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Experiences of Family Therapy for Eating Disorders:A Systematic Literature Review**Abstract**

Background: Family therapy approaches, including Family-Based Treatment (FBT) and Multi-Family Therapy (MFT), are widely used in the treatment of eating disorders (ED). However, less is known about how these interventions are experienced by young people (YP) and their families. This review synthesises qualitative evidence to explore lived experiences.

Method: A systematic search of eight electronic databases was conducted and seven were selected (ScienceDirect, JSTOR, ProQuest, PsycINFO, PsycARTICLES, EBSCOhost, and Google Scholar). Studies were published between January 2016 and April 2026. Search terms combined ED diagnoses, family therapy models, and experiential keywords. Inclusion criteria focused on peer-reviewed qualitative studies involving YP and/or families receiving family-based interventions. Screening followed a staged process (title, abstract, full-text review), with quality appraisal conducted using the CASP checklist. Six studies met inclusion criteria and were synthesised thematically.

Results: Three overarching themes and subthemes were identified. Firstly, *eating disorders and relational disconnection* found disrupted relationships before treatment, and tensions intensified throughout concerning control, agency and identity, often leading to resistance, particularly with FBT. Secondly, *rebuilding connection and communication within families*, particularly in MFT highlights that shared understanding can reduce isolation and be the foundation to restoring damaged relationships, however this can be complex. Finally, *developmental change and shifting family roles* highlights parental experiences throughout FBT particularly the Maudsley model, and the intensity of blame, failure and conflict within family roles. Often treatment focus was physical recovery while emotional and psychological needs received less attention, affecting the overall experience and recovery.

Conclusion: Family therapy is experienced as beneficial and challenging. Greater flexibility, attention to identity, and inclusion of YP voices may enhance treatment experience/effectiveness.

Introduction**What is an ED?**

Voss (2022) defines ED based on The Diagnostic and Statistical Manual of Mental Disorders, suggesting three factors: eating behaviours are understood to be persistently disturbed, eating and absorbing food is distorted, and substantial damage to one's physical and mental health. Furthermore, Voss suggests two main groups of ED including those with body image disturbances (Anorexia Nervosa; Bulimia, Binge Eating

Disorder, Atypical Anorexia Nervosa), and those that are impacted by sensory disturbances, health co-morbidities and nutrient deficits. The long-term consequences can be serious including the disruption to normal adolescent development, interference academically, socially, and personally and in severe cases, can lead to self-harm and death. DSM-5 recognises Anorexia has the highest death rate of any psychiatric disorder either by medical complications or suicide (American Psychiatric Association, 2022).

Impact of ED on YP

According to Potterton et al. (2022) and Chan et al. (2025), adolescence is a key developmental stage characterised by significant physical, emotional, and social changes, during which identity formation and autonomy are actively shaped. ED often emerges during this period, reflecting heightened vulnerability linked to biological, psychological, and social pressures. ED is associated with disruption to normal adolescent development, including impaired identity formation, rigid cognitive patterns, and difficulties with emotional regulation. These studies indicate that ED not only affects physical health but also interferes with peer relationships, family functioning, and the development of a sound sense of self. Consequently, they suggest adolescence represents a particularly high-risk period, as disordered eating can become intertwined with identity development and social experiences, reinforcing symptoms over time.

Role of the family

Erriu et al. (2020) highlights the importance of family relationships in adolescent ED, showing how both risk and protective factors in relationships can influence how the condition develops and continues. Research consistently shows that ED significantly disrupt family functioning, affecting communication, emotional relationships, and family roles, while also placing considerable psychological burden on caregivers. Mensi et al. (2021) suggest that families of adolescents with ED often experience low tolerance for conflict, increased emotional strain, difficulties respecting boundaries, and changes in family roles, resulting in more conflictual interaction patterns. The authors also highlight that fathers, may struggle to maintain their role in supporting their daughter's development, becoming less engaged in caregiving because they are unsure what to do. Family structure often becomes reorganised around ED, with shifts in adolescent autonomy, and increased parental monitoring/control around eating behaviours, leading to an imbalance in family functioning. The study also emphasises significant stress, worry and emotional exhaustion because uncertainty regarding appropriate responses contributes to a high-burden emotional environment within the family unit (Mensi et al. 2021).

FBT/MFT Overview

Family therapy is widely recommended as a treatment for adolescents with ED, particularly within guidelines and clinical research. It is widely supported for its clinical effectiveness, and evidence demonstrates improvements in weight resoration and symptom reduction (Wergeland et al. 2025). The most established model is Family-Based Treatment (FBT), which positions parents as central to recovery and supports them to take an active role in interrupting the ED behaviours, while gradually returning autonomy to the YP. Furthermore, and importantly, FBT adopts a non-blaming attitude, externalising the illness from the individual and viewing the family as part of the solution rather than the cause (Rienecke and Le Grange, 2022). Multi-family therapy (MFT) extends this approach by bringing several families together, enabling shared experiences, mutual support, and reduced isolation. Overall, family therapy approaches emphasise relational processes, recognising that recovery occurs within the family system as well as the individual (Escoffie et al., 2022).

Lived experiences of therapy

Qualitative research also highlights that the lived experiences of YP and their families during FBT does not always align with the desired outcomes. While treatment may be clinically successful (Rienecke and Le Grange, 2022), it is often described as emotionally demanding, distressing, and at times, disempowering with families feeling both supported and exposed. Furthermore, parents experience high levels of responsibility and pressure while taking control temporarily withholding adolescent autonomy. However, families value the opportunity MFT creates, bringing families together with shared experiences enabling them to feel understood while communicating openly sharing thoughts and feelings about ED. Participants valued recovery though they felt treatment was emotionally difficult (Escoffie et al., 2022).

Sibeoni et al. (2017) suggests in her study that YP describe FBT as emotionally intense and stressful. They feel frustrated by parental control in the early stages resulting in communication breakdown. Furthermore, expressing their

perspectives during treatment was a challenge. Often emotional needs felt secondary to weight gain, consequently they were left feeling misunderstood/unheard unable to build trust with their clinician.

Similarly, Fox and Diab (2015) suggest that adolescents frequently report a loss of autonomy and limited opportunity to express perspectives, describing feeling controlled by their parents, excluded from decision-making, highlighting tension between treatment/structure and adolescent voice. Participants in this study felt socially withdrawn, lacked confidence and social skills, which impacted interpersonal relationships contributing to social isolation.

In contrast to Sibeoni et al. (2017), the authors identify the development of trust between YP and therapists, participants valued the sensitive support received while discussing daily issues, including emotional regulation. However, this study focused on inpatient experiences of anorexia nervosa (AN) not outpatient (Fox and Diab, 2015). Nevertheless, themes of adolescent identity difficulties, feelings of being misunderstood, and relational strain within families suggest a need for greater collaboration during treatment.

Gap and rationale

Overall, positive clinical outcomes do not necessarily correspond to positive therapeutic experiences. Understanding this is important, as lived experience can influence engagement, commitment, and the overall meaning of recovery beyond symptom change. Therefore, this systematic review addresses the question: what are the experiences and perceived impacts of family therapy interventions for eating disorders among YP and their families?

Method

The Search Process

In order to conduct a thorough examination of the literature, eight electronic databases were selected for use. A database search of published literature dating from January 2016 to April 2026 was conducted. Seven electronic databases were selected for this purpose:

ScienceDirect, JSTOR, ProQuest, PsycINFO, PsycARTICLES, EBSCOhost, and Google Scholar. Search terms were developed using Boolean operators and truncations to maximise retrieval. Core search strings included combinations of: "eating disorder" OR "anorexia nervosa" OR "bulimia nervosa"* "family therapy" OR "family-based treatment" OR "Maudsley" OR "multifamily therapy" "experience" OR "perception"* OR "lived experience" OR "qualitative"* "adolescent" OR "young people" OR "child"*

Reference lists of included papers were also hand-searched to identify any additional relevant studies. Grey literature was excluded because the review focused on peer-reviewed empirical evidence.

Inclusion and Exclusion Criteria

Studies were selected according to predefined inclusion and exclusion criteria.

Inclusion criteria:

- Published between January 2016 – April 2026
- Peer-reviewed journal articles
- Qualitative empirical design (e.g., interviews, focus groups, thematic analysis, IPA)
- Focus on family therapy / family-based interventions (including FBT, Maudsley, multifamily therapy)
- Participants included young people with eating disorders and/or their families
- English language publications

Exclusion criteria:

- Quantitative-only studies
- Reviews, meta-analyses, editorials, or commentaries
- Adult-only samples (unless family therapy is delivered within youth services)
- Studies not focused on treatment/intervention experience
- Non-peer-reviewed literature

Following screening, six papers met the inclusion criteria.

Quality Assessment, Screening and Coding

Screening followed a staged approach aligned with the guidance of systematic reviews.

- Title screening - removal of clearly irrelevant studies
- Abstract screening - assessment against inclusion criteria

- Full-text review - eligibility confirmation
- Quality appraisal - CASP checklist applied
- Data extraction and coding - thematic synthesis preparation

The six studies included in the final synthesis are summarised below in Table 1.

Table 1: Summary characteristics of studies reporting Experiences of Family Therapy for Eating Disorders

Study	Country	Study Design	Data Collection Method	Sample
Brinchmann & Krvavac (2021)	Norway	Qualitative	Semi-structured interviews	Young adult women + families in multifamily therapy
Conti et al. (2017)	Australia	Qualitative	In-depth interviews	Adolescents with AN receiving Maudsley/FT
Coopey & Johnson (2022)	UK	Qualitative	Interviews	Young people in inpatient FT & MFT
Gao et al. (2025)	USA	Qualitative pilot study	Semi-structured interviews	Adolescents receiving FBT
Medway et al. (2019)	Australia	Qualitative narrative study	Interviews	Adolescents + parents in FBT
Nilsen et al. (2021)	Norway	Qualitative thematic analysis	Family interviews / reflections	Families in inpatient FBT programme

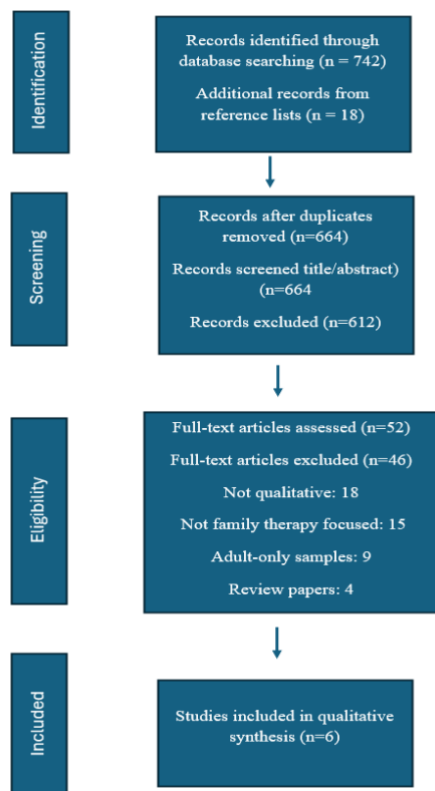
Two appraisal instruments were utilised: PRISMA-P (Moher et al., 2015) to guide transparent reporting of the search and selection process (Figure 1) and CASP Qualitative Checklist (2018) to assess methodological rigour, credibility, and relevance (Table 2).

Table 2: CASP Qualitative Appraisal

Study	Clear Aims	Appropriate Methodology	Research Design	Recruitment Strategy	Data Collection	Reflexivity	Ethical Issues	Data Analysis	Findings Clear	Value
Brinchmann & Krvavac (2021)	✓	✓	✓	✓	✓	Partial	✓	✓	✓	High
Conti et al. (2017)	✓	✓	✓	✓	✓	✓	✓	✓	✓	High
Coopey & Johnson (2022)	✓	✓	✓	✓	✓	Partial	✓	✓	✓	High
Gao et al. (2025)	✓	✓	✓	✓	✓	Limited	✓	✓	✓	Moderate–High
Medway et al. (2019)	✓	✓	✓	✓	✓	✓	✓	✓	✓	High
Nilsen et al. (2021)	✓	✓	✓	✓	✓	Partial	✓	✓	✓	High

Key: ✓ = Criterion met

Overall, all six studies were deemed methodologically robust, with minor limitations relating primarily to reflexivity reporting and sample size in pilot work.

Figure 1: PRISMA-P Flow chart

Results

Across six qualitative studies, sample sizes were small (up to 12 families), involving YP with AN often alongside parents and occasionally siblings or other family members. Participants were mainly adolescents (12–18 years), with some young adults up to 25 years. Parents were typically middle-aged. Samples were predominantly female, though a small number of male and transgender participants were included. Studies, included Norway, Australia, the United Kingdom, and the United States, and used interviews. Overall quality was moderate to high (CASP), though reflexivity was sometimes underreported. Key themes were identified across studies associated with connection and disconnection in family therapy.

1. ED and relational disconnection

1.1 Pre-treatment relational disconnection and emotional distance

Disconnection existed prior to therapy and because of the ED. Coopey and Johnson (2022) identify that the illness creates strain, blame, and distance, which therapy consequently attempts to repair. Their findings suggest that pre-treatment, the ED had already damaged relationships, and that emotional distance and conflict were already present within the family system.

Families described the ED as creating emotional separation, with one father explaining *“it was just as if there was a wall between her and us in relation to the disease”* Brinchmann & Krvavac, p7, illustrating a clear sense of relational disconnection. This metaphor of a “wall” reflects not only emotional distance but also a breakdown in communication and mutual understanding. Similarly, broader social and emotional disconnection was identified, with one participant describing withdrawal from connection in relationships, *“I still sat with them at lunch at school, but it was almost like no relationship there... I was just a zombie.”* Medway et al., p7. This means disconnection extends beyond the family to wider social networks, reinforcing the extensive relational impact of the disorder.

1.2 Disconnection and strain during FBT

Findings indicate that some YP experienced increased strain in family relationships during early stages of FBT. In phase one, parental control regarding eating was described as leading to a loss of autonomy, with YP reporting feelings of regression to a younger developmental stage. One YP described feeling *“thrown straight back to when I was 10 years old and reliant on my parents telling me what I can and can’t do,”* highlighting the intensity of this experience Medway et al., p8.

Further on in treatment, this was also associated with an increased intensity in parent–child relationship, where interactions became highly

focused on food and weight restoration. There was reduced opportunities to discuss emotional/social difficulties, suggesting that psychological needs were neglected and focus was largely on physical recovery. One YP stated, *"It's almost made my parents prioritize my physical health over my mental health... when I was struggling the most mentally and emotionally... it was not talked about as much as I would have hoped."* Gao et al., p6. This highlights a potential imbalance within FBT, where the necessary focus on weight restoration may inadvertently contribute to emotional disconnection. Furthermore, life becoming task-focused, parents taking control of eating was experienced as creating an emotionally strained relationship. Communication within the family was often centered around compliance with eating, rather than emotional expression or mutual understanding.

In some cases, pre-existing family challenges, including conflict and limited understanding, remained present throughout treatment. Participants described disengaging from therapy for lack of parental understanding or a weak therapeutic relationship. One YP reflected, *"Therapy helped but not in the way I thought it would... It helped me by annoying me until I wanted to avoid it... I just wanted to be living my life"* Medway et al., p9.

Another YP said:

"It made a lot more arguments. I'd go to therapy and whatever would get me all rilled up because I wouldn't be listened to, and it was all of this shit that I didn't want to talk about so I'd leave feeling like shit. And I'd cry on the car home." Gao et al., p3.

Overall, FBT aims to involve the family as a central resource in recovery, however its structure may intensify relational strain. This highlights a critical tension within the therapeutic models – the same mechanisms that facilitate physical recovery appears to also contribute to further relational disconnection.

1.3 Parental exclusion and feeling sidelined in treatment

In addition to YP, parents can experience disconnection within treatment. Although they initially reported relief in allowing clinicians to take the lead, some later felt excluded from the process and perceived a hierarchy between themselves and professionals. These conflicting emotions occurred simultaneously – reassurance that their child was receiving care, alongside a sense that their role as parents was not recognised as important.

They reported their child appeared to listen more to therapists than to them, positioning clinicians as the primary experts. This dynamic unintentionally shifts authority away from the parents, reinforcing a sense of parental inadequacy and reducing confidence in their role.

As a result, parents felt disconnected not only from the treatment process but also from their child. One father reflects:

"Still I felt it was difficult. I didn't feel that I took part. I don't know if this was because I opted out or not, but I don't think so. It was like you were supposed to join in and take part, yet you were on the sideline." Nilson et al., p8.

Together, these findings suggest that disconnection within family therapy is multi-layered, affecting both YP and parents. While therapy is designed to increase involvement, these experiences indicate that involvement may not always translate into a sense of inclusion or relational closeness.

2. Rebuilding connection and communication within families

2.1 Developing understanding and shared meaning

Despite experiences of disconnection, several studies highlight the role of therapy in rebuilding connection through developing shared understanding. Coopey and Johnson (2022) found that families understanding the ED, and the YP feeling understood, including recognising they are not alone was central to reviving connection. The process of understanding enabled families to

gradually make sense of the illness and treatment with understanding becoming the foundation for improved communication, as family members were better able to interpret behaviours and respond more appropriately.

One participant explained, *“groups and stuff for like parents to understand... it helps like with my parents and stuff to understand and helps me to deal with things a bit better”* Coopey et al., p4.

2.2 Rebuilding relationships and reducing isolation

The development of shared understanding appeared to facilitate the rebuilding of strained relationships. Participants described improvements in family closeness, with one YP stating they were *“getting closer again”* Coopey et al., p5 to a sibling. This indicates that relational repair is possible when communication improves and emotional understanding increases.

MFT also provided a shared space for families to connect with others experiencing similar challenges. This reduced isolation and increased empathy. Participants valued the opportunity to feel understood by peers, *“I think it was nice to talk to other people... they knew they weren’t alone and they gave them the tools to progress”* Coopey et al., p5. Similarly, *“I realized that at last there were people who understood what I was talking about”* Brinchmann et al., p6.

These findings identify that connection is not only rebuilt within individual families but across families, creating a broader sense of shared experience through MFT, normalising experiences and reducing feelings of isolation, which are often associated with an ED.

Families also reported improved communication and emotional openness, *“we became much better at talking to each other after having been in MFT”* (Brinchmann and Krvavac, 2021), indicating therapy provides the tools and environment necessary for more effective communication.

2.3 Ambivalence in reconnection and ongoing relational tension

The process of rebuilding connection was not straightforward. Some participants described ambivalence, where improvements in connection co-existed with ongoing tension. One sibling reflected, *“we came closer to each other, but also... we became divided.”* Nilsen et al., p8. In this case, the mothers increased focus on one family member due to hospitalisation led to reduced attention for the sibling, altering family dynamics in complex ways. However, the sibling suggested a strengthening relationship with her dad during that time. Nevertheless, this highlights how therapeutic contexts may simultaneously strengthen and strain family relationships, impacting how they connect as a unit.

Overall, reconnection is not a linear process, but one that may involve periods of adjustment and difficulty.

2.4 Restoring parental understanding and confidence

Increased understanding also extended to parents’ ability to support their child. Gao et al. (2025) reports a YP described being able to explain their experiences, with their parent listening and responding more appropriately. Similarly, Nilsen et al. (2021) found that increased understanding enabled parents to implement helpful strategies, such as establishing routines and structure around mealtimes.

This contributed to increased parental confidence, with one parent saying, *“when we were able to see how difficult it was, we could understand better how it really was for her.”* Nilsen et al., p7. *“We regained a belief in our ability to function as parents... we recovered self-confidence and belief in that we can be parents and authority figures for our daughter.”* Nilsen et al., p8.

Overall, the rebuilding of connection is not only about emotional closeness, but also about restoring parental agency and competence within the family system.

3. Developmental change and shifting family roles

Findings from Medway et al. (2019) identify that, over time families may experience a shift in

roles and relationships as treatment progresses. Initially, conflict arose between parental control and adolescent autonomy. However, as YP began to normalise their eating, control was gradually handed back, supporting a transition towards independence.

For some YP, reconnecting with normal developmental activities acted as a motivator for recovery. However, others felt they had missed key developmental stages due to the intensity of treatment and continued to experience psychological difficulties such as low self-esteem and reduced confidence (Medway et al. 2019). This suggests that while behavioural recovery may be achieved, relational and developmental recovery may take longer to fully emerge.

3.1 FBT – Parents experience blame, failure and conflict

Furthermore, FBT/Maudsley also reshapes family roles and affects adolescent development including the tension within parental and YP relationship. During treatment, parents were made responsible for refeeding, which led to feelings of blame, failure and conflict when the desired outcome was unsuccessful. One dad discusses his wife, *“I felt like she was on trial in those sessions towards the end. And Hayley’s failure to put on weight was Margaret’s failure to feed her enough.”* Conti et al., p6. Stress and increased family arguments escalated throughout treatment even though parents and YP were trying their best, and therapist relationship was positive.

The Maudsley program pushed parents to focus ultimately on weight gain therefore, crying was seen a problem and emotional needs neglected. The YP felt unheard and invisible, everything attributed to the ED as appose to the person. Unsuccessful weight gain resulted in experiencing a sense of judgment, blame and guilt as parents. Hayley’s mum expresses, *“[...] it was very much a sense that, well Maudsley works but you’re clearly not doing it right... I felt wretched.”* Conti et al., p10, Extract 5. She suggests Hayley’s lack of success could be the result of the rigid FBT itself and so tailoring to unique needs should be considered.

The YP voice was often overlooked, Hayley’s dad described her as being *“put...to the side,”* Conti et al., p12, Extract 7a, impacting identity and autonomy. Parents were concerned that she was ignored for a structured process, and although FBT supported weight gain, it increased tension resulting in resistance in roles. Her mum believed *“the key, i.e., herself was deliberately excluded from the process...”* Conti et al., p12, Extract 7b.

Overall, connection and disconnection coexisted emerging as central themes shaping experiences. MFT was described as both challenging and reparative, with improved family connection identified as an important mechanism of change.

In contrast, findings from FBT studies suggest while parental control supported behavioural recovery, it could also contribute to relational tension and reduced autonomy.

Taken together, these findings highlight that family therapy operates within a tension between restoring connection and, at times, intensifying disconnection. Rebuilding relationships is complex, shaped by the illness and treatment structure. (Brinchmann and Krvavac, 2021; Medway et al. 2019).

Discussion

This systematic literature review explored lived experiences and perceived impacts of FBT for YP with ED and families. Overall, the findings support existing research demonstrating that while family therapy can be effective in supporting behavioural recovery, it has complex relational and developmental impacts.

Consistent with Voss (2022) and Potterton et al. (2022), ED was shown to significantly disrupt adolescent development, particularly relating to identity formation, autonomy, and emotional regulation. The findings highlight that disruptions are not only internal but deeply relational. Coopey and Johnson (2022) identify pre-treatment disconnection, described as emotional distance and breakdown in communication, which supports Errui et al. (2020) and Mensi et al. (2021), who emphasise the impact of ED on family functioning and external relationships.

Families in this review were already experiencing strain, suggesting that therapy begins within an already disrupted family unit (Brinchmann & Krvavac, 2021; Medway et al. 2019). However, this review builds on research by highlighting how this tension can intensify or restore because of therapy.

Family therapy, particularly FBT, reflected the tensions described in the introduction. In line with Rienecke and Le Grange (2022), FBT positioned parents as central to recovery, with responsibility for feeding. While this facilitated weight restoration, it also reinforced findings from Sibeoni et al. (2017) and Fox and Diab (2015), YP reported reduced autonomy, feeling unheard, and emotionally overlooked. This review extends this by showing such dynamics contribute to relational disconnection, with communication becoming task-focused and centered on food rather than emotional understanding (Gao et al. 2025).

Consistent with Sibeoni et al. 2017) who identified a lack of trust between YP and clinicians, Medway et al. (2019) identifies YP found it hard to build trust with their therapist (and parents) because they felt misunderstood due to neglect of their emotional needs compared to physical recovery and weight gain. Although the practice of separating illness from the person is intended to reduce blame, it was sometimes experienced as silencing the adolescent, with negative implications for identity development (Gao et al. 2025; Medway et al. 2019).

Parental experiences also align with Mensi et al. (2021), highlighting high emotional burden, role confusion, and reduced confidence. Furthermore, Conti et al. (2017) identifies parents feeling a significant amount of blame particularly throughout the Maudsley FBT, resulting in a sense of failure as a parent and ongoing conflict. This finding contradicts Rienecke and Le Grange, (2022) who argue FBT fosters a no-blame approach, suggesting that a non-blaming ethos of FBT may not always be effective in practice. Some also felt excluded from treatment, indicating that involvement does not always link to inclusion (Nilsen et al. 2021; Conti et al. 2017). Consequently, professionals might consider FBT models, approaches and flexibility

based on individual needs to ensure blame reduction.

Consistent with Mensi et al. (2021), fathers in these studies struggled to maintain their caregiving role reporting feelings of uncertainty and exclusion. They experienced helplessness and role confusion, particularly in relation to responsibility for recovery. For some parents, this led to a reduced sense of worth, for others, emotional distress and withdrawal from active involvement, reinforcing the broader impact of ED on paternal identity and engagement within the family system (Nilson et al. 2021; Conti, ey al. 2017).

However, others felt relief that professionals were helping. Nilsen et al. (2021) found parents had a renewed sense of confidence as parents and caregivers with support to understand ED, understand YP needs and strategies to support appropriately.

Empathy and understanding highlighted renewed family connections and closer relationships. Furthermore, sharing experiences with similar families was valued through FMT, building connections and reducing isolation (Gao, et al. 2024). This is consistent with Escoffie et al. (2022), where positive outcomes were evident. MFT particularly, supported improved communication, shared understanding, and reduced isolation. This facilitated relational repair and a shift away from blame to collaboration and improved confidence (Gao et al. 2025; Brinchmann & Krvavac, 2021).

Overall, connection and disconnection coexisted, with relationship change being complex (Nilsen et al. (2021). Developmentally, the findings reinforce adolescence as a critical period and while family therapy initially reduces autonomy, recovery was associated with restoring the YP voice and agency, highlighting the need to balance behavioural and emotional needs.

Limitations

Firstly, the number of studies and samples included are small which limits generalisability (Stratton, 2024), largely female and focused mainly on anorexia nervosa. DSM-5 and Voss (2022) suggest 2 main groups of ED which

include 7 different definitions (American Psychiatric Association, 2022). Therefore, small samples and focusing mostly on AN female reduces applicability to more diverse populations (Stratton, 2024), and other ED, including families beyond western countries.

All studies used qualitative interviews, which are time-consuming and difficult to measure because they do not produce numerical data. Instead, findings can be subjective and influenced by researcher bias, so careful planning is needed to ensure questions and answers are clearly understood (Lambert and Abingdon, 2019; Demirci, 2023).

Qualitative interviews are structured conversations where neutrality and rapport must be actively managed, meaning the data is shaped by the interaction between interviewer and participant. The researcher's tone, questions, and relationship with participants can influence responses, which may affect the accuracy of the data. Participants' engagement also plays a role, making it difficult to remain fully neutral (Zhang & Okazawa, 2022).

This also links to the use of reflexivity. Conti et al. (2027) and Medway et al. (2021) were the only studies that fully addressed reflexivity, while the other four were partial or limited. This shows inconsistency across studies and suggests that researchers' interpretations may reflect their own beliefs rather than participants' true perspectives. It may also be unclear how the findings were shaped, which reduces the credibility of the results (Olmos-Vega et al., 2023).

Implications

Findings suggest that although family therapy is effective for physical recovery, greater attention is needed to emotional and relational processes. Clinicians should use more flexible, individualised approaches and ensure that young people's voices are included throughout treatment. Supporting emotional expression alongside

weight restoration may help reduce strain within families and help the YP deal with the deeper issues that might be connected to the ED. In addition, recognising and addressing parental feelings of blame and burden may improve engagement and outcomes, particularly in FBT. MFT approaches that encourage shared understanding and peer support may also be especially helpful in rebuilding family relationships and connection during recovery.

Future research

Future qualitative research would benefit from full reflexivity (Olmos-Vega et al., 2023) and larger, more diverse samples (Stratton, 2024), including a wider range of eating disorder diagnoses, more male participants, and populations beyond Western countries. This would improve the diversity of experiences captured and strengthen understanding of family therapy's impact more broadly.

Longitudinal studies, including those spanning up to 20 years (Eddy et al., 2017), could also help explore how relational and developmental outcomes change over time, capturing both short-term effects of treatment on family relationships and longer-term impacts across the lifespan.

Further research should also examine how FBT can be adapted to better support adolescent autonomy, identity development, and emotional wellbeing while maintaining its effectiveness for physical recovery. In addition, the ethos of FBT should be considered to ensure that families are not exposed to feelings of blame during treatment.

Conclusion

Family therapy is experienced as both beneficial and challenging. Its effectiveness and acceptability may be improved through greater flexibility, increased attention to identity and emotional needs, and more consistent inclusion of YP voices in the therapeutic process.

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