

RESEARCH ARTICLE

Perceived change mechanisms in multi-family therapy for anorexia nervosa: A qualitative follow-up study of adolescent and parent experiences

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Abstract

Objective: Multi-family therapy (MFT-AN) is a promising group-based treatment for adolescent anorexia nervosa. This study aimed to explore how young people and parents perceived change to occur during MFT treatment.

Methods: Young people (10–18 years) diagnosed with anorexia nervosa or atypical anorexia nervosa and their parents who completed MFT-AN alongside family therapy for anorexia nervosa within the preceding 2 years were eligible for this study. Semi-structured qualitative interviews were conducted. Recordings were transcribed verbatim and analysed using reflexive thematic analysis.

Results: Twenty-three participants (8 young people, 10 mothers and 5 fathers) completed interviews. Five main themes were identified; (1) Powerful connection, (2) Intensity, (3) New learning and perspective shifts, (4) Comparisons, and (5) Discharge is not recovery. There was a strong sense that being with others in a similar position in an intense environment were key factors in promoting change. Comparisons were inevitable and could promote insight and foster motivation, but could also be unhelpful at times. Participants spoke about how recovery continues beyond service use and requires ongoing attention and support.

Conclusions: Through the mechanisms of connection, intensity, new learning and comparisons change is perceived to occur in MFT-AN. Some of these are considered unique to this treatment format.

KEYWORDS

adolescents, anorexia nervosa, family based treatment, family therapy, group therapy, Maudsley family therapy, multi-family therapy, qualitative

Key points

- Multi-family therapy is perceived as a unique, challenging and helpful treatment for young people with anorexia nervosa.

- The combination of connecting with others in a similar position, the treatment intensity, new knowledge obtained in the group and the impact of comparisons between group members was described as leading to hope, increased mentalisation and change.
- Participants described how recovery continues beyond service use and that the end of treatment is not the same thing as recovery from anorexia nervosa.

1 | BACKGROUND

Multi-family therapy (MFT) groups have been part of anorexia nervosa treatment for decades. Multi-family therapy is a group-based intervention for up to eight or nine families, who work together with the support of a therapeutic team (Baudinet, Eisler, Dawson, et al., 2021). There are several different MFT models, all of which vary in intensity and duration. Regardless of the model, all are designed to improve outcomes by promoting solidarity and learning, to reduce the sense of isolation and to develop new ways of managing illness behaviours (Dawson et al., 2018; Simic & Eisler, 2015). Some MFT models offer a brief 3- or 5-day stand-alone treatment (Knatz Peck et al., 2021; Whitney et al., 2012; Wierenga et al., 2018), whereas others offer up to 12 months of adjunctive group therapy that is offered alongside other types of interventions (Gelin et al., 2016; Scholz et al., 2005; Simic et al., 2021; Stewart et al., 2015).

A recent systematic scoping review reported that MFT for adolescent anorexia nervosa is associated with significant improvements in eating disorder symptoms, as well as in a range of broader individual and family factors, such as mood, self-esteem, quality of life, family functioning and expressed emotion (Baudinet, Eisler, Dawson, et al., 2021). While MFT is now a recommended treatment for adolescent anorexia nervosa by several practice guidelines (Couturier et al., 2020; Heruc et al., 2020; NICE, 2017), the evidence base is still emerging. Only a small number of published studies exist, most of which are exploratory and/or underpowered. Only one outpatient randomised controlled trial (RCT) ($n = 169$) has been published to date (Eisler, Simic, Hodsoll, et al., 2016), although two published RCT protocols (Baudinet, Eisler, Simic, et al., 2021; Carrot et al., 2019) indicate more can be expected.

As the quantitative evidence base continues to build, less is known about the experience of MFT, particularly from the young person's perspective. Six studies have been published to date that investigate the experience of MFT for adolescent anorexia nervosa (Baumas et al., 2021; Coopey & Johnson, 2022; Engman-Bredvik et al., 2016; Voriadaki et al., 2015; Wiseman et al., 2019a, 2019b) and one for bulimia nervosa (Escoffé et al., 2022), although,

only four of these include the young person's voice (Baumas et al., 2021; Coopey & Johnson, 2022; Escoffé et al., 2022; Voriadaki et al., 2015). Of the remaining three qualitative studies, two attempted to recruit young people, but all declined (Wiseman et al., 2019a, 2019b), and one focused on the parent-only experience (Engman-Bredvik et al., 2016).

The qualitative data available indicate that MFT is perceived to be helpful, intense and challenging (Baudinet, Eisler, Dawson, et al., 2021). Participants report that it promotes new learning and improves family connections (Baumas et al., 2021; Coopey & Johnson, 2022; Wiseman et al., 2019b). Parents often say that MFT provides a new support network that helps to reduce isolation (Engman-Bredvik et al., 2016; Wiseman et al., 2019b). The inevitable comparisons between people that occur in any group are reported to be a challenge for some, especially when different people were at different stages of recovery (Baumas et al., 2021). As might be expected, many people also report feeling anxious at the commencement of MFT, however, this typically settles as treatment progresses (Voriadaki et al., 2015).

This study aims to add to this emerging evidence base, by exploring how young people and parents perceive change to occur during MFT. This will aid future research design as very little is known about the MFT treatment process and change mechanisms.

2 | MATERIALS AND METHODS

Ethics approval was granted for this project by the Stanmore Research Ethics Committee London (IRAS: 234354; REC: 20/LO/0839).

2.1 | Sample

Young people (12–18 years) with (1) a diagnosis of anorexia nervosa or atypical anorexia nervosa and their parents; (2) who received MFT as part of their outpatient treatment at the Maudsley Centre for Child and Adolescent Eating Disorders (MCCAED); and (3) completed treatment within the previous 2 years were eligible for

this study. MCCAED is a large, specialist child and adolescent eating disorder services in London, UK. The service has a catchment area of approximately two million people and sees people up to the age of 18 years. Potential participants were initially identified by the clinical team at MCCAED, who then made initial letter and telephone contact. Once consent to contact from the research group was received, up to three attempts at contact were made per family.

2.2 | Diagnostic assessment and screening

All young people completed the Development and Well-being Assessment (DAWBA) (Goodman et al., 2000) and the Eating Disorder Examination Questionnaire (EDE-Q; Fairburn & Beglin, 2008) prior to attending their initial assessment with the service. The DAWBA is a structured diagnostic tool that generates ICD-10 (World Health Organization, 2004) and DSM-5 (American Psychiatric Association, 2013) predicted psychiatric diagnoses for 2–17-year olds. It has good reported validity as a diagnostic tool (Aebi et al., 2012). Primary diagnosis of an eating disorder was confirmed during the clinical interview. Symptom severity was also assessed at assessment using the EDE-Q (Fairburn & Beglin, 2008), a 28-item measure with a total (global) score made up by four subscales: restraint, eating concerns, shape concerns and weight concerns. It has good internal consistency and has been used previously with clinical (Jennings & Phillips, 2017) and community adolescent samples (Carter et al., 2001).

2.3 | Treatment description

All participants in this study received outpatient MFT for anorexia nervosa (MFT-AN; Simic et al., 2021) alongside single-family therapy for anorexia nervosa (FT-AN; Eisler, Simic, Blessitt, et al., 2016). MFT-AN groups of up to eight families per group are delivered five to six times per year at MCCAED (see Simic et al., 2022 for service description and outcomes). Not all young people who receive FT-AN attend MFT-AN. Attendance is determined by several factors; including family preference, their availability to attend, availability of space in the group, and the timing of the group. Young people were not eligible for MFT-AN if they were current inpatients, nasogastric tube dependent for all food intake, did not have a diagnosis of anorexia nervosa or related restrictive eating disorder, had no available family members to attend treatment with them, or who were currently experiencing significant intra-familial trauma or abuse

that would result in them feeling too unsafe to participate in treatment in the same room together.

Families received five to eight full days (each 10 AM–4 PM) of MFT-AN alongside FT-AN sessions. An initial block of four or five consecutive days were offered (usually within the first 3 months of treatment), followed by up to six single follow-up days, spread across the following 3–6 months. Treatment length and number of days was variable and based on the needs of each group.

Multi-family therapy is based in the principles of FT-AN (Eisler, Simic, Blessitt, et al., 2016). It mirrors the FT-AN phases by beginning with engagement (phase 1) and symptom management (phase 2), then moving onto broader adolescent and family lifecycle needs (phase 3), before finishing with relapse prevention and therapeutic work around ending (phase 4). In phase 1 and 2 of treatment, there is a strong focus on practically supporting families with mealtimes and ensuring the young person returns to a physically healthy weight. This also includes introducing and problem-solving new ways of managing eating-related distress. Content of sessions in phase 3 and 4 are more governed by each family's specific needs. Common themes include returning to age-appropriate independence around food, eating and exercise, tolerance of uncertainty, increasing engagement with peers, education and other activities, and relapse prevention. The number and frequency of FT-AN sessions was not predetermined, rather was based on family need and clinical presentation. Early in treatment sessions were offered weekly, moving to fortnightly and beyond as treatment progressed. Typically, FT-AN continued after the final day of MFT-AN. The duration of FT-AN following MFT-AN was, again, based on clinical need and the treatment progress of each family.

FT-AN shares similar principles to the three-phased family based treatment (FBT; Lock & Le Grange, 2012). Both FT-AN and FBT are typically offered over 6–12 months, are phased, emphasise working with the family, with parents having a central role managing the child's eating early on in treatment. Both also broaden the scope of treatment in the later phases of treatment once healthier food and eating practices are established and physical health has improved. The treatments differ somewhat in their respective emphasis on formulation (Baudinet, Simic, et al., 2021), the inclusion of specific techniques (e.g. the family meal session, strategically raising parental anxiety), engagement of the young person and expectations placed on them throughout treatment, and the use of externalisation during treatment (Baudinet et al., 2022).

MFT-AN extends the FT-AN model by increased intensity and providing participants with additional supports via the group process. It is activity based and involves verbal, non-verbal and creative therapeutic tasks

that are completed in various group constellations, including, as one large group, within family groups, small mixed groups, groups based on family roles (i.e. parent, young person, sibling, etc), etc. For further details see the treatment manual (Simic et al., 2021).

All MFT-AN clinicians who delivered treatment in this study had been trained in both FT-AN and MFT-AN. FT-AN supervision was provided every 2–4 weeks and MFT-AN supervision provided before, during and after each MFT-AN intensive week by the developers of the treatments.

2.4 | Data collection

All participants provided informed consent. Qualitative interviews were conducted between June and December 2021. All were conducted via video-call by authors JB (male, clinical psychologist, DClinPsych, extensive experience of MFT), TH (female, assistant psychologist, MSc, no experience of MFT) and FK (female, assistant psychologist, MSc, no experience of MFT). Each lasted approximately 60–75 min with only the interviewer and participant(s) present.

TH and FK had no prior relationship with any of the participants. JB had been involved in facilitating some of the MFT groups from which participants were recruited. For these families, interviews were offered with TH or FK. Participants were informed at the beginning of their interview that the aim of the research was to explore their experience of change mechanisms within treatment.

In total, 21 interviews were completed. 19 individual interviews with just one participant and the interviewer present. The remaining two interviews were conducted with 3 people present; a mother and father, both from the same family, and an interviewer. In both instances individual interviews were initially offered, however, participants felt attending together would provide additional richness to the discussion without impacting their ability to express their opinion and disagree with each other. Interviews were recorded and then transcribed verbatim. These were not returned to participants for review. To ensure uniformity, an interview topic guide was given to all interviewers and two pilot interviews conducted prior to data collection (see Supporting Information S1).

2.5 | Analysis plan

Data generated were analysed by authors JB and AK (female, assistant psychologist, PhD) using reflexive

thematic analysis (Braun & Clarke, 2020). This was conducted within a critical realist framework, from which experience and meaning are considered subjective and influenced by social and cultural context. JB approached the data with extensive knowledge of MFT and many years of experience clinically delivering, writing about and teaching on the MFT model. Conversely, AK approached the data with no clinical experience, but some theoretical knowledge, of the treatment. These different viewpoints were considered a strength of the analysis and provided new insights and depth to the findings.

The analysing authors followed the six phases of reflexive thematic analysis (Braun & Clarke, 2006, 2020). Both had an initial period of immersion in the data to familiarise themselves with them. Each then independently generated codes and preliminary themes, after which the analysing authors met. Via an iterative process over three separate 1-h meetings, themes were then revised to reach a final consensus on themes that were felt to best reflect the data. This consensus was reached with no difficulties as the codes and themes identified individually were easily mapped onto each other. Young person and parent data were initially reviewed separately. Due to a large overlap in all participants' experiences, the data were then synthesised and presented together.

A deductive and flexible approach (Fletcher, 2017) was used during analysis that drew on existing MFT theory and literature. For example, it was expected that participants would talk about the impact of MFT on perceived isolation. However, coding was not constrained by these expectations, and codes were amended, added and deleted as needed. The concept of data saturation was not used during the analysis as it was recognised that different meanings are generated by different researchers and the process is inescapably subjective (Braun & Clarke, 2021). No software was used to assist analysis.

2.6 | Member checking

Synthesised member checking was completed in line with suggested guidance (Birt et al., 2016). As part of the consent process all participants indicated whether they wanted to be contacted once a draft of the result was completed. Those who consented were sent a summary and participants were given an opportunity to respond via telephone, video call or email about whether the results reflected their experiences and whether there was anything they would amend or add.

3 | RESULTS

3.1 | Participants

A total of 24 eligible families were discharged from MCCAED within the 2 years preceding study recruitment. This number is relatively small due to MFT not being offered between March 2020 and when recruitment commenced due to restrictions on face-to-face group-based interventions in the UK during the COVID-19 pandemic. Of the 24 eligible families, the clinical team deemed three to be inappropriate to contact due to ongoing distress or risk issues. Contact was attempted with the remaining 21. Four of these were unable to be reached after a maximum of three attempts by a clinical staff member. Of the remaining 16, 1/16 (6.25%) actively declined, 4/16 (25.0%) passively declined (provided initial consent or requested further information but were unreachable or unavailable to complete an interview thereafter), and 12/16 (75.0%) consented to participate, with at least one family member completing an interview. The final sample included 8 young people, 10 mothers and 5 fathers from 12 families. Reasons for non-participation included not having time to participate, not being interested in the study, or not wanting to discuss or revisit their treatment journey. The latter was the reason commonly provided by adolescents specifically.

All young people who completed an interview ($n = 8$) identified as female, cisgendered and white British. Mean age at interview was 16.32 years ($sd = 1.61$, range = 14.04–17.95). All were living at home and attending high school full time at the time of study participation. Two were also working part time. At assessment with MCCAED, mean age was 14.01 ($sd = 1.14$, range = 12.37–15.53) with the majority of young people ($n = 7$) meeting diagnostic criteria for anorexia nervosa, restrictive subtype, and one for atypical anorexia nervosa. Mean percentage median Body Mass Index (%mBMI) was 83.30% ($sd = 5.33$, range = 76.91–94.58). Half the sample (50.0%) had at least one predicted DSM-5 comorbid diagnosis on the DAWBA. Additionally, one (12.5%) was diagnosed with Autism between discharge from MCCAED and completing an interview.

Young people from participating families ($n = 12$) were slightly younger than those from eligible non-participating families ($n = 9$) (mean difference = 1.33 years, $t(19) = 2.21$, $p = 0.04$). The two groups did not significantly differ in eating disorder symptom severity (EDE-Q Global Score; mean difference = 0.12, $t(19) = 0.41$, $p = 0.69$) or %mBMI at assessment (mean difference = 1.39; $t(19) = 0.21$, $p = 0.84$) using independent samples t -tests. Regarding ethnicity, all

but one participant in both groups identified as white. Two of the eligible young people who passively declined identified as male. All eligible young people and parents identified as cisgendered.

Regarding parents, mean age at interview was 49.90 ($sd = 5.46$, range = 41–59) and 52.20 ($sd = 5.02$, range = 44–56) years for mothers and fathers, respectively. All identified as cisgendered and all but one father identified as white (white British, $n = 10$; white other, $n = 4$; black British, $n = 1$). One young person had same-sex female parents. Parents were separated in one of the 12 families. All fathers ($n = 5$) and most mothers ($n = 7$) were employed full-time. One mother was self-employed and two were employed part-time. One mother was also studying part-time.

3.2 | Treatment characteristics

The 12 participating families were recruited from seven different MFT-AN groups. All were recruited and consented to participate within 24 months of completion of MFT/FT-AN. Treatment course and response was relatively heterogeneous. The mean duration of combined MFT/FT-AN treatment was approximately 1 year, however it ranged from less than 6 months to nearly 2 years (mean = 11.69 months, $sd = 5.23$, range = 4.67–21.57). The mean duration from the final day of MFT to interview was 23.39 months ($sd = 5.48$, range = 17.72–35.21) and between discharge from MFT/FT-AN to interview was 15.08 months ($sd = 9.42$, range = 2.73–29.98). Participating ($n = 12$) and eligible non-participating families ($n = 9$) did not significantly differ in treatment duration (mean difference 0.61 months, $t(19) = 0.27$, $p = 0.79$), number of sessions attended (mean difference = 4.44, $t(19) = 0.96$, $p = 0.35$), or the amount of weight gained during treatment (mean difference = 0.15% $mBMI$, $t(19) = 0.05$, $p = 0.96$) tested using independent samples t -tests.

3.3 | Member checking

All participants agreed to be contacted with a summary of the results. Contact was made via email, to which four (17.4%) participants (one mother, two fathers and one young person) from three families agreed to offer reflections on the findings. One father provided reflections. He felt the results accurately reflected the treatment mechanisms within MFT, including the model presented in Figure 1. He also noted that it would be important to include the sibling experience into future evaluations.

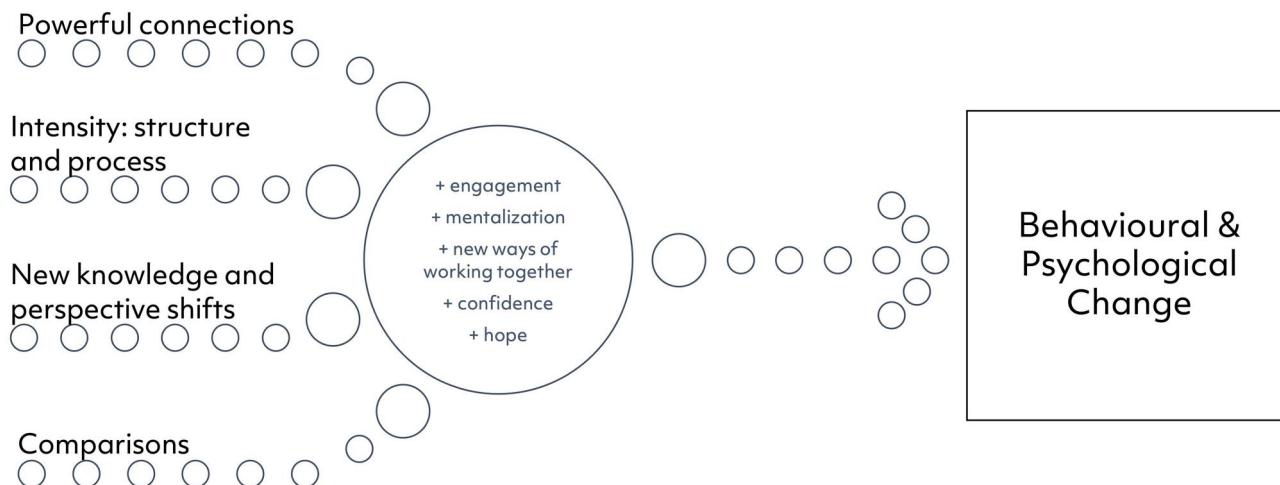


FIGURE 1 Perceived mechanisms and process of change in multi-family therapy for anorexia nervosa. [Colour figure can be viewed at [wileyonlinelibrary.com](https://onlinelibrary.wiley.com/doi/10.1002/erv.3006)]

3.4 | Qualitative findings

Five themes and nine subthemes were identified and are presented in Table 1 with illustrative quotes. The way these combined to generate change are presented in Figure 1.

3.5 | Theme 1: Powerful connection

There was a strong sense from participants that MFT-AN helped foster connection in multiple ways. This was perceived as beneficial, as well as challenging at times, and was considered one of the main change mechanisms for most.

3.5.1 | 1a. Reduced isolation

Almost all participants described feeling less isolated by attending MFT-AN. Many noted a powerful sense of relief associated with sharing their experiences with others who were ‘*in the same boat*’ (father 1). One mother noted: ‘*I wasn’t alone. Suddenly there were all these other families who were also struggling*’ (mother 1). This was mirrored by the young people, one of whom said: ‘*[MFT] really helped us to, kind of, see that we weren’t alone*’ (young person 3). This extended to a broad sense of reduced isolation and improved connection within families.

... it made us more of a family because we were together for that whole [MFT] week. So, I think I got closer to my parents, and I became a bit less frustrated with them because they understood more what I was going through.

(young person 6)

Both young people and parents also said that this contributed towards a noticeable point of change during their treatment journey.

I think they [my parents] found it very comforting to see other parents going through something very similar. And sort of like not being alone in that sense. And, yeah, I think that might have certainly been a turning point for them and that kind sort of second-hand turning point for me.

(young person 5)

3.5.2 | 1b. Stronger together

Additionally, many observed that relationships, particularly parent-child relationships, softened over the course of MFT-AN. This helped families feel more contained and trusting of each other during the recovery process. One mother noted that it gave her a ‘*new understanding of what ... [was] going on with her [ill daughter] and kind of explained a lot of her behaviour and made it easier in a way for us to help her*’ (mother 3). This, in turn, helped young people begin to become more recovery-focused and maintaining this closeness acted, for some, as an important motivator.

MFT definitely helped them [my parents] to approach it [the illness] more calmly and with a more understanding manner, which made me almost be like, okay, well, because it's calm and I can tell that they're doing it out of love and care that I want to do this for them.

TABLE 1 Themes and sub-themes of adolescent and parent experiences.

Theme	Subtheme	Illustrative quote
1. Powerful connection	1a. Reduced isolation	<i>I think it was definitely a good thing seeing other girls that were going through it. And it did make you feel a bit less alone, especially seeing all their families who are also going through the same struggles. (young person 1)</i>
	1b. Stronger together	<i>Spending more time with my parents was also helpful. Although I didn't really enjoy it at first, it was helpful because it helped to unite us, in a way, and talk about my problem. (young person 6)</i>
2. Intensity: Structure and process	2b. Helpful challenging	<i>it was painful, uncomfortable and exhausting, but it was very helpful (mother 6)</i>
	2b. Early containment and focus	<i>if we hadn't have done it, I don't think we would have evolved with [our child], and evolved as fast. (father 5)</i>
3. Comparison: a double-edged sword	3a. Insight	<i>It was very powerful watching other people ... Seeing some of my own feelings reflected back. But also seeing ... [what] people had triumphed over or their views being slightly different was quite ... interesting and helpful. (mother 1)</i>
	3b. Hope and motivation	<i>There were people who were so much worse off than us and had even worse experiences. So it kind of, it brought it all down to earth a little bit and thinking, okay, it's like, you can deal with this, this is not, but also what other people had to go through and they still made it through the same. (mother 2)</i>
	3c. Competition	<i>I was extremely competitive with people in my group who were far slimmer than I was ... (young person 8)</i>
4. New learning and perspective shifts	4a. Increased understanding	<i>I think one of the most isolating things about this illness is lack of understanding. (mother 8)</i> <i>It [MFT-AN] gave them a greater understanding of eating disorders as a whole and how to deal with it and how it affects me and others (young person 1)</i>
	4b. Firm to be kind	<i>I think parents need to be firm, but firm in a not intimidating way. ... if their children say, Oh, I don't want to eat this, and if they just let their children off, it'll lead them down a slippery slope of things like that (young person 6)</i>
5. Discharge is not recovery	-	<i>it's [discharge] forced me to – forced, but in a good way – it's forced me to be more independent, and I think now, recovery is a choice. I want to not be – I don't want to be sick anymore (young person 6)</i>

Because at that point, I didn't want to do it for me.

(young person 8)

3.6 | Theme 2: Intensity: Structure and process

The second important theme regarding treatment mechanisms was the intensity of MFT-AN and how this helped challenge unhelpful or stuck patterns of behaviour and/or thinking. The less intensive, single-day follow-up days were generally considered less helpful.

They were described as a time to consolidate learning and 'bring it all together' (young person 7) or create space to 'think about stuff in between' (mother 2) sessions. One mother noted that the intensive MFT-AN week at the beginning of treatment was 'far more helpful than all the follow-ups' (mother 7), and that there was something in the intensity that was needed to promote change. Having said that, there was a minority of parents that felt a bit more space between MFT days may have been helpful to foster more reflection. One mother reflected that she didn't notice change initially, but when she came to the follow-up days that is when she realised things had moved on a bit (mother 1).

3.6.1 | 2a. Helpful challenging

While perceived as helpful and needed by most, MFT-AN was also described as challenging, exhausting and unpleasant, at times. One young person said: *'I don't like going there [to MFT-AN], but I know it's working'* (young person 2). Many reflected that both the physical and emotional intensity helped to break down patterns of behavioural avoidance and denial about the illness and it's maintaining factors. One mother noted that: *'It was hard, it was difficult, it was emotional, it was tense, but I think at the end of the day ... it was really cathartic'* (mother 9). Another young person talked about how it *'definitely challenge[s] you to get a bit outside of your comfort zone ... you couldn't just kind of sit in a corner and refuse [to participate]'* (young person 1).

One father said that MFT *'definitely needed to be intense ... you can't take this thing [anorexia nervosa] lightly, you've got to confront it full on ... the first week [of MFT-AN], it was just horrible. I think with hindsight, I think it's needed'* (father 2). The *'non-stop'* nature of MFT-AN mirrored and modelled the focus and persistence needed by participants to reach recovery.

Some commented on how this enabled shifts that may have been difficult to achieve otherwise. For many it was difficult to revert to established illness-typical behaviours and that the context helped promote participation in treatment, as well as recovery when young person motivation was low.

She [my daughter] obviously tried the same strategy in the multi-family group, but she couldn't quite pull it off, so she had to participate extremely reluctantly, but she had to participate.

(mother 6)

3.6.2 | 2b. Early containment and focus

Many participants commented on how the intensity functioned to focus individuals and families, which, in turn, helped people be more open to each other and to the process of treatment. This was said to have fostered understanding and perspective taking, which contained families' anxieties and distress. This was hypothesised to have sped up the treatment process. One mother said they needed MFT-AN *'early in the [treatment] process. ... for a way of sharpening the minds and getting people talking and open'* and that *'it got us to a point that we were more open for treatment and more able to accept family therapy'* (mother 5). Similarly, a father noted that if his family *'hadn't have done it [MFT-AN], I don't think we would have evolved with*

[our child], and evolved as fast' (father 5). One young person reflected that: *'I wasn't very happy about doing it. I was quite angry, so I didn't maybe go in with the best mind. But I think ... looking back ... it probably was one of the best ways to start my treatment because it's [MFT-AN], you know, quite pressurising, I guess'* (young person 4).

3.7 | Theme 3: Comparisons: A double-edged sword

For many, the inevitable comparisons that resulted from having treatment with others in the MFT-AN group context impacted people in multifaceted ways. On the one hand it helped foster understanding and motivation, however, it was also associated with competitiveness that could drive eating disorder cognitions and/or behaviours if not managed effectively. Both appeared to result from an increase in mentalization.

3.7.1 | 3a. Insight

Participants said that comparisons helped increase insight and understanding of themselves and the illness. One young person said that *'watching it [anorexia nervosa] happen to other people helped me understand my bit [of the anorexia nervosa] a bit more'* (young person 2). Another said that *'it gives you a greater perspective on eating disorders as a whole, because it shows you ... how it manifests differently for everyone'* (young person 1). Many noticed that observing illness behaviours in another person, helped them recognise it within themselves.

You can recognise in, like, other people, like, what was going on. ... Me being able to recognise that was kind of like a good thing, because I could recognise what the illness is doing [to me].

(young person 2)

This benefit was considered unique to MFT with one parent noting that *'I don't think you would have got that from being just with the therapist on your own'* (mother 3).

3.7.2 | 3b. Hope and motivation

For many, comparisons helped motivate people to stay focused on recovery. Seeing others struggling or be in a worse-off position generated anxiety and could strengthen people's resolve not to go backwards. One mother said: *'On one level it scared the shit out of us ... and to go, wow, that could be where we're headed if we don't work hard on it'*

(mother 5). Conversely, seeing other people trying out new behaviours and making progress helped make recovery seem more real and possible. One young person described how the young people 'all got to see each other grow and change. And that maybe gave some of them a bit more hope' (young person 1). Similarly, a mother commented that: 'when you're with other people, it helps you to realise that maybe it's kind of possible, because if other people are doing it, you can do it as well' (young person 6).

3.7.3 | 3c. Competition

Comparisons, however, were not always helpful. Several described how comparisons could foster competitiveness and drive eating disorder cognitions and/or behaviours if unaddressed, especially around weight comparisons. Of note, these negatives were usually balanced-out by the benefits that arose out of comparisons.

I was extremely competitive with people in my group who were far slimmer than I was, ... But I also do think that it did really help me with the social aspect of it ... [I thought] finally, I actually am around people who I can relate to.
(young person 8)

She [my daughter] would have seen that there are a couple of girls that were much slimmer than her. So there was that kind of comparison, which is not great, but also maybe she would have seen towards the end of the sessions that there were some girls who are more compliant, and she probably would have compared herself with those as well.
(mother 6)

3.8 | Theme 4: New knowledge and perspective shifts

The fourth theme describes the way MFT-AN helped promote understanding and challenge unhelpful patterns. For many, making progress in treatment first required preconceived ideas about the illness and ways of relating to each other to be challenged. Then new ways of working together could be established. Participation in MFT-AN helped to promote this in various ways.

I think [MFT-AN] ... supports you to think about things you don't, might not, want to think

about, things that you haven't thought about, gives you another perspective on things you have thought about. ... it takes you to places you don't even know you need to go to, I suppose.
(mother 1)

3.8.1 | 4a. Increased understanding and skills

One of the most important and marked shifts was in participants' understanding of the illness and learning new ways of managing it. Both young people and parents noted how little they understood anorexia nervosa and that only through increased understanding could they begin to make more effective steps towards recovery.

[my parents] just learned anorexia as a whole. Because beforehand, I don't think they understood it. Nor did I, I didn't really understand it either. And we were just all a little bit in the dark. And I think from that, with my parents' understanding what it is, just literally then they actually started to shift their way of trying to help me and it really did help.
(young person 8)

In addition to learning about what anorexia nervosa is, MFT-AN also helped people understand the experience of living with it. One mother said that rather than just getting the 'facts and information,' MFT-AN gave her 'a real insight into what it [is] actually like to live with anorexia' (mother 1). This occurred, partly through discussion, but also by participants seeing their own struggles and hopes being expressed and mirrored back to them by others in the group.

I think when you're in it [anorexia nervosa], it's quite hard to reflect. But when you're watching others in it ... there's time to sort of reflect a bit more.
(mother 1)

These shifts in understanding helped generate hope. With the support of the other MFT-AN participants and facilitators, people described trying out new ways of managing the symptoms during MFT-AN, which helped build confidence and a sense of self-efficacy. One mother talked about how in MFT-AN 'you learn a technique and you become more courageous of tackling the behaviour that is reinforcing the illness' (mother 6).

3.8.2 | 4b. Firm to be kind

One specific shift described by most was parents learning how to be firm in the kindest possible way and young people finding a way to accept parental support. Parents particularly noted how MFT-AN helped them learn how to be very persistent and repetitive in order to help the young person in the early stages of recovery. One father said he and his wife were ‘*relentless*’ (father 5) and that is what his daughter needed to return to a healthy volume and variety of food. Similarly, one mother said that ‘*repetition was key [to recovery]. And ... no one really giving in*’ (mother 3). It was through this persistence that parents were able to connect and communicate their love and dedication to each other and their child.

She realised she wasn't going to be left to rot on her own. She just wasn't, and we weren't going to give up on her. And then she sort of found her sense of self, maybe because I think underlying so much of it was a lack of sense of worth in herself, and that she was worth all of these people doing this for her.

(mother 3)

Understandably, the young people found this particularly challenging. Many parents and young people noted that they could be ‘*angry*’ or ‘*frustrated*’ when parents became more persistent and firm in their support. Nevertheless, most young people said this was ultimately needed and that ‘*it's important to be challenged ... like, doing stuff that's out of your comfort zone*’ (young person 6) in order to be able to recover.

Some parents described using the technique of externalisation as a means of remaining connected with their child and maintaining warmth and kindness. One father said that, as parents, they ‘*separated the illness from her [ill daughter]. So although we were being firm, [we] were telling her we were being firm with the illness, not with her*’ (father 2).

3.9 | Theme 5: Discharge is not recovery

Theme five reflected participants’ experiences after discharge from services. Almost all participants, regardless of family role, described the need for ongoing persistence, focus and continued challenging of some behaviours after discharge. Most said they did not consider themselves/their child to be ‘*fully recovered*’ at the point of discharge from treatment. Being discharged before self-identifying as recovered was daunting for

some, however, many also reflected on struggling to know what recovery looked like.

Almost all participants said increased knowledge, new skills and increased support from family and the other MFT-AN participants helped the young people stabilise their physical health and provided all family members the confidence and tools to manage unhelpful and maladaptive thoughts or urges. However, continuing to attend treatment sessions was not deemed necessary.

I felt like I wasn't completely recovered. ... I think I was recovered in a sense where I didn't think I needed help anymore, like, constant therapy sessions. I felt recovered in that respect. But I think some things of my disorder were still there...

(young person 6)

Some participants commented on how being discharged was needed in order to make the next step in the recovery process. Finishing provided the opportunity to properly establish independence, without the safety net of a professional support network. There was also a sense from some that it would be helpful to incorporate more specific treatment targeting eating disorder (particularly body image) cognitions and explorations around the illness onset and vulnerability factors.

4 | DISCUSSION

This study aimed to explore how young people and parents perceive change to occur during MFT-AN. Five themes were identified; four were perceived treatment mechanisms, and one related to the process of discharge and the move to true independence thereafter. The four change mechanisms were distinct yet interrelated. The first perceived mechanisms, ‘*powerful connection*’, highlighted the way MFT-AN helped participants to feel less alone and find new ways to connect with each other. The intense structure and process (theme 2) of MFT-AN was emphasised as another important element that promoted change. All participants described MFT-AN as physically and emotionally taxing. While not always pleasant, most thought this was needed to interrupt unhelpful habits, perceptions and/or ways of managing illness behaviours. Nevertheless, it was challenging and some wanted more time between sessions to be able to absorb information more thoroughly. Similarly, the inevitable comparisons (theme 3) that participants made in the group setting were seen as both helpful and unhelpful if not monitored closely. They were considered unhelpful if they strengthened eating disorder cognitions, such as comparisons

about body weight. However, more often, comparisons were described as useful in that they helped people recognise their own illness behaviours. In turn, they could motivate people either by noticing other people's progress towards recovery, or by noticing that things could be worse if things deteriorated. Lastly, the fourth mechanism, 'new knowledge and perspective shifts', reflected that there was a sense that MFT-AN helped people gain new understanding of the illness and each other, especially around how to be firm and consistent when managing illness behaviours, whilst maintaining kindness and connection within relationships.

These findings are generally consistent with previous reports of the MFT experience (Baumas et al., 2021; Dawson et al., 2018; Engman-Bredvik et al., 2016; Voriadaki et al., 2015; Wiseman et al., 2019a). Extending our understanding of the treatment experience to perceived change mechanisms begins to shed light on the specific processes that might be needed during treatment. Even though FT/MFT-AN are typically recommended treatments for adolescent anorexia nervosa internationally (Hilbert et al., 2017), there has been relatively little empirical investigation into the change mechanisms and theoretical underpinnings of the approach. It has been repeatedly demonstrated that treatment is effective, yet how, why and for whom it works best remains relatively unknown.

Isolation and feeling misunderstood are described as core difficulties associated with eating disorders and can be barriers to change (Espíndola & Blay, 2009; Hempel et al., 2018; Levine, 2012). The MFT-AN mechanisms identified in this study appear to directly influence both of these factors. Those with lived experience are in a unique position to offer hope, understanding and information through 'insider knowledge' (Dickerson, 2011), which can be more impactful than information delivered by health professionals (Lock et al., 2004). This fits with recent shifts within the field, which emphasise the need to include peer support in treatment. From the current study it is unclear whether the intervention and new learning MFT-AN provides and the inclusion of peer support each uniquely contribute towards change, or whether they are only effective, or most powerful, in combination. This is a question for future quantitative and qualitative research. Further investigation of when peer support is most beneficial, and whether it can be unhelpful, is also needed.

This increased ability to connect with others, including the clinical team, in new ways may also function to improve engagement. Therapeutic alliance is one of the only known predictors of improved treatment outcomes in FT-AN (Jewell et al., 2016). Via the treatment mechanisms identified in this study, participants described being able

to find new ways of working together, trust each others' intentions more, and manage distress with more confidence and kindness. Essentially, MFT-AN appears to promote epistemic trust (how much one trusts and is willing to consider information provided by others (Fonagy & Allison, 2014)) and relational containment within families (Wallis et al., 2017), both of which may help to facilitate change.

These current findings also suggest the importance of targeting and understanding the role of mentalization; the capacity to understand others' internal states and behaviours, such as thoughts, feelings and desires (Fonagy & Allison, 2014; Fonagy et al., 1991) in treatment. The mechanisms identified in this study, particularly 'comparisons', suggests MFT-AN may promote mentalization, although this has not been empirically tested. A recent study found that mentalizing difficulties, particularly high parental certainty about mental states in others, may predict a poorer response to FT-AN (Jewell et al., 2021). An interesting question for future research will be whether MFT-AN, and potential other group-based interventions, help promote mentalization more than other non-group-based interventions.

The current findings also suggest MFT-AN may be particularly useful at promoting both young person and parent self-efficacy, the belief one has in their ability to complete tasks successfully and cope with future challenges (Bandura, 1997). Parent, but not adolescent, self-efficacy has been associated with improved outcomes in family-based treatment for adolescent anorexia nervosa with some evidence to suggest early improvements in self-efficacy may mediate treatment response (Byrne et al., 2015; Sadeh-Sharvit et al., 2018). The perception that MFT-AN helped to increase confidence, hope and experimentation in the current study, suggests it may be a powerful way of addressing self-efficacy. Whether this is more potent than single-family therapy is another question for future empirical investigation.

Lastly, intensity appears to be something unique to MFT-AN that is perceived as important for recovery and may speed up the treatment process. In many ways, the first 4–5 consecutive days of MFT-AN offered early in treatment are positioned between typical outpatient treatment and more intensive day programme interventions (cf Baudinet & Simic, 2021 for review) or other intensive outpatient treatments (e.g. Fink et al., 2017; Rockwell et al., 2011). Given consistent reporting that early change during eating disorder focused family therapies, particularly early weight gain, predicts end-of-treatment outcomes (Hamadi & Holliday, 2020), it would be useful to empirically determine whether the intensity of MFT-AN increases the likelihood of early change and/or reduces treatment length.

The fifth theme, 'discharge is not recovery', reflected participants' experiences in the months and years after treatment ended. The uncertainty described by many about what a 'full recovery' is and the recognition by many that an important part of the recovery process only happens after treatment has ended highlights the importance of including specific future oriented conversations about life post discharge as part the ending phase of treatment. Participants' uncertainty about how to define recovery is something the field of eating disorders has been grappling with more broadly. The long-standing debate over how best to define, measure and report on recovery from anorexia nervosa and other eating disorders continues to this day (Bardone-Cone et al., 2018; Richmond et al., 2020). Furthermore, a recent systematic review found that relapse rates from anorexia nervosa are reported to be between 9% and 52% and the first year post discharge is when people are particularly vulnerable (Khalsa et al., 2017). Taken together, more explicit discussion of what recovery might look like, what to expect from treatment, and how to manage any lapses or relapses in symptoms post discharge needs to be emphasised in future revisions of MFT/FT-AN.

4.1 | Strengths and limitations

This study has several strengths. Firstly, including the voice of more young people is particularly important given it is relatively absent from the adolescent MFT literature. Whilst still relatively small ($n = 8$ young people), it is larger than any other published qualitative study investigating adolescent MFT-AN. The follow-up design is also a strength and provides a new perspective on how participants reflect on treatment with the perspective of hindsight. This also allowed for some exploration of peoples' experiences post discharge.

Nevertheless, the sample size is relatively small, especially for fathers and young people, and the treatment experience was relatively heterogeneous, making generalisability of the findings tentative. The voice of young males with eating disorders is notably missing and there is a lack of racial diversity in the sample. The variability in treatment length is both a strength and a limitation of this study. On the one hand, heterogeneity provides insights into a wider range of experiences, not just that of people who respond well to treatment and do not require further mental health support after eating disorder treatment. Conversely, given the relatively small sample size, this heterogeneity limits the generalisability of the findings and means nuances in treatment experiences may be missed.

Lastly, selection bias may be present given not all families in MCCAED will have the means or ability to attend MFT-AN and only a selection of those able to attend were willing to complete qualitative interviews. This may have potentially resulted in a study sample who were more engaged with the service and treatment.

5 | CONCLUSION

Multi-family therapy is described as a unique, challenging and helpful treatment for young people with anorexia nervosa. The ability to connect with others in a similar position, the treatment intensity, new knowledge and the impact of comparisons between group members are all considered important treatment components that affect change. These factors appear to increase hope and understanding and reduce isolation. This is hypothesised to increase mentalisation, epistemic trust, relational containment and self-efficacy. Recovery also continues post discharge. Knowledge and skills acquired during treatment continue to be relevant in the months and years ahead. The inclusion of more explicit conversations about treatment expectations, recovery and life after discharge may be important to incorporate more into current MFT/FT-AN models.

AUTHOR CONTRIBUTIONS

JB led on all aspects of this study. US and IE supervised these processes. JB, TH, FK, and NM were involved in data collection. JB and AK analysed the data with support from MS. MS contributed to study design and manuscript preparation. All read and approved the final manuscript.

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CONFLICT OF INTEREST STATEMENT

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DATA AVAILABILITY STATEMENT

Data will be made available upon reasonable request for those participants who have consented to this.

ETHIC STATEMENT

Ethics approval was granted for this project in August 2020 by the Stanmore Research Ethics Committee London (IRAS: 234354; REC: 20/LO/0839). All participants provided written consent to participate and for the publication of results, including anonymised quotations.

PATIENT CONSENT

All participants provided written, informed consent/assent.

PERMISSION TO REPRODUCE MATERIAL FROM OTHER SOURCES

Not applicable.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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