parts or understandings. During these conversations it appeared as though whatever was on his mind, whatever was most pressing, would find its way into the conversation with Drew introducing it. Through our dialogue and the creativity of doing together, meaning was created, and other perspectives and understandings were generated. These were our unique kitchen conversations. I became aware of a dramatic shift for Drew when he shared an essay with me that he had written for college admission. With Drew's permission, I will share that essay here:

"My extracurricular activities are drawing, writing, and creating hand-made French chocolates. Growing up, I was unable to practice drawing as my overwhelming anxiety

immobilized me. This was also true for my writing. I love how drawing and art can transmit emotions through either the most simple or complex mediums. I also truly love the written word with all the clever and intricate phrases one can create. Drawing and writing seemed locked inside me, along with the emotions that such expression might reveal. As I studied French chocolate making over the past two years, the conversations I had with my instructor ranged from tempering chocolate and chocolate as an art form to deconstructing learned ideas about anxiety. As my skill level increased, I began making chocolates for friends, family, and some to sell during the holiday season. As I unlocked this unique form of self-expression and learned new ways to think about anxiety, I also unlocked the artist and writer within."

When I first read Drew's college essay, I was moved by his words but even more that he allowed me to read something he had written, since prior to that, I had not seen any of his written word or artwork. Drew had expressed many times that he would write and rewrite papers, inevitably not turning it in because it wasn't "perfect." Despite his brilliance, Drew believed whole-heartedly he was a failure academically and was sure he would be embarrassed if anyone read his writings. I was so honored that Drew allowed me to read his essay and to understand more about him through the intimate details of his love for writing and art. I read it repeatedly, making sure I didn't miss a word. I loved that the conversations he remembered were about chocolate and deconstructing learned ideas about anxiety. It was such a beautiful way to acknowledge what caught his attention and what made a difference. However, it was Drew's comments about his increasing skill level allowing him to share his chocolate with friends and family and even valuing his own work enough to charge for his chocolates that stood out to me. As I continued to reflect, it occurred to me that while this was a technically challenging and difficult skillset and Drew had reached mastery, he benefitted most from not having anyone to compare himself to and thus

diminish his achievement to fit his failure narrative. This allowed him to acknowledge his own effort and success and consequently, his confidence and self-worth improved. Drew's identity story had changed; he could now see himself as successful. As he became more comfortable with his new identity, he began writing and drawing. The problem of anxiety and perfectionism getting in the way Drew's ability to write, was not solved, but rather was dissolved through the process of building skill and mastery, challenging dominant discourses, and ultimately enriching his identity story.

Throughout these culinary arts therapy sessions, I used a collaborative-dialogic lens as my theoretical foundation as it aligns with my natural curiosity about things and wonder about other ways of understanding that which I think I might know. The process of self-reflexivity helped me create shift in my way of thinking, moving away from accepting and reinforcing the dominant discourse of what it means to be an adolescent struggling with anxiety and questioning the contextualization of the situation and broadening the context. I was public and generous with my inner conversations and curiosities, offering them to generate conversation and explore other perspectives and understandings. Through this process the story was expanded and new possibilities for moving forward were generated (McNamee, 2015).

Concluding Thoughts

Many of the principles that inform collaborative-dialogic practices perspective orienting assumptions and philosophical stance are mirrored in my therapeutic process of baking, pastry, and chocolate work. There is a congruency in the viewpoints and attitudes of each practice that allow for a parallel process of creation within these two disciplines. Thus, these two different processes are happening simultaneously, spontaneously, weaving the experiences and understandings of each into a beautiful new experience, created together and previously unknown.

Collaborative-dialogic practices in a culinary setting is an effective treatment for anxiety in adolescents with its focus not on the problem, but rather on new possibilities that are created through relational dialogue. For vulnerable, anxious adolescents, many of the identified symptoms, such as: poor social skills, avoiding social interaction, loneliness, low self-esteem, perceptions of rejection, and decreased ability to solve problems, would be well served through this collaborative process of transformational conversations (Anderson, 2012a), practical skill building, and mastery in a culinary setting. Through dialogue and the creativity of doing together, meaning is created, and other perspectives and understandings are generated. For anxious adolescents, their problems may no longer be problems to be solved as they are dissolved or resolved in language (Anderson, 2007, 2012a). Given the current pandemic, lockdowns, and the need for adaptable therapeutic services for adolescents struggling with anxiety, culinary arts therapy, though it takes more preparation as a participant must prepare ingredients and equipment prior to the session, can be successfully modified for teletherapy sessions, and provide an important dialogic space for vulnerable adolescents.

Being able to combine my two passions, baking and collaborative-dialogic practices, in a therapeutic setting is a privilege, and it feels as though I have come full circle, returning to a very special yet simpler time when cooking together invited conversation and genuine connectedness. Thank you, Papa, for giving me my start with my first kitchen conversations, for being fully present for me, and for valuing my contribution to our soup. It really was the best soup.

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English Summary

Background

This dissertation analyzed how culinary therapy can be used in the treatment of adolescents struggling with anxiety to decrease symptoms through skill building, mastery, improved self-esteem and confidence, social competency, and identity formation. I contend that transformation and generative change for adolescents in culinary therapy results from a particular kind of conversation and the therapist's "way of being" (Anderson, 1997). This study demonstrated the importance of relating with adolescents positively, communicating their importance, letting them know that they are valued and appreciated, and approaching the therapeutic relationship from a position of equality as partners (Anderson, 2012b) engaging in processes of mutual inquiry, discovery, creating meaning, and knowledge together, and allowing other voices and perspectives to be part of the conversation. Adolescents facing anxiety have not received the help they need and deserve to decrease their troublesome symptoms for numerous reasons such as 1) Shame, guilt, and the stigma attached to "therapy," 2) limited or no access due to lack of insurance or ability to pay, 3) transportation problems, 4) anxiety is under-diagnosed or not diagnosed at all, 5) traditional therapy doesn't work well, and 5) society unknowingly or unwittingly continues to reinforce the dominant discourse of pathologizing and reinforcing a narrative of failure for developing adolescents. This ritualized way of diagnosing and treating anxiety in adolescents does not lessen the number of adolescents with anxiety but instead perpetuates it.

The theoretical frames of this study are social construction and collaborative-dialogic practices. From this philosophical orientation, I observe traditional and collaborative-dialogic assumptions about adolescent anxiety and examine the developmental theories of childhood

development, highlighting their importance for vulnerable adolescents in any treatment process. From this social construction perspective, I describe the problem and contemplate other possibilities for treating adolescent anxiety in a more accessible, natural, and nurturing environment.

Problem Definition

Anxiety in adolescents is a rising epidemic and deserves alternative therapeutic approaches or processes for effective treatment that are easily accessible and that adolescents want to participate in. Adolescence is the period of time between childhood and adulthood when the development of self-esteem, confidence, identity formation, and beliefs and values are at the forefront of every adolescent. This is a critical stage in development as the adolescent negotiates between role confusion and identity. Erik Erickson, a developmental psychologist, was the first to refer to this period of time as the "identity crisis" years (Gross, 2020). Adolescents are exceptionally vulnerable during this time, and the onset of anxiety symptoms often begins during this developmental stage and carries with it a substantial number of adverse effects on the social and emotional development and academic success of the adolescent (Locke et al., 2015).

While several empirically supported treatments for adolescents facing anxiety have been developed, cognitive behavioral therapy (CBT) alone or with the addition of pharmacotherapy is considered the gold standard for treating anxious adolescents. However, after reviewing the literature, CBT has substantially high non-completion rates and does not demonstrate long-term remission stability (Heiervang et al., 2018; Asarnow et al., 2019). CBT has shown very limited success (Baker et al., 2021), and according to Heiervang et al. (2018), many therapists who use CBT know it doesn't work. Simply stated, we need more effective treatments for adolescents with anxiety.

Aims

Designing accessible, developmentally appropriate, and effective treatment for adolescents struggling with anxiety is essential to stabilize and reverse the surging trend of the current epidemic. The aim of this dissertation was to determine if culinary therapy, using collaborative dialogue in a safe, natural, and nurturing environment of a school, would be an appropriate and operational method of treatment for anxious adolescents. An analysis of all participants' interviews provided a rich narrative of the adolescent participants' experience and if they noticed changes in their self-esteem or identity or had increased or decreased anxiety.

Methods

The processes of this research were guided by a social construction epistemology that emphasized the socially constructed nature of reality (Gergen & Gergen 2008). The focus was on the social interaction between researcher and participant, a relational process of shared meaning through language and socially negotiated reality (Roy-Chowdhury, 2010).

Seventeen adolescents struggling with symptoms of anxiety participated in this study, each completing between 10-12 culinary therapy sessions with the researcher, who is both a therapist and a pastry chef. Data was collected through interviews with the adolescent participants, one parent per participant, and a teacher with whom the student indicated having a positive relationship. The result was subjective experiences of the adolescent participant, as well as observations from the parents and teachers after the culinary sessions. A Generalized Anxiety Disorder 7-Item Scale was used to assess the symptoms of anxiety of each adolescent participant before the start of the first culinary session and after the final culinary session.

The researcher used thematic analysis as a method to analyze and interpret the entire data set while paying careful attention to the meaningfulness of the data as the most essential criterion

for forming codes and themes. This data was more accurate and richer due to the close relationship between student participants and the researcher, as knowledge and meaning are constructed through relationships. The analysis revealed underlying patterns that illustrate how particular meanings develop.

Results

The analysis confirmed that student participants indicated they preferred culinary therapy to traditional therapy as it was comforting and calm. They were relaxed, exploring their own beliefs without feeling intimidated. Student participants appreciated the opportunity to co-create with the therapist, opportunities to connect with their peers, and establish authentic relational engagement that created a sense of belonging. As student participants' kitchen and baking skills improved, so did their self-esteem, class attendance, and grades. Student participants developed resiliency and were more comfortable facing their futures as they saw failure as an opportunity to learn something new, not as a label that would define them. All seventeen student participants experienced a decrease in anxiety symptoms when comparing their pre and post-scaled results.

Conclusion

Current treatment protocols for treating adolescent anxiety, including the gold standard, cognitive behavioral therapy, are ineffective. Culinary therapy, an activity-based intervention using a collaborative-dialogic approach, is successful in decreasing adolescent anxiety and is a treatment option that is enjoyed by adolescents. Locating culinary therapy in a natural and safe school environment significantly improves access and adherence to therapy. Action-oriented therapy, like culinary therapy, in the school environment provides practical, accessible, positive, and efficacious treatment for adolescents struggling with anxiety, and they like it!

Nederlandse Samenvatting

Achtergrond

In dit proefschrift wordt onderzocht hoe culinaire therapie in de behandeling van adolescenten met angst kan gebruikt worden om hun symptomen te verminderen door middel van het aanleren van vaardigheden, beheersing, verbetering van het gevoel van eigenwaarde en zelfvertrouwen, toename van sociale competentie en identiteitsvorming. Deze transformatie en generatieve verandering voor adolescenten in culinaire therapie is het resultaat van een bepaald soort gesprek en de "manier van zijn" van de therapeut (Anderson, 1997). Dit onderzoek toonde aan hoe belangrijk het is om positief met adolescenten om te gaan, hen te laten weten dat ze belangrijk zijn, dat ze gewaardeerd en geapprecieerd worden, en de therapeutische relatie te benaderen vanuit een positie van gelijkwaardigheid als partners (Anderson, 2012b) door deel te nemen aan processen van wederzijds onderzoek, ontdekking, het samen creëren van betekenis en kennis, en door andere stemmen en perspectieven deel te laten uitmaken van het gesprek. Adolescenten die kampen met angsten hebben niet de hulp gekregen die ze nodig hebben en verdienen om hun lastige symptomen te verminderen om verschillende redenen, zoals: 1) schaamte, schuldgevoel, of het stigma dat aan "therapie" kleeft, 2) beperkte of geen toegang tot zorg door gebrek aan financiële middelen, 3) vervoersproblemen, 4) gebrek aan adequate diagnosestelling 5) traditionele therapie die niet goed werkt, en 6) de samenleving die onbewust of ongewild doorgaat met het versterken van het dominante discours van pathologiseren en het versterken van een verhaal van mislukking voor zich ontwikkelende adolescenten. Deze geritualiseerde manier van het diagnosticeren en behandelen van angst bij adolescenten vermindert het aantal adolescenten met angst niet, maar houdt het juist in stand.

De theoretische kaders van dit onderzoek zijn sociale constructie en collaboratief-dialogische praktijken. Vanuit deze filosofische oriëntatie worden traditionele en collaboratief-dialogische aannames over adolescente angst bekeken en ontwikkelingstheorieën van jongeren onderzocht, waarbij het belang ervan voor kwetsbare adolescenten in elk behandelingsproces benadrukt wordt. Het probleem wordt beschreven vanuit dit sociale constructie perspectief en andere mogelijkheden om angst bij adolescenten te behandelen in een meer toegankelijke, natuurlijke en verzorgende omgeving worden overwogen. **Omschrijving van het probleem**

Angst bij adolescenten is een opkomende epidemie en verdient alternatieve therapeutische benaderingen of processen voor een effectieve behandeling die gemakkelijk toegankelijk is en waaraan adolescenten willen deelnemen. De adolescentie is de periode tussen kindertijd en volwassenheid waarin de ontwikkeling van eigenwaarde, vertrouwen, identiteitsvorming en overtuigingen en waarden op de voorgrond staan. Dit is een kritieke fase in de ontwikkeling waars de adolescent te maken krijgt met rolverwarring en identiteit. Erik Erickson, een ontwikkelingspsycholoog, was de eerste die naar deze periode verwees als de “identiteitscrisis”- jaren (Gross, 2020). Adolescenten zijn uitzonderlijk kwetsbaar in deze periode en het begin van angstsymptomen begint vaak in deze ontwikkelingsfase en heeft een aanzienlijk aantal nadelige gevolgen voor de sociale en emotionele ontwikkeling en het academische succes van de adolescent (Locke et al., 2015).

Hoewel er verschillende empirisch ondersteunde behandelingen voor angstige adolescenten zijn ontwikkeld, wordt cognitieve gedragstherapie (CGT) alleen of met toevoeging van farmacotherapie beschouwd als de gouden standaard voor de behandeling van angstige adolescenten. Na bestudering van de literatuur blijkt echter dat CGT substantieel hoge percentages van het niet afronden van de therapie laat zien en geen langdurige stabiliteit van

remissie (Heiervang et al., 2018; Asarnow et al., 2019). CGT heeft aangetoond zeer beperkt succesvol te zijn (Baker et al., 2021), en volgens Heiervang et al., (2018) weten veel therapeuten die CGT gebruiken dat het niet werkt. Simpel gezegd hebben we effectievere behandelingen nodig voor adolescenten met angst.

Doelstellingen

Het ontwerpen van toegankelijke, ontwikkelingsgerichte en effectieve behandelingen voor adolescenten met angst is essentieel om de stijgende trend van de huidige epidemie te stabiliseren en om te keren. Het doel van dit proefschrift was om te onderzoeken of culinaire therapie, waarbij gebruik wordt gemaakt van een collaboratieve dialoog in een veilige, natuurlijke en verzorgende omgeving van een school, een geschikte en operationele behandelmethode zou zijn voor angstige adolescenten. Een analyse van de interviews van alle deelnemers leverde een rijk verhaal op over de ervaringen van de adolescenten en of ze veranderingen in hun gevoel van eigenwaarde of identiteit hadden opgemerkt, en meer of minder angst hadden.

Methoden

De processen van dit onderzoek verliepen vanuit een sociale constructie-epistemologie die de sociaal geconstrueerde aard van de werkelijkheid benadrukt (Gergen & Gergen 2008). De focus lag op de sociale interactie tussen onderzoeker en deelnemer, een relationeel proces van gedeelde betekenis via taal en sociaal onderhandelde realiteit (Roy-Chowdhury, 2010).

Zeventien adolescenten die worstelen met symptomen van angst namen deel aan dit onderzoek, waarbij ze elk 10-12 culinaire therapiesessies volgden met de onderzoeker, die zowel therapeut als patissier is. De gegevens werden verzameld door middel van interviews met de adolescente deelnemers, één ouder per deelnemer en een leraar met wie de leerling aangaf een

positieve relatie te hebben. Het resultaat waren subjectieve ervaringen van de adolescent en observaties van de ouders en leerkrachten na de culinaire sessies. Een Gegeneraliseerde Angststoornis 7-Item Schaal werd gebruikt om de symptomen van angst van elke adolescente deelnemer te beoordelen vóór de eerste culinaire sessie en na de laatste culinaire sessie.

De onderzoeker gebruikte thematische analyse als methode om de volledige dataset te analyseren en te interpreteren, waarbij zorgvuldig aandacht werd besteed aan de betekenisvolheid van de gegevens als het meest essentiële criterium voor het vormen van codes en thema's. Deze gegevens waren nauwkeuriger en rijker door de nauwe relatie tussen de adolescenten en de onderzoeker, aangezien kennis en betekenis worden opgebouwd door middel van relaties. De analyse onthulde onderliggende patronen die illustreren hoe bepaalde betekenissen zich ontwikkelen.

Resultaten

De analyse bevestigde dat deelnemende adolescenten aangaven dat ze de voorkeur gaven aan culinaire therapie boven traditionele therapie, omdat het troostend en rustig was. Ze waren ontspannen en onderzochten hun eigen overtuigingen zonder zich geïntimideerd te voelen. De deelnemende studenten waardeerden de mogelijkheid om te co-creëren met de therapeut, de mogelijkheid om contact te maken met hun medestudenten en tot een authentieke relationele betrokkenheid te komen die een gevoel van erbij horen creëerde. Naarmate de keuken- en bakvaardigheden van de deelnemende studenten verbeterden, namen ook hun zelfvertrouwen, aanwezigheid in de klas en hun cijfers toe. Zij ontwikkelden veerkracht en zagen hun toekomst met meer vertrouwen tegemoet, omdat ze falen beschouwden als een kans om iets nieuws te leren en niet als een label dat hen zou definiëren. Alle zeventien deelnemende studenten ervoeren een afname in angstsymptomen bij het vergelijken en bespreken van de resultaten zoals gemeten

vóór en na de culinaire sessies.

Conclusie

De huidige behandelprotocollen voor angst bij adolescenten, inclusief de gouden standaard, cognitieve gedragstherapie, zijn niet effectief. Culinaire therapie, een op activiteiten gebaseerde interventie die gebruik maakt van een collaboratief-dialogische aanpak, is succesvol in het verminderen van angst bij adolescenten en is een behandelingsoptie die door adolescenten wordt gewaardeerd. Door de culinaire therapie in een natuurlijke en veilige schoolomgeving te laten plaatsvinden, worden de toegang tot en de therapietrouw aanzienlijk verbeterd. Actiegerichte therapie, zoals culinaire therapie, in de schoolomgeving biedt een praktische, toegankelijke, positieve en effectieve behandeling voor adolescenten die worstelen met angst, en ze vinden het leuk!

Josephine Paul

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EDUCATION

Vrije Universiteit Brussel Brussels, Belgium
PhD-student Social Health Sciences since 2018 Expected May 2024

St Mary's University San Antonio, Texas
Master of Arts, Marriage and Family Therapy May 2012

- Distinguished Graduate, GPA 3.97
- Baptist Health Care Academic Scholarship Recipient

California State University Sacramento, California
Bachelor of Vocational Education January 2005

- Summa Cum Laude, GPA 4.0

EMPLOYMENT HISTORY

Josephine Paul, LMFT, PLLC Houston, TX
Xavier Educational Academy April 2013 - present
Founder and Director, Mental Health Services

Contracted to provide services related to the delivery of mental health care across the entire student body, including their families at the designated school location, as well as provide consultation services and training to the school staff to support the overall mental health goals of the school.

- Developed a successful mental health care department within a private educational institution to provide therapeutic services to staff, students, and their families.
- Expanded the program to include teacher training on mental health topics, parenting courses, and student groups
- Developed and hosted "Coffee and Conversations with Counselors," an evening for parents & therapists.
- Created a culinary therapy and culinary arts vocational education program at Xavier Academy, including writing independent educational plans for each student participant per Texas Educational Competencies.
- Supervise four provisionally licensed mental health professionals.
- Researched and created a school Crisis Preparedness and Response Plan.
- Collect mental health information and student outcomes data to monitor the overall performance and effectiveness of services provided.

Kai Ping Culinary High School Taipei, Taiwan
Guest Chef-Chef Instructor April 2015

Gave demonstrations and provided oversight to student teams creating sorbet, dessert, and boxed take-home couture French chocolates for a sponsorship dinner to benefit the students of Kai Ping. Provided four additional days of instruction in the kitchen/classroom setting to students and adult learners in the community. Visited classrooms to observe and shared conversations and reflections with staff to learn and share about this non-traditional school guided by collaborative-dialogic practices.

- Collaborated with 3 chef colleagues from the American Culinary Federation to create a 7-course meal to be prepared by students under our guidance and instruction for sponsorship dinner.
  Demonstrated, coached, and mentored young culinarians over 3 days as they prepared, plated, and served the pastry items.
- Collaborated with school staff to set curriculum, including all recipes, for four additional days of pastry classes with Kai Ping Students.
- Participated in the filming of a new documentary about Kai Ping Culinary High School.
- https://www.youtube.com/watch?v=FR5jQnYlmtk

Napa County Office of Education (Vintage High School & Community Education) Napa County, California
Hospitality and Culinary Arts Instructor August 1998-December 2002

Provided education and training for entry-level employment, advanced training, and career advancement. Developed and implemented lesson plans to teach required skills for students to master culinary/hospitality

career competencies.

- Authored the first revision of the course curriculum in 12 years, including support of core competencies.
- Successfully integrated at-risk students into prestigious community settings through education, skills, and etiquette training resulting in poised and postured young adults.
- Quickly improvised creative, project-based lesson plans to accommodate students' preferred modalities of learning.
- Created strategic alliances with students and liaised between them and school counselors and psychologists to ensure their needs were accommodated.
- Advocated for and supported students on probation which resulted in decreased probation time as an outcome of their visible participation in my educational, skills-based program.

Just Josie's/Josie Paul's Custom Cakes and Confections Napa Valley, California
Owner/Chef February1987-December 2008

Created, developed, and opened a specialty free-lance pastry shop to provide showpieces, gourmet chocolates, wedding cakes, etc., to Napa Valley and San Francisco Bay Area resorts, hotels, restaurants, and caterers. Solicited, maintained, and built an extensive client base through community networking and self-designed marketing materials. Designed, created, and produced specialty items. Managed all aspects of ordering, inventory, billing, accounts receivable, and product development, as well as recruiting, training, and managing employees.

- Successfully helped raise $3.1 Million for health care in Napa Valley as guest pastry chef alongside Chef Bradley Ogden at the Napa Valley Wine Auction in 1994.
- Designed, produced, and donated chocolate showpieces and chocolate pastries for 500 guests for the benefit of the Child Abuse Council of Napa for 10 consecutive years.
- Provided exceptionally effective interpersonal communication skills and imparted a polished, reassuring customer experience.
- Demonstrated highly creative, organized, and efficient work with extraordinary attention to detail.

HONORS/AWARDS

Taos Associate, The Taos Institute	March 2021
Selected for International Certificate in Collaborative Practices, Train the Trainers, Houston, TX	2017-2019
Faculty, Houston Galveston Institute, Awarded in Galveston, TX	June 2018
Selected for ICCP Scholarship, Houston, TX	2016-2017
Starfish Award, International Summer Institute, Cancun, Mexico	June 2017
Baptist Health Care Academic Scholarship Recipient, San Antonio, TX	2010
Finalist, Domaine Carneros, Search for The Ultimate Wedding Cake, Christie's East, NY, NY.	1994

CONFERENCES/TALKS

Paul, J. & De la Cuadra, R. (2023, May). *Engaging families in dialogue.* International Certificate in Collaborative Practices, online.

Paul, J. (2022, February). *Including families in mental and relational wellness for children at school.* University College Lillebelt, Odense, Denmark.

Paul, J. (2021, June). *Kitchen conversations: culinary therapy using collaborative-dialogic practices.* Online, international audience.

Paul, J. (2020, December). *Collaborative practices in a school environment.* Online Seminar.

Paul, J. & De la Cuadra, R. (2019, June). *Collaborative education: Learning through relationships.* Life Changing Conversations, 4th Congress for International Certificate in Collaborative Practices, Brno, Czech Republic.

Paul, J. (2019, August). *Anxiety in adolescence.* Xavier Educational Academy, Houston, Texas.

Paul, J. (2018, May). *Emotional development from birth through adolescence.* Yoga for Children Conference, Houston, Texas.

Paul, J. (2018, August). *Kitchen conversations: A mixed method analysis of the experience of anxious adolescents using collaborative dialogic practices in a culinary setting.* International Certificate in Collaborative Practices, Houston, Texas.

Paul, J. & De la Cuadra, R. (2017, April). *Collaborative education: Learning through relationships.* Life Changing Conversations, Houston, Texas.

Paul, J. & De la Cuadra, R. (2017, June). *Collaborative education: Learning through relationships.* International Summer Institute, Cancun, Mexico.
Carleton, D., Goodrich, T. J., & **Paul, J.** (2017, April). *Who Cares? You Should!* International Certificate in Collaborative Practices, Houston, Texas.

PUBLISHED ARTICLE

Paul, J. (2022). Kitchen conversations: Dialogic space in a culinary setting for adolescents facing anxiety. *International journal of collaborative practices, issue 12,* 28-36.

SERVICE

Cycle for Hope, non-profit providing mental healthcare and awareness, Director	August 2023-present
Cooper's Tutu's and Tiara's, seamstress for low-fee rental tutu's	2016-2021
Journal Article Reviewer, International Journal of Collaborative Practices	March 2020
Board Member, Artsbridge, Boston, Massachusetts	2019-2021
Board Member, Houston Galveston Institute, Houston, Texas.	2018-2020
Planning Committee, 4th Annual Congress of ICCP, Brno, Czech Republic,	2018-2019
St. Mary's University, Marriage & Family Therapy Organization, Vice-President, SA, TX.	2011-2012
Board Member, Ballet Conservatory of South Texas, Secretary, San Antonio, Texas	2010-2013
Council Member, Distinguished Young Woman National Program	2010-2011

LICENSES/CERTIFICATIONS

Texas Education Agency, Certificate in Trade and Industrial Education, Culinary Arts	2022-present
Licensed Marriage & Family Therapist & Supervisor Texas, License #202049	2013-present
California Teaching Credential in Vocational Education, Food & Beverage Preparation	1998-present

PROFESSIONAL AFFILIATIONS

Houston Galveston Institute (HGI) Faculty	2019-present
Taos Institute, Associate	2020-present
Phi Kappa Phi Honor Society	2005-present
American Culinary Federation	2014-present
American Association for Marriage & Family Therapists	2010-present

PROFESSIONAL DEVELOPMENT

International Summer Institute, 5-day Symposium (San Miguel, Mexico)	June 2023
Supervision Continuing Education Day – Relational Approach to Supervision	October 2021
5th International Congress of Collaborative-Dialogic Practices (online)	June 2021
Online Therapy: Ethics, Logistics, and Opportunities	January 2021
Dialogic and Collaborative Practices in Challenging Times, 3-day Seminar	January 2021
Collaborative & Dialogic Practices – Relationships & Generative Conversations	September 2019
Leadership Management: Building Trust	August 2019
4th International Congress of Collaborative-Dialogic Practices Pre-Congress Workshops (Czech Rep.)	June 2019
Screening Brief Intervention and Referral to Treatment Core Training	February 2019
Collaborative Practice with Couples: Exploring Creative & Practical Approaches	January 2019
Supervision and Consultation Day	August 2018
Research as Story-telling: Learning with our Clients as an Everyday Practice.	August 2018
International Summer Institute, 5-day Symposium (Cancun Mexico)	June 2018
Supervision Workshop	February 2018
Walk-In and single Session Collaborative Conversations Seminar	January 2018
Expand Your Practice: Providing Technology-Assisted Services 2-Day Seminar	January 2018
Reflecting Practices: Co-Designing Reflective Processes with the Client. 2-Day Conference	November 2017