



‘Somebody Else’s Roadmap’: Lived Experience of Maudsley and Family-based Therapy for Adolescent Anorexia Nervosa

Janet Conti^{1*}, Jamie Calder², Sara Cibralic¹, Paul Rhodes³, Tanya Meade¹, and Daphne Hewson¹

¹ Western Sydney University, New South Wales

² Australian Catholic University, New South Wales

³ Sydney University, New South Wales

The Maudsley and more recent family-based therapy manualised approaches are positioned by some as the gold standard, evidence-based therapy for adolescent anorexia nervosa (AN). However, a significant proportion of adolescents and their families either discontinue this therapy and/or find that it simply does not work for them. These adolescents and families are under-represented in the literature on therapeutic interventions for adolescent AN. This paper begins to address this gap with an in-depth qualitative case study that explores the lived experience of Maudsley family therapy (MFT)/family-based therapy (FBT) for one female adolescent (age 14 years) and her family over the period of 3 years (ages 11–14). Although initially handing over the responsibility for her eating was comforting and reinstated a sense of control in the family system, these experiences were not maintained. When she did not progress past the first phase of FBT, she and her family experienced the approach as blaming. She felt silenced and family alliances were weakened. This paper analyses how the family members negotiated and preserved their identities within this disabling context.

Keywords: anorexia nervosa, adolescent, Maudsley, family-based therapy, voice, identity, blame

Key Points

- 1 The Maudsley and family-based therapy (MFT/FTB) for adolescent AN provided an initial transition from an inpatient to an outpatient context and a grounding therapeutic alliance for this family and their adolescent daughter.
- 2 The FBT, however, could not progress beyond phase I, which resulted in a protracted stage of stuckness that culminated in a sense of failure, blame, and conflict within the family, which undermined early therapeutic gains.
- 3 When a manualised approach such as FBT does not work, space needs to be created, in the context of treatments for adolescent AN, toward tailored approaches that prioritise the voice and preferences of adolescents and their family.
- 4 Future family therapy interventions for adolescent AN may consider whether to focus on charging parents with responsibility for their child's eating or encourage them to provide a secure base for their child's safety through eating and weight restoration.
- 5 Greater consideration needs to be accorded to family interventions that address conflict and its resolution, family guilt and blame, a prioritisation of the adolescent's emotional expression and voice, and weight restoration, while at the same time enhancing identity and family processes.

Family-based therapy (FBT) (Lock & Le Grange, 2013; Lock, Le Grange, Agras, & Dare, 2001), is a manualised therapy that is based on the Maudsley family therapy model (MFT) (Dare & Eisler, 1997) and is considered by some as ‘the gold standard

*Address for correspondence: j.conti@westernsydney.edu.au

evidence-based treatment of adolescent anorexia nervosa' (Murray, Thornton, & Wallis, 2012, p. 1026). FBT is proposed by its authors (Lock & Le Grange, 2013) to be a non-blaming family approach that draws on the therapeutic practice of externalisation (Maisel, Epston, & Borden, 2004; White & Epston, 1990) of adolescent anorexia nervosa (AN) as an illness. The first phase begins with 'orchestrating an intense scene' (Lock & Le Grange, 2013, p. 59) aimed to escalate parental anxiety in order to mobilise and unify parents to take responsibility for refeeding their adolescent child. Therapists are required to 'insist that the parents remain relentless until they are convinced that the patient clearly understands that she will not be able to return to anorexic behavior while a part of the parents' household' (Lock & Le Grange, 2013, p. 126). Psychological processes and family dynamics are intentionally not addressed in the early treatment phases (Dring, 2015).

After a steady weight gain for the adolescent and significant steps toward weight restoration, the second phase involves returning control over eating to the adolescent with a continuation of the limited focus on issues outside this goal. The third phase of treatment begins once the adolescent has achieved a healthy weight and control over their eating and the focus shifts to adolescent issues, including development and autonomy, anxiety, depression, and social reintegration (Lock & Le Grange, 2013; Murray et al., 2012).

A five-year follow-up RCT of the Maudsley family model for AN ($n = 18$) found that of those families who completed the treatment, 72.2% of adolescents were reported to have 'good outcome', 5.6% had 'intermediate' and 22.2% 'poor outcome'; with outcome measured by weight restoration and improvements in eating disorder symptomatology (Eisler, Simic, Russell, & Dare, 2007). A four year follow-up randomised control trial (RCT) of the manualised version of FBT reported weight restoration in 75% of adolescents (up to 90% of ideal body) with a further 5% to 85% ideal body weight (Lock, Couturier, & Agras, 2006) as reported by the parents in 50% of the cases. However, these reported weight gains were not without ongoing difficulties with 40% of the adolescents experiencing 'considerable on-going psychological and psychiatric difficulty' (Lock et al., 2006, p. 672). Up to 27% of these families discontinued these family-based psychotherapeutic interventions with higher drop-out rates most frequently occurring in the early phase (i.e., the first 2–3 months) of longer treatment interventions over 12 months (DeJong, Broadbent, & Schmidt, 2012). A higher drop-out rate of 21.4% has been found for FBT than for individual therapy for adolescent AN (Lock et al., 2010).

MFT and FBT models of family therapy have their origins in the mid 1970s in structural family therapy, an approach that construed a child with AN as coming from a 'psychosomatic family' characterised by conflict avoidance, rigidity, overprotectiveness, and intergenerational alliances, with the child's symptom being understood as a 'regulator in the family system,' particularly in relation to parental conflict (Minuchin, Rosman, & Baker, 1978, p. 32). After earlier work on ways to inform psychodynamic therapy with family process (Pincus & Dare, 1978), Christopher Dare collaborated with Ivan Eisler at the Maudsley Hospital in London in research that questioned the heart of the psychosomatic family as applied to adolescent AN. On finding that 'a consistent family structure does not necessarily identify a causative factor in the development of an eating disorder' (Dare & Eisler, 1994, p. 224), there was a critical shift away from family blame for the cause of AN. This was central in the development of MFT as an approach to adolescent AN that was intended to be a

respectful and less confrontational intervention informed by both research data as well as therapist 'intuitions and sensitivity in summing up the entirety of the present problem and its context' (Dare et al., 1995, p. 54). Within this context, MFT therapists have been advised to 'pay close attention to the inner experience of the patient and of other family members, and must use this understanding to make contact with each family member' (Dare & Eisler, 1997, p. 320).

With the manualisation of the MFT approach to FBT (Lock & Le Grange, 2013; Lock et al., 2001) an increased tendency to shift away from addressing family dynamics and adolescent struggles within the context of their family has emerged. Alongside this, there has been an increased focus on the adolescents' eating behaviour and weight gain (particularly in the earlier phases). This has led to 'discouraging the discussion of feelings, relationship issues and developmental difficulties' until the final phase of FBT, by which time these discussions and family interventions 'may be very difficult to revive' (Dring, 2015, p. 66). The intention to remain agnostic about etiology, therefore, has risked failure to engage therapeutically with the experience of AN as a personal, familial, and sociocultural crisis.

Proposals to augment the basic Maudsley approach have expanded (Loeb, Le Grange, & Lock, 2015) and include parent-to-parent consultations (Rhodes, Gosbee, Madden, & Brown, 2005) and multifamily therapy interventions (Eisler et al., 2016) that are designed to support families and build self-reflectiveness, competencies and hope. A recent systematic review (Richards, Rhodes, Subar, & Touyz, 2017) argues that while some of these innovations focus on the young person's psychological issues, the majority increase the intensity of parent-driven behavioural intervention. Therefore, there has been a reluctance to significantly modify the core constructs of specific phases of the original model (Rhodes et al., 2005) that are assumed to be the key elements in the efficacy of the MFT/FTB.

There exists a paucity of research into adolescent and family experiences of MFT/FTB. For example, a metasynthesis of experiences, of family therapy for AN (Medway & Rhodes, 2016) found that only two of the 15 qualitative research papers were specifically focused on adolescent and family experiences of MFT/FTB, with one consisting of data generated from open-ended survey questions (Krautter & Lock, 2004). One of these studies found that the most helpful aspect of MFT/FTB was parental support whereas the least helpful, as endorsed by two out of the total of four participants, was the sessions. To quote participants, the sessions 'were very stressful and I cried each time I left' and 'Feeling like I was on lock down and couldn't leave the house. It got better when I was able to start attending a class and go outside of home over time' (Chen et al., 2010, p. 222).

This paper aims to explore an experience of MFT/FTB by one adolescent and her family. Specifically, an in-depth examination focused on how this family negotiated their identities, roles, and alliances in the context of a protracted phase 1 treatment. This paper seeks to learn from the often marginalised experiences and expertise of adolescents and their families in order to inform how current treatments for adolescent AN may be improved.

Research Design

A qualitative case study analysis was conducted with an adolescent and her family with a focus on their experience of MFT/FTB.

Participants

The participants were the four members of one family who commenced MFT/FT for the youngest child, Hayley, after she had been hospitalised for AN at the age of 11 years.

Treatment history

Hayley's initial treatment for AN was a 2–3 week inpatient hospital admission for medical stabilisation at the age of 11 after a weight loss, over 3 months, from 29 (10th percentile for age) to 25 kg (well below the 5th percentile). During this inpatient admission she regained most of this weight, from 25 kg to 28 kg (just below the 5th percentile; height: 5th percentile for age). For 2 years she then engaged in MFT/FT with her parents, Margaret and Jack, and her brother, Richard (then 13 years) as an outpatient. During these 2 years of MFT/FT (aged 11–13 years) Hayley's weight fluctuated between 28–30 kg and by the end of treatment both her weight and height were significantly below the 5th percentile. She had neither gained weight nor grown in height between the ages of 11 and 13 years.

Over the 2 years of outpatient treatment, Hayley was in a protracted phase 1 of FBT where her parents were charged with the responsibility for her refeeding. At one point, with a weight gain to 30 kg, she qualified to progress to phase 2 of FBT. However, both Hayley and her parents struggled to shift the already established dynamic of her parents taking responsibility for her eating. Fourteen months into treatment, Margaret requested that Hayley have individual therapy and although the therapist then provided CBT in addition to MFT/FT, Margaret described this as 'very piecemeal' and facilitated by the therapist because 'we'd requested it but it really wasn't part of "the formula."'

At the age of 13 years, Hayley's parents and doctors became concerned at the lack of any substantive change in her weight or height after 2 years of treatment with MFT/FT. Subsequently she was referred to inpatient treatment but was assessed as not critically unwell enough for an admission. In light of their past positive experiences of inpatient treatment, Hayley's parents were open to this as a treatment option and disappointed when this was unavailable. Coinciding with this time, a critical incident in therapy led to Jack deciding to cease MFT/FT. Although Margaret continued MFT/FT with Hayley for another couple of months, the therapist subsequently discontinued therapy and recommended an intensive hospital-based MFT/FT intervention.

During the 4 months when Hayley was in-between therapies, she experienced a turning point where she gained weight to 30 kg. She was then referred to another therapist and a specialist dietitian. Over the next 2 years of this outpatient team treatment, Hayley's weight gradually increased to 41 kg (near the 5th percentile for age) with a corresponding growth in her height to near the 5th percentile.

Procedure

After being approved by the Human Ethics Committee at Western Sydney University, the family responded to an advertisement distributed through health professional networks. Each member of Hayley's family was interviewed individually, followed by an interview with the whole family. The interviews (all by the first author) were semi-structured, with broad questions that scaffolded between experience of AN and MFT/

FBT treatment and with identity questions drawn from the paradigm of narrative therapy (White, 2007). Enquiry was also made as to what was found to be most and least helpful, and ideas on what could have been done differently. The use of semi-structured interviews meant that some of the questions were prepared in advance (see Appendix 1) whilst others were guided by participant responses and were therefore unstructured, arising within the context of the interview (Miles & Gilbert, 2005). Interviews were audio-taped, transcribed verbatim, and de-identified with pseudonyms. Each member of the family was given their interview transcript and invited to remove any parts of the interview deemed potentially identifiable. The family members were consulted throughout the process of data analysis and were asked to review the final manuscripts for agreement of interpretation.¹

Method of data analysis and interpretation

This case study was analysed through the lens of critical discursive analysis (Wetherell, 1998, 2007; Wetherell & Potter, 1988, 1992) and sought to address the research question by focusing on how each family member ascribed meaning to and negotiated their identities and roles within the context of their unique experiences of MFT/FTB. The research interview was understood as a context within which personal meanings and social identities were continually (re)constructed, (re)negotiated, and (re)formed through argument, addressing dilemmas, and rhetoric (Billig et al., 1988; Burr, 2015). Within this context, identity is understood as actively constructed within different discursive contexts whereby each family member was engaged in a process of meaning-making and spoke about their experiences through 'patterned everyday methods, as psycho-discursive practices' (Wetherell, 2007, p. 676). Stretches of text were selected that were relevant to the research question and were particularly centred upon how each family member negotiated their roles, identity, and family alliances within the context of their engagement with MFT/FTB. Light transcription (Edley, 2001) was used to broadly track variations in the subject's positioning and the emergence of divergent accounts of identity within the spaces of authoring created through dialogue.

Data analysis

The scope of this analysis goes beyond traditional outcomes based on weight gain/symptoms patterns to the processes of meaning-making and what this family had to do to reclaim their sense of identity as individuals and as a family. Initial coding of interviews generated themes related to treatment experiences and impacts, ways treatment influenced and was influenced by AN and aspects of divergent therapeutic interventions that were helpful in assisting Hayley to take steps to reclaim her life from AN and its effects. These were constructed into three themes:

1. Trying and 'failing': impacts of MFT/FTB on family alliances.
2. 'Failing' and standing for self and others: roles and identity formation.
3. What can be learnt for future therapies for adolescent AN?

Theme 1: Trying and 'failing': Impacts of MFT/FTB on family alliances

(a) Conflict. All the family members mentioned increased stress and conflict that arose in the context of AN and its treatment with MFT/FTB.

EXTRACTS 1

Hayley: [...] it didn't focus on my emotions and what was going on in my head and focused on, and the Maudsley approach was happy to sort of put those thoughts at bay so long as the food went in. And when I cried or when I screamed, I don't think my parents really understood how hard it was, what I was feeling, what I thought about myself. Like they obviously knew it was hard but I think maybe they thought I was being difficult. So this sort of battle between me and my parents didn't really cause healthy relationships. My brother, although he is a good brother, one of the protocols of it was that he came along when he could've, when he didn't have something pressing on and (pause) because it was sort of monotonous, I felt bad for dragging him along.

Margaret: I can't quantify it but I think that there's stress in that – if you see your parents in conflict, which you don't usually, because that wasn't our normal “modus operandi.” But when that is part of your “therapy,” it can be quite detrimental.

The ‘monotonous’ focus of the Maudsley script in phase 1 diverted the focus for Hayley from addressing ‘my emotions and what was going on in my head.’ This impacted her identity formation (‘what I thought about myself’). She associated this identity impact with increased conflict in her relationship with her parents (depicted as a ‘battle’) where she was left guessing as to how others thought of her and feeling ‘bad,’ for example, for her brother’s mandated attendance. Margaret’s use of quotation marks signalled a misnomer in the naming of MFT/FBT as ‘therapy,’ which did not fit with the family’s experience of an exacerbation of conflict. Margaret’s concern was centred on her children and the effects of seeing ‘your parents in conflict’ as she wondered whether what they were doing to try to save their daughter’s life was in fact ‘therapy’ at all.

(b) Blame, suffering, and failing. The rising conflict in the family became intertwined and complicated by blame.

EXTRACT 2a

Jack: [...] in our case we were on trial. I'd be shocked if Margaret didn't even use that expression. [...] criminally 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 ultimately. [...] unfortunately I think the mother's going to take an absolute pounding in this process, probably more than anybody.

EXTRACT 2b

Margaret: [...] a very, sort of ruthless approach to someone who's suffering. So there's suffering and yet it's about “well you haven't gained weight, so you're effectively going to be punished” and (sigh) I'm not all for saying everything's alright when it's not, but for the sufferer, that was the stick. For us, the stick was the sort of encouragement to tell on each other. That sort of, almost a Hitler youth thing “Oh Richard, how have your parents been going?” you know. And that actually is very unnerving because you think to yourself, goodness! He's being asked to talk to an authority about our failings and wants to be

truthful as you would expect a teenager to be. [...] And then the other overwhelming thing that I think about now is that, it was a bit like a charade, that you had to go in and there was sort of like, cues of what you should say at certain times. So, the sense that you were genuinely having a conversation about 'how's something going' or 'what should you do differently' or 'how can we help' or blah, blah, blah, seemed to be undermined by this sort of role play that the system had that, you would be cued to say something so that Hayley would hear that that was a signed off agreement that parents had agreed to that under guidance and that was like we'd all done "the right dance."

Jack's narrative highlighted the extent to which this purported non-blaming approach inadvertently ended up blaming, with the pervasive and unspoken assumption that Hayley's struggle to gain was her mother's 'failure to feed her enough.' Clear in these narratives is the extent of what Hayley's parents would go through (a 'pounding' (Jack) and 'ruthless approach' (Margaret)) to save their daughter's life. Margaret partly exemplified this through her son's recruitment into publicly breaking alliances with his parents in therapy. She used the metaphor 'almost a Hitler Youth thing' in an effort to emphasise the damaging effects of these power dynamics in a therapeutic context and to convey her distress. To highlight the profoundly negative effects of this on family alliances, Margaret questioned not only a process that shamed her and her husband, but expressed concerns about possible impacts on her son's identity formation where he was positioned as an outsider to his family. Finally, in this extract she highlights the extent to which therapy was disempowering through processes of correction by the therapist. This had the inadvertent effect of marginalising their unique expertise as parents through an absence of 'genuine' conversation to safely address the real struggles that were going on within the family.

(c) Hidden family stories. With the growing stress and conflict over the months and years, a range of experiences became hidden family stories adding further to guilt, blame, and suffering in the family.

EXTRACT 3a

Margaret: I think there were many times where I felt either the anorexia or the process we were in, tested all of us to our limits. Whether it was the volume of response, it's a fraught situation when you're in the middle of it and nobody can imagine because they've never seen a child in that state and you can't describe it because people wouldn't believe you, it wouldn't be believed. But to answer your question, I think the bit that helped me was that I didn't believe I'd done anything that wasn't all about keeping her safe and keeping her nourished. I knew I probably could've um expressed myself better or stayed calmer in a situation.

EXTRACT 3b

Richard: Yeah I think, I'm not complaining about any like lack of support or anything but I just, there were some times when I just got really angry and I was just, I would like to cool myself a bit.

Conti et al.

EXTRACT 3c

Hayley: [...] I used to be crying on a daily basis um and just felt like no one understood and felt like when mum and dad were doing this family-based therapy if I got anxious and started crying then they'd get mad at me for crying and then they'd say, like they'd call me, just, they'd call me mean things but I know they didn't mean it but everyone just got (pause) it wasn't a good dynamic but it's got much better.

And later:

Hayley: [...] I definitely can see sort of more clearly that they didn't mean what they said. That it was just, everyone was going through a really tough time and it wasn't just me and that I know mum and dad just wanted me to be healthy more than anything. But I think what they didn't sort of see with Maudsley was they just like solely focused on my physical health but they didn't really take on much consideration as to like my mental health and how much of a toll everything was taking on me.

Margaret doubted that others would 'believe' some of the family stories that highlighted the extent that AN and its treatment with MFT/FFT impacted upon Hayley's life and the life of the family; these stories became hidden. Hayley's actions and her family responses cannot be interpreted in isolation. Hayley's distress escalated with being faced with the prospect of eating and weight gain with an absence in the Maudsley script of 'focus on my emotions' (extract 1). Both Margaret and Richard expressed regret about moments where they responded to her distress in a context that 'tested us all to our limits' (extract 3a). Hayley retrospectively understood the utterance of painful words was a response to the shared systemic suffering within her family that was unaddressed with an approach that 'solely focused on my physical health' (extract 3c). Through neglecting to address the mounting stress in the family when the refeeding process became protracted and increasingly stressful, a context was generated where family members were recruited into acting in ways that both shamed them and were also against their better judgement (White, 1997) – 'I probably could have expressed myself better' (Margaret) and 'I would like to cool myself a bit' (Richard). Nevertheless, important within the context of Hayley's family was their better judgement, visible to Hayley in her retrospective accounting of others' words – 'I definitely can see sort of more clearly that they didn't mean what they said.' Nevertheless, these hidden family stories were desperate moments of stress and fear that were overwhelming and filled with regret and self-blame.

Theme 2 – 'Failing' and standing for self and others: Roles and identity formation

Within their narratives, each family member engaged in a process of identity negotiation and within their role within the family.

(a) 'How did it get to this stage? On my watch?' (Hayley's father).

EXTRACT 4a

Jack: I just felt completely helpless on multiple fronts. My hardest hitting feelings were actually at the very beginning. That's when I felt most desperate and guilty I guess and you know (Interviewer: Guilty? In what way? What did you feel guilty about?) [...] she just didn't seem herself at all and I got up in the middle of the night, just, I felt sick to my stomach

and sweating that something was wrong with her. A feeling I'd never ever had before. I just wandered in and I just crawled into the bed next to her, put my arms around her and then that's when I just felt her skin and bones and her cold skin and her just lifeless body. I sobbed and sobbed and sobbed that – how did it get, how did it get to this stage? On my watch? [. . .] I thought I was going to lose her.

EXTRACT 4b

Jack: I felt really helpless for my son who in the middle of all this, parents, Hayley was sick and here's this 13-year-old boy. I felt bad about that.

EXTRACT 4c

Jack: [. . .] because of the extreme nature of her illness and my complete ignorance to it, I must've tended to fall in behind what the experts were saying we ought to do. [. . .] the 95% Maudsley track record or whatever it was that rolled out gave me a high level of confidence 'will this work?' So follow them, follow it consistently, don't deviate because we haven't got any of that expertise or experience they do.

EXTRACT 4d

Jack: [. . .] it was one very poignant meeting where Margaret and I had kind of just got to our wits end at the lack of weight gain yet the efforts we were putting in, especially Margaret but all of us, day after day after day to get through, into Hayley and manage exercise and do all the things that we'd been taught and trained and so on and yet just, complete inertia on progress. [. . .] We had resigned ourselves to the fact that we were volunteering to try and take her in to get a second hospital treatment because [. . .] we were worried about her [. . .] and the therapist started to talk about "well you can take her into emergency [. . .] you then explain that you've done everything that you can, that you no longer feel that you can provide the nourishment and you're asking for their help." And I looked at her, and I just said, "[. . .] You want me to hand her over, that we can't care for our child?" And she looked at me and she said, "Well we're at that point" [. . .] I didn't see her again. [. . .] I've thought about it many times since, it's one thing for me to say to myself, "I can't provide for my daughter. I'm not providing. I should've seen this coming. I can't help her" [. . .] but to have someone else basically tell me you're not making it as her father struck a real chord and that's how I took it, was "you can't be her father so maybe the state can." But then that wasn't true. [Interviewer: I wonder what you were standing for in your anger there, standing up for in terms of what you knew about yourself as a father?] Probably I think I was standing up for all of us. I was standing up for Hayley who I knew was doing everything that was being asked of her and I probably hadn't been giving her enough credit for her own strength up until that point. I was standing up for Margaret, who had been constantly doing everything that was asked of her but still believing maybe there was something else going on and I didn't give that nearly enough air time. And I was standing up for myself. No one was going to tell me that I didn't have my daughter's best interest.

Within the context of terror that he might lose his daughter, Jack's positioning of himself within the masculine provider/protector discourse deprived him of his identity as a father and a man – 'How did it get to this stage, on my watch?' (extract 4a). In assuming the primary responsibility to both provide for and protect his family, AN posed a challenge to his identity as a male and father and ultimately contributed to a profound sense of 'helplessness' that in some way he had fallen short of his own expectations of himself in his role as husband and father (extract 4b).

Taking responsibility for Hayley's refeeding through 'fall(ing) in behind what the experts were saying' (extract 4c) initially offered Jack a way out of this sense of 'helplessness' and fitted with his investment in the identity position of provider/protector. This was until a 'poignant meeting' where the therapist's rationalisation for inpatient treatment positioned him as unable to 'provide nourishment' (extract 4d) for his daughter. His response of anger can be understood as an act of resistance (Wade, 1997) in which his sense of identity as a father had been violated (Phillips, 1998) by the MFT/FBT script and its subtexts, which imply that when the family fails to 'beat' the AN, they are also failing in their roles within the family. His anger also marked out a threshold by which he refused to continue to have his identity confined to a masculine provider/protector discourse and the subtext of the Maudsley script that had questioned the heart of his identity as a father – 'basically tell me you're not making it as her father' (extract 4d).

Although Jack's break from therapy resulted in a break in the family unit in therapy, nevertheless he resisted the invitation to see himself as a father who was 'not making it' (extract 4d). A re-authoring of his response of anger (extract 4d) in the context of the research interview connected him with his insider knowledge as a father that transported him beyond the Maudsley script to see that Hayley was doing everything she could at the time to stand up to AN and align himself with Margaret's perspective that perhaps Hayley's difficulties in progressing may be the treatment itself. At this point Jack re-authored the experience of leaving therapy as an act of resistance where he reclaimed a sense of identity as a father on different terms, a father who could 'provide' for his family in a different way through standing with his family in their efforts and from a place of hope that Hayley might one day reclaim her life from AN, even if this was not via the MFT/FBT 'roadmap'.

(b) 'I felt wretched' but 'I knew' my daughter (Hayley's mother).

EXTRACT 5

Margaret: [...] it was very much a sense that, well Maudsley works but you're clearly not doing it right. [Interviewer: How did that affect how you saw yourself as a mother?] Oh my goodness I was, I've never been so challenged in my life as a mother. I felt wretched. You know it's such a, a fundamental thing to feed and protect your child and anorexia has already challenged that in its essence and then to, on a weekly basis, be in a context (emotional tone to voice) where your failings are on show and also on show to your children. Well that's how I interpreted it, you know, that if this isn't working, then you've done something wrong. You've not done enough (emotional tone). [...] one really ironic thing in the whole process after our therapist had effectively ended the relationship based on the fact that she could do no more for us, she then recommended that we go to an intensive Maudsley program and effectively start again with people who were outpatients and

we'd be literally starting from scratch and it was like "ok so Maudsley's failed or we've failed Maudsley but now you're recommending more." And I just knew psychologically it would have been the worst thing in the world for Hayley to be treated in that way again.

Margaret experienced inadvertent blame where therapy became an audience to the growing narrative of her failure as a mother to (re)feed her daughter with devastating effects – 'I felt wretched.' The public shaming she experienced in the context of therapy further undermined her sense of herself as a good mother that had already been challenged by AN itself. In this stretch of text Margaret highlights the extent to which this purported non-blaming therapy became blaming, despite the anti-blame rhetoric of the model. Although she continued to put up with therapy that she experienced as blaming and recruited her into the sense of herself as a failure as a mother, Margaret refused to submit Hayley to a more intensive MFT/FTB. In doing so, she reclaimed her sense of identity as a mother who was protecting her daughter from further therapy that risked negative psychological impacts on her.

(c) 'Distraction' vs 'trust' (Hayley's brother).

EXTRACT 6a

Richard: I mean, at home obviously, when it's been tough it's been tough and that's been putting a bit of stress on mum and dad, which then puts stress on me and then, I guess affects me then.

EXTRACT 6b

Richard: I think well my main role I think has been distraction. [...] I've been told by them and by some of the therapists we saw was just "be there for her as an external person that's not telling her to eat."

EXTRACT 6c

Richard: [...] what I should've done the whole time but I think I did it parts of the time, ... be that like, ... one person that's not the person who's giving her the food to eat that she can trust.

Although Richard was impacted by his sister's experience of AN and its treatment, his narrative reconstruction tended to minimise these effects (extract 6a). MFT/FTB marginalised him to the periphery of the family through being allocated the role of 'distraction' (extract 6b). Nevertheless, Richard refused to confine his role to distraction and in extract 6c he actively re-negotiates his identity as a brother who values trust. This allocation of a 'neutral' role and a family member to be trusted by his sister stands in contrast to his parents' allocation of roles of battling anorexia and a potential source of distrust for his sister. Therapeutic opportunities to strengthen family members' preferred identities through their values and to strengthen such commitments to be a particular sort of brother, mother, father, or sister risk being lost to the MFT/FTB script. This risk is especially so in the earlier phases of therapy when these relationships may be significantly stretched with the focus on navigating the challenging terrain of refeeding and weight restoration.

(d) Loss and reclaiming of identity and voice (Hayley).

EXTRACT 7a

Jack: Where I think we've gone off the rails is in hindsight, is when I feel as though we almost put her as a person to the side and followed, followed a process or followed somebody else's roadmap.

EXTRACT 7b

Margaret: [...] the whole person of Hayley and Maudsley had somewhat ignored that from the very start. I accept that when she was very sick, you know, we talk in these beautiful terms of "it was the eating disorder and not Hayley in the room" and all those euphemisms but effectively Hayley was still in the room but she was treated as though she wasn't. And it was actually really, I'm getting goose bumps talking about it because that was probably the most unnerving thing that the person who I believe has been the key to recovery, i.e., herself (emotional tone), was deliberately excluded from the process and talked about as though she wasn't even in the room.

EXTRACT 7c

Hayley: Every time like everything around food that I said, they thought it was the eating disorder.

EXTRACT 7d

Hayley: [...] There was a point [...] when I was classified as "in stage 2" because my weight was in a normal range [...] and then when I did have opportunities to choose [food] myself. I found there was still sort of that voice saying "choose the lower option." And I never really felt strong enough to combat that voice and to, you know, say "No, I want this instead um I'm not listening to you.

Both Hayley's parents expressed significant concern about how she was 'put [...] to the side' (extract 7a) and 'ignored' (extract 7b), thereby becoming invisible in the therapeutic process (experienced by Margaret as 'unnerving'). Additionally, Hayley's identity became further lost to AN as her own preferences became interpreted through the practice of externalisation of the illness as 'the eating disorder' (extract 7c). Within this context, externalisation of the eating disorder (illness) led her to being de-authored; her authority to name and discern her experience on her own terms meant Hayley herself was also externalised with the illness.

Both Hayley's parents resisted the MFT/FFT script being prioritised over Hayley's voice through prioritising their knowledge that Hayley was 'the key to recovery' (Margaret) and that the process of MFT/FFT was not their 'roadmap' (Jack). Being treated as a passive recipient of treatment in phase 1 of MFT/FFT, Hayley was invisible and without voice, leaving her ill-equipped to stand up to AN and take responsibility for her eating even when she did qualify for phase 2 of treatment (extract 7d).

Rather than externalisation having the intended non-blaming effect, Hayley was instead silenced and externalisation became experienced by Margaret as a 'euphemism' (extract 7b). When externalisation is confined to the metaphor of illness (Conti, 2013), a dualism arises where the experience is totalised in negative terms, to have a voice of its own (Tierney & Fox, 2010) and construed as entirely separate from the person – 'it was the eating disorder and not Hayley in the room' (extract 7b). Upon what criteria is it decided that a person's voice is theirs or the voice of the eating disorder? And who decides? And at what point does the totalisation of an adolescent's actions (particularly those related to their eating and exercise behaviours) as 'the eating disorder' risk their identity being externalised and further lost to 'the eating disorder'?

Nevertheless, the effects of externalisation of the eating disorder were evident when Hayley reconstructed her narrative about a turning point during the four months post MFT/FTB and before she engaged in a new therapy.

EXTRACT 8

Hayley: I think I had enough to convince myself that the eating disorder is lying to me and that like up there was just that sort of spark of hope and determination which really helped me to imagine life without it.

After ceasing MFT/FTB, instead of defending AN and feeling guilty about the 'stress' it was causing others, Hayley was freed to engage her own self agency to stand up to AN ('had enough') and its effects and to name this on her own terms ('the eating disorder is lying to me'). At this point, Hayley engaged in a process of self-reflection about whether or not AN fitted in the sort of life she hoped for. As motivational interviewing proposes, the question asked is not, 'Why isn't the person motivated?' but rather, 'For what is the person motivated?' (Miller & Rollnick, 2002, p. 18). From this position, change is not understood as moving away from something that is judged negatively; change is about moving toward something different that is judged as preferred. Implicit in this understanding is that the person has a vision for something different for their life and identity. This was a central process in Hayley's narrative reconstruction of the time during which she experienced, 'a spark of hope and determination ... to imagine life without it.'

This also emphasises the significance of the experiencing person themselves having discursive agency (Conti, 2016) in the position of primary author of their experiences. This includes being consulted and part of the decision-making process in relation to naming AN and its effects on one's own terms, a position that frequently appears to be lost in the MFT/FTB script.

Theme 3: What can be learnt for future therapies for adolescent AN?

Intertwined with this family's experiences was their reflections on what could be important in taking forward and what could have been done differently.

(a) Significance of mobilising family commitment in therapy. A strength of MFT/FTB is the structured processes by which families are recruited into significant commitment to save the life of their child.

EXTRACT 9

Hayley: [...] although it [MFT/FBT] was very unenjoyable, I don't think I would have been able to gain that weight and get to the medically stable point if it had sort of been all up to me. I don't think I was in a mentally ok place to, even if I was having really helpful cognitive therapy. I think at that point I still definitely needed my family support because otherwise I think, even if it was unintentionally, I would've just slipped back. So having their support and knowing that I wasn't going to (pause), knowing that it wasn't sort of all on my shoulders, that they were helping me, to get the food in and to physically be healthy was good. [...] I had a really nice therapist, and knowing that (pause) I didn't always have to have a sort of battle in my head – "Should I have this or not?" "Should I be having something with lower calories than this?" Knowing that that sort of decision making wasn't up to me, um, ah, gave me a little bit of relief. [...] I think I also (pause) knowing that my parents cared for me and were prepared to take me to whatever treatment or you know, spend as much as they needed to get me back, so that helped me to know I wasn't on my own."

There was little doubt for Hayley that structured support and guidance from her family and MFT/FBT therapist were essential for her to survive the acute phase of undernutrition in AN. She found that handing over of responsibility for her eating was helpful at that point. In this handing over, her family's commitment to her recovery was experienced and understood as care and support (they 'cared for me' and 'I wasn't on my own'). However, the key question remains: how do therapists engage families in a structured program that draws on family support as a resource whilst not further contributing to the escalation of both interpersonal conflict and blame? How does therapy in this context also prioritise the voice of the experiencing person and equip them to stand against AN on their own behalf?

(b) Structural adherence to model vs tailoring to the family's unique reality.

EXTRACT 10a

Richard: [...] at first it was, we really, none of us really knew what to do. I mean we did by the book and stuff but it's obviously not by the book because everyone's unique.

EXTRACT 10b

Jack: I think that the rigidity and inflexibility of the practitioners of Maudsley that we came into contact with, you know it was such a shame, is really what I can say because [...] the heavy lifting was done, which was the trust. [...] she had Hayley in her hands, she had Margaret and I in her hands. And at different points of either the lack of progress or our frustration or anything to just flex the approach and to lean on the trust that had been built. Well I think we'd have gone to the edge of the earth with her you know until it became so rigid, dogmatic, prescribed and then ultimately, you know, suicidal. I just think it's a real shame because there's a gift and there's a benefit that then just gets kind of thrown away.

Although 'the book' assisted the family in the early stages of treatment, Richard highlighted that 'the book' was unable to handle the uniqueness of individual families (extract 10a). Jack emphasised that the problem in therapy was less about the therapeutic relationship where 'the heavy lifting was done, which was trust' in the person of the MFT/FTB therapist and more about their rigid adherence to the MFT/FTB script that was 'ultimately, suicidal' (extract 10b). Additionally, when the MFT/FTB model was clearly not working for this family, the parents' application of the model was questioned, rather than the model being questioned. Built on the medical discourse of a dose–response relationship and the positioning of MFT/FTB as best practice for the treatment of adolescent AN, it was assumed that the only other option was more of the same – that is, 'an intensive Maudsley program' (extract 5). This implies that the family were in need of correction and remediation, having failed the therapy process in some way. Jack highlighted how this rigid application of MFT/FTB, without flexible tailoring to an individual adolescent and their family, ultimately killed the 'gift' of the therapeutic relationship that had been established between the MFT/FTB therapist and the family.

(c) Addressing emotions and prioritising the adolescent's voice.

EXTRACT 11a

Hayley: I'd sort of try to keep it all in and even if I was really anxious I'd try to sort of just like scrunch my hand or just try not to let it show because I thought then they'd [family] be disappointed in me and thought I wasn't doing well. But my [current] therapist explained that it was, that it's actually better to cry and it's ok to cry and I think she said that to mum. And she said instead of saying "I don't want that," say things like, "Mum I'm scared of this because I'm worried it's going to make me fat" [. . .] If I was upset I sort of let myself be upset but not scream at them, or say "you're trying to make me fat" or whatever. And then, and they were able to sort of talk more rationally to me and (pause) and help me feel better.

EXTRACT 11b

Hayley: [. . .] my current therapist and I see a dietitian as well, it wasn't like, it wasn't like as soon as I saw them everything was great but [. . .] generally helped me to understand if there's a meal and I get anxious around it or nervous or start to cry or any of those signals, instead of just going "I'm scared of the food," she sort of helped me to think "well why are you scared of the food? What does that mean?" and helped me to think rationally and enjoy food more and trust her and the dietitian, [. . .] I've gained weight and much as healthy as I've ever been and there was much less arguments.

In extract 11a, Hayley highlighted the significance of addressing the difficult emotions that accompany eating and weight gain in AN and the dimension of meaning (extract 11b). Her experience of the discouragement of emotions in the FBT script echoes Greg Dring's (2015) argument that the focus of phase one does not allow much room for discussion of the adolescent's emotional response to eating and weight gain. Hayley's account of the effects of allowing for, communicating, and ascribing

meaning to her emotions in therapy and to her parents, demonstrates that this was an important dimension of therapy. For her, it led to a development of the skills to emotionally cope with increasing her food intake and weight.

Hayley's and her family's experience of this subsequent therapeutic intervention also needs to be interpreted in the context of her turning point (extract 8) between therapies, as well as the developments that happened in the family in the context of the initial therapy transactions. It is entirely plausible that there was an order effect where one therapy readied the family for another and this analysis needs to be considered in this light.

EXTRACTS 12

Jack: I think the times over the duration that I would identify the most helpful for her is when it's been about her and where she's been more active than passive in treatment and the discussions.

Margaret: [...] this therapy is building something, rather than the other, which was effectively looking for, looking for fault.

Hayley: [...] so gaining weight combined with the help psychologically [...] makes me feel like I'm recovering and that the eating disorder is not defining me.

These multi-voiced constructions highlight the therapeutic processes that have been important for Hayley but were absent when she recounted her experience of MFT/FT. This included personal agency (Jack) 'building something' (Margaret), and the therapeutic conversations that both unpacked meaning and scaffolded her toward reclaiming her life and identity from AN and its effects ('the eating disorder is not defining me,' Hayley). In this, Hayley can be seen as moving toward inhabiting a 'more elaborated' identity (Malson et al., 2011, p. 33). This more elaborated identity was re-authored in therapeutic conversations where the focus was on discerning and claiming her voice against AN. This differs significantly from previous MFT/FT conversations that focus on and inadvertently privilege the voice of AN.

Discussion

In-depth analysis of how this adolescent and her family experienced the core processes of MFT/FT identified inadvertent detrimental effects through increased interpersonal conflict, blame, and challenge that eroded family alliances. This outcome occurred despite the original intention of the MFT model to be non-blaming of families and agnostic about the etiology of AN. Alongside these effects were small acts of resistance (Wade, 1997) where family members renegotiated family alliances through standing for each other and themselves as they sought to preserve and re-author their preferred identities and shared relational histories that had been challenged by both AN and its treatment.

Effects of confining therapy to the FBT script

The discouragement of discussions around family dynamics and emotions in FBT, particularly in the early phases when relational dynamics are most fraught (Dring, 2015) had a number of effects for Hayley and her family. First, Hayley was disempowered,

lost her voice, and her sense of identity was eroded. Paralleling this, her family members were given little opportunity to give voice to their anxiety and other responses to AN and its effects. The progressive loss of a systemic focus in family-based therapies for AN, in an effort to avoid blaming families (Dring, 2015), means that therapeutic opportunities are lost and adolescents and their families are left ill-equipped to address the substantial impacts of AN and its effects. For this family, the FBT script did not have room to address the escalation of the stress and conflict in the family where a number of therapeutically important family stories became hidden and unaddressed. The continued returning to the FBT script to focus on eating and weight restoration meant that therapeutic opportunities were lost, including the generation of rich understandings of this family's story of grief and loss, survival, and reclaiming of identity and the strengthening of relationships through shared pain and suffering.

A premise of MFT/FTB is that it is a non-blaming family approach to adolescent AN that works when implemented correctly. However, implicit in allocating responsibility for refeeding the child to the parents is the danger that MFT/FTB is in fact providing the parents with a locus of blame when or if this refeeding and weight gain do not eventuate. Unwritten yet implicit in the MFT/FTB script that charges parents with the responsibility for their child's refeeding, is that the failure of the adolescent to gain weight is because of its implementation. Importantly, within this context the model itself is positioned as beyond interrogation or negotiation because of the assumption that 'Maudsley works.' Thus, therapy participants are instrumentalised as either correct in their application or inherently faulty and to blame when it does not work. Additionally, positioning MFT/FTB as beyond interrogation because 'it works' further allocates blame to those who have implemented it (i.e., parents and/or the therapist). The inevitable dynamics that emerge bear a striking resemblance to the winner/loser polarity and related strong-willed/yielding polarity within a semantics of power, which Valeria Ugazio (2013) has proposed to be a central relational dynamic in the experience of AN itself. In other words, does charging parents with the task of refeeding their child, like nurses in a hospital program, create a context for significant conflict that risks perpetuating therapeutically damaging patterns, such as the disempowerment of the adolescent? Furthermore, does this perpetuate any control dynamics that are inherent in AN itself?

Language matters in externalising conversations

The use of the therapeutic intervention of externalisation of the problem (White & Epston, 1990) in MFT/FTB could be seen as selective and possibly flawed. It is selective in that it confines the terms of speaking to an illness discourse where its task is to separate 'the illness from the patient' (Lock et al., 2001, p. 52). Its flaws lie in its impotence in addressing blame, and neglect in empowering the adolescent to claim their voice in the naming and discernment of their experiences as problematic. The use of externalisation to separate the adolescent from what is frequently termed 'the voice of anorexia' (for example, Tierney & Fox, 2010) leads to the inevitable question of how is the voice of AN discerned from the voice of the adolescent, and who decides this determination? This discernment is a further dimension of the semantics of power of AN itself (Ugazio, 2013) where the question of who wins and who loses in being the primary author of the adolescent's experience – the adolescent, the family, and/or the therapist?

Confining externalisation to an illness discourse means that the problem is built on a moral repertoire whereby the experience is totalised as bad and wrong (Conti,

2013, 2016). This risks alienating those who experience AN as a part of them and/or egosyntonic (Bemis Vitousek, 2005) and sets up the task of therapy as adversarial where the aim is to vanquish the problem from a person's life; such an aim leads to increased 'vulnerability' and 'fatigue' and 'reduced personal agency' (White, 2007, p. 37) if this does not eventuate.

Arguing for the significance of metaphor in externalising conversations, White (2007) has cautioned against excessive reliance on contest metaphors that totalise the problem as an entirely negative force in order to seek out its eradication. Externalisation that facilitates the separation of the self from the illness (or 'separation externalisation') (Conti, 2013, p. 139) limits the scope for a more relational understanding of the experience of AN, in which the therapeutic focus shifts to reclaiming identity from AN rather than being limited to separating and vanquishing it from a person's life (Conti, 2016, 2017; White, 2011). Use of relational and 'experience-near' (Geertz, 1975, p. 47) metaphors for what is known as AN has been found by Conti (2017) to provide the women who use them with discursive tools to mediate complex meanings and social realities so as to overturn categories of self-definition and expand 'the horizon of possibilities' (Bruner, 1990, pp. 59–60) for themselves, including taking steps to reclaim their lives from AN and its effects. In this, the heart of the journey becomes the construction of narratives of self-transformation (Garrett, 1998) and the performance of the meaning of these new-old identity narratives (Hewson, 1991).

Externalisation as a standalone practice constitutes a fraction of the therapeutic work in the paradigm of narrative therapy (from which this practice borrowed for the MFT/FBT). Within narrative therapy, this practice is intertwined with inviting the experiencing person to map the effects of the problem (White, 2007; White & Epston, 1990) and from this standpoint, the problem is named on their own experience-near terms that can handle the contingencies of their complex social reality. The next part of this conversation is to invite the person to take a stand on these effects and explore what this stance says about who they are as a person and their valued sense of themselves (White, 2007). This is the heart of the re-authoring process in narrative therapy of which externalisation is only one point along the way.

Evidence-based practice

This research paper might be understood as 'a thorn in the side of evidence-based treatment' (Murray et al., 2012, p. 1026) to those who argue for the imperative of health professionals being unified in their therapeutic approach to adolescent AN. The positioning of MFT/FBT as the only evidence-based therapeutic intervention for AN and the further assumption that the only reason it does not work is because the manual has not been implemented 'correctly' by family members and/or therapists is highly questionable. Early writers on evidence-based medicine have argued that

Evidence based medicine is not "cookbook" medicine. Because it requires a bottom up approach that integrates the best external evidence with individual clinical expertise and patients' choice, it cannot result in slavish, cookbook approaches to individual patient care. External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be integrated into a clinical decision.

(Sackett et al., 1996, p. 72)

There exists a tension between the manualised FBT and the extent to which it can be applied flexibly (Eisler, Wallis, & Dodge, 2015). Nevertheless, the research evidence for the efficacy of MFT/FBT in weight restoration in AN should 'never replace' the expertise of clinicians nor the individual preferences of family members. Continuing to neglect these other valuable forms of evidence into successful therapeutic interventions with AN means that treatments risk being tyrannised by the implementation of manualised programs whose inflexibility to the needs and preferences of individuals and families risks causing damage to the very people for whom therapies and therapists seek to support healing.

This paper needs to be interpreted in light of the fact that it is an in-depth analysis of the experience of one family with one MFT/FBT therapist. Nevertheless, this family's experiences challenge the core of the practice of MFT/FBT. It highlights the potential for harm and the need to consider other ways of engaging adolescents and their families in therapy that may mitigate further compounding their suffering. What is needed is further enquiry into the effects of MFT/FBT for adolescents who experience AN and their families. Further dialogue is needed to explore some of the effects of the core tenets of this therapy, including charging of parents with responsibility for their child's eating and weight restoration (regardless of whether the adolescent gains weight), externalisation when confined to illness discourse and the early phases where there is intentional avoidance of systemic family interventions, and addressing the adolescent's personal struggles.

Practice implications

Critiquing MFT/FBT does not contest the imperative of nutritional restoration in AN. What is being questioned is the assertion that therapy be confined to weight gain through a highly manualised method that loads heavy responsibility on the parents without consideration of the psychological effects on each family member and on the family system. The model is potentially traumatising for the adolescent and their family. It can be identified as 'family' therapy, only in terms of its requirement for family involvement, but it fails to address systemic processes until the third stage (Dring, 2015). By this time, the potentially detrimental effects (for individual family members and for family roles and relationships) of the interventions might compound any problematic systemic processes that were present at the start of therapy. And for those families who make it to the third stage, what is the evidence that these are remediated before termination?

We suggest that the questions to ask are: Does the end justify the means? Does therapy have to be so painful? Does it matter that therapy can have detrimental effects in the process of facilitating weight gain? Is there a way to facilitate weight restoration without causing psychological damage to the adolescent and their family members? Is there a way to facilitate weight restoration at the same time as enhancing identity and family processes?

Some practice-based implications of this study include a shift in therapeutic focus toward the following:

1. Engagement in therapeutic conversations to scaffold the adolescent toward reclaiming their voice and a sense of identity from AN (Dring, 2015; Ugazio, 2013). Perhaps initial therapy to address the symptoms and effects of AN (clearly essential to save lives) could be followed up by other substantive questions once the medical crisis has subsided.

2. Parental role being re-prioritised to provide support through a secure base (rather than being charged with the responsibility) for their child's safety through eating and weight restoration. This approach prioritises the adolescent, putting their 'feelings into words' (Dring, 2015, p. 239) and their parents in being able to listen to their feelings even if at times they may not agree with what their child is saying.
3. Rather than confining the therapeutic practice of externalisation to an illness discourse, aligning this practice with the narrative therapeutic interventions within which this practice was developed. This includes mapping the effects of the problem with the adolescent and on their own experience-near terms (White, 2007). Within this context, the therapeutic focus prioritises the adolescent's active involvement in the often complex process of discerning AN and its effects and encourages them to take a position on whether or not AN fits with the sort of life they hope for.
4. Maintaining a non-blaming therapeutic stance to address family systemic patterns, including attachment issues. Therapy that addresses family issues intergenerationally can prioritise both a non-blaming stance and the accountability of the effects family members' actions have on each other. For example, attachment-based family therapy (Wagner et al., 2016) does not assume family ruptures have caused AN, however it does not avoid addressing family challenges and relational ruptures. Instead, it focuses on scaffolding the adolescent to 'develop a mature, emotionally regulated and entitled voice, to both stand up for themselves effectively as well as to understand others' points of view (e.g., reflective functioning)' (Wagner et al., 2016, p. 213).
5. Identification of family therapy systemic patterns and themes (such as attitudes to control, eating and body weight, conflict and its resolution, emotional expression, and children's concerns about their parents) that are addressed trans-generationally and through attachment approaches, for example, attachment narrative therapy (Dallos, 2006). In the early phases of therapy, when conflict is most likely to be acute, therapists should have flexibility to tailoring therapy to the adolescent and their family, including decisions around whether they are seen as a family (conjoint) or with the adolescent seen separately from their parents (separated). Little long-term difference in treatment outcomes has been found between separated and conjoint family therapy for adolescent AN (Eisler et al., 2007; Le Grange et al., 2016). The therapist's capacity to tailor their family therapy sessions to individual families (rather than all family members being required to attend all sessions) would be a welcome development in this field and would provide scope to flexibly address conflict and prevent the buildup of family tensions and secrets.

Conclusion

MFT/FT, while a recommended and most commonly used treatment for adolescent AN, was not 'the roadmap' for Hayley and her family. The ongoing prioritisation of Hayley's eating and weight restoration in a protracted phase 1 meant that the therapeutic goal of liberation from AN was obscured by a rigid application of the MFT/FT formula. This paper highlights the need for more open dialogue about evidence-based practice for adolescent AN. In the clinical application of any therapeutic modality, regardless of the research evidence, there needs to be scope for clinicians to offer adolescents and their families interventions that are sensitive to their needs, tailored to their individual contexts and preferences, which was the intention of the original

authors of MFT (Dare et al., 1995). That may include therapeutic interventions other than MFT/FTB therapy. Therefore, further research is needed into a greater diversity of interventions for adolescent AN, to ensure an optimal fit between the adolescent, their family, and the therapeutic modality.

Endnote

- ¹ Email feedback from Margaret after reading final draft: 'Reading through our comments and your analysis clarifies the nature of what we were dealing with both from the AN directly, and indirectly from the prescribed "treatment." I believe that you have sensitively integrated our struggle and it completely resonates with our lived experience.'

Acknowledgements

This research has been supported by a Women's Research Fellowship Grant from Western Sydney University. The authors would like to acknowledge Emma Sheens, formerly at the University of Sydney, for her valuable contributions to this paper.

References

- Bemis Vitousek, K. (2005). *Alienating patients from the 'anorexic self: Externalizing and related strategies*. Paper presented at the Seventh International Conference on Eating Disorders, London.
- Billig, M., Condor, S., Edwards, D., Gane, M., Middleton, D., & Radley, A. (1988). *Ideological Dilemmas: A Social Psychology to Everyday Thinking*. London: Sage.
- Bruner, J. (1990). *Acts of Meaning*. Cambridge: Harvard University Press.
- Burr, V. (2015). *Social Constructionism*. New York: Routledge.
- Chen, E.Y., le Grange, D., Doyle, A.C., Zaitsoff, S., Doyle, P., Roehrig, J.P., & Washington, B. (2010). A case series of family-based therapy for weight restoration in young adults with anorexia nervosa. *Journal of Contemporary Psychotherapy*, 40(4), 219–224. <https://doi.org/10.1007/s10879-010-9146-0>.
- Conti, J.E. (2013). *'It's part of what makes me.'* Women's constructions of 'anorexia nervosa' in their identity journeys over ten years. Unpublished Doctoral Dissertation, Macquarie University, Sydney.
- Conti, J.E. (2016). 'I don't think anorexia is the way out.' Reconstruction of meaning in women's narratives of anorexia nervosa over ten years. *Journal of Constructivist Psychology*, 29(2), 165–183. <https://doi.org/10.1080/10720537.2015.1072485>.
- Conti, J.E. (2017). Recovering identity from anorexia nervosa – Women's constructions of their experiences of recovery from anorexia nervosa over 10 years. *Journal of Constructivist Psychology* (Published online), 1–23. <https://doi.org/10.1080/10720537.2016.1251366>.
- Dallos, R. (2006). *Attachment Narrative Therapy*. Maidenhead: Open University Press.
- Dare, C., & Eisler, I. (1994). Redefining the psychosomatic family: Family process of 26 eating disorder families. *International Journal of Eating Disorders*, 16(3), 221–226.
- Dare, C., & Eisler, I. (1997). Family therapy for anorexia nervosa, in D.M. Garner & P.E. Garfinkel (Eds.), *Handbook of Treatment for Eating Disorders*, (2nd ed.) (pp. 307–324). New York: Guilford.
- Dare, C., Eisler, I., Colahan, M., Crowther, C., Senior, R., & Asen, E. (1995). The listening heart and the chi square: Clinical and empirical perceptions in the family therapy of anorexia nervosa. *Journal of Family Therapy*, 17(1), 31–57. <https://doi.org/10.1111/j.1467-6427.1995.tb00003.x>.

- DeJong, H., Broadbent, H., & Schmidt, U. (2012). A systematic review of dropout from treatment in outpatients with anorexia nervosa. *International Journal of Eating Disorders*, 45(5), 635–647. <https://doi.org/10.1002/eat.20956>.
- Dring, G. (2015). *Finding a Voice: Family Therapy for Young People With Anorexia*. London: Karnac.
- Edley, N. (2001). Analysing masculinity: Interpretative repertoires, ideological dilemmas and subject positions, in M. Wetherell, S. Taylor & S.J. Yates (Eds.), *Discourse as Data: A Guide for Analysis* (pp. 189–224). London: Sage.
- Eisler, I., Simic, M., Russell, G.F.M., & Dare, C. (2007). A randomised controlled treatment trial of two forms of family therapy in adolescent anorexia nervosa: A five-year follow-up. *Journal of Child Psychology and Psychiatry*, 48(6), 552–560. <https://doi.org/10.1111/j.1469-7610.2007.01726.x>.
- Eisler, I., Wallis, A., & Dodge, E. (2015). What's new is old and what's old is new: The origins and evolution of eating disorders family therapy. In K. Loeb, D. Le Grange & A. Lock (Eds.), *Family Therapy for Adolescent Eating and Weight Disorders. New Applications*. (pp. 6–42). New York: Routledge.
- Eisler, I., Simic, M., Hodsoll, J., Asen, E., Berelowitz, M., Connan, F., & Landau, S. (2016). A pragmatic randomised multi-centre trial of multifamily and single family therapy for adolescent anorexia nervosa. *BMC Psychiatry*, 16(422), 1–14. <https://doi.org/10.1186/s12888-016-1129-6>.
- Garrett, C.J. (1998). *Beyond Anorexia: Narrative, Spirituality, and Recovery*. Cambridge: Cambridge University Press.
- Geertz, C. (1975). On the nature of anthropological understanding. *American Scientist*, 63(1), 47–53.
- Hewson, D. (1991). From laboratory to therapy room: Prediction questions for reconstructing the 'new-old' story. *Dulwich Centre Newsletter*, 3, 5–12.
- Krautter, T., & Lock, J. (2004). Is manualized family-based treatment for adolescent anorexia nervosa acceptable to patients? Patient satisfaction at the end of treatment. *Journal of Family Therapy*, 26(1), 66–82. <https://doi.org/10.1111/j.1467-6427.2004.00267.x>.
- Le Grange, D., Hughes, E.K., Court, A., Yeo, M., Crosby, R., & Sawyer, S.M. (2016). Randomized clinical trial of parent-focused treatment and family-based treatment for adolescent anorexia nervosa. *Journal of the American Academy of Child and Adolescent Psychiatry*, 55(8), 683–692. <https://doi.org/10.1016/j.jaac.2016.05.007>.
- Lock, J., & Le Grange, D. (2013). *Treatment Manual for Anorexia Nervosa: A Family-based Approach*. New York: Guilford.
- Lock, J., Le Grange, D., Agras, W.S., & Dare, C. (2001). *Treatment Manual for Anorexia Nervosa. A Family Based Approach*. New York: Guilford Press.
- Lock, J., Couturier, J., & Agras, W.S. (2006). Comparison of long-term outcomes in adolescents with anorexia nervosa treated with family therapy. *Journal of the American Academy of Child & Adolescent Psychiatry*, 45(6), 666–672. <https://doi.org/10.1097/01.chi.0000215152.61400.ca>.
- Lock, J., Le Grange, D., Agras, W.S., Moye, A., Bryson, S.W., & Jo, B. (2010). Randomized clinical trial comparing family-based treatment with adolescent-focused individual therapy for adolescents with anorexia nervosa. *Archives of General Psychiatry*, 67(10), 1025–1032. <https://doi.org/10.1001/archgenpsychiatry.2010.128>.
- Loeb, K., Le Grange, D., & Lock, J. (2015). *Family Therapy for Adolescent Eating and Weight Disorders*. New York: Routledge.
- Maisel, R., Epston, D., & Borden, A. (2004). *Biting the Hand that Starves You. Inspiring Resistance to Anorexia/Bulimia*. New York: Norton.

- Malson, H., Bailey, L., Clarke, S., Treasure, J., Anderson, G., & Kohn, M. (2011). Un/imaginable future selves: A discourse analysis of in-patients' talk about recovery from an 'eating disorder'. *European Eating Disorders Review*, 19(1), 25–36. <https://doi.org/10.1002/erv.1011>.
- Medway, M., & Rhodes, P. (2016). Young people's experience of family therapy for anorexia nervosa: A qualitative meta-synthesis. *Advances in Eating Disorders: Theory, Research and Practice*, 4(2), 189–207. <https://doi.org/10.1080/2166262630.2016.1164609>.
- Miles, J., & Gilbert, P. (2005). Introduction. In J. Miles & P. Gilbert (Eds.), *A Handbook of Research Methods for Clinical and Health Psychology* (pp. x–xi). Oxford: Oxford University Press.
- Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing. Preparing People for Change*. New York: Guilford Press.
- Minuchin, S., Rosman, B.L., & Baker, L. (1978). *Psychosomatic Families: Anorexia Nervosa in Context*. Cambridge MA: Harvard University Press.
- Murray, S.B., Thornton, C., & Wallis, A. (2012). A thorn in the side of evidence-based treatment for adolescent anorexia nervosa. *Australian & New Zealand Journal of Psychiatry*, 46(11), 1026–1028. <https://doi.org/10.1177/0004867412455231>.
- Phillips, A. (1998). *The Beast in the Nursery*. London: Faber and Faber.
- Pincus, L., & Dare, C. (1978). *Secrets in the Family*. London: Faber & Faber.
- Rhodes, P., Gosbee, M., Madden, S., & Brown, J. (2005). 'Communities of concern' in the family-based treatment of anorexia nervosa: Towards a consensus in the Maudsley model. *European Eating Disorders Review*, 13, 392–398. <https://doi.org/10.1111/j.1752-0606.2009.00115.x>.
- Richards, I., Rhodes, P., Subar, A., & Touyz, S. (2017). Augmentations to family-based treatment of anorexia nervosa: A systematic review. Paper to be submitted for publication.
- Sackett, D.L., Rosenberg, A.M.C., Muir Gray, J.A., Haynes, R.B., & Richardson, W.S. (1996). Evidence based medicine: What it is and what it isn't. *British Medical Journal*, 312, 71–72.
- Tierney, S., & Fox, J.R.E. (2010). Living with the 'anorexic voice': A thematic analysis. *Psychology and Psychotherapy: Theory, Research and Practice*, 83, 243–254. <https://doi.org/10.1348/147608309x480172>.
- Ugazio, V. (2013). *Semantic Polarities and Psychopathologies in the Family. Permitted and Forbidden Stories*. New York: Routledge.
- Wade, A. (1997). Small acts of living: Everyday resistance to violence and other forms of oppression. *Contemporary Family Therapy*, 19, 23–39.
- Wagner, I., Diamond, G.S., Levy, S., Russon, J., & Litster, R. (2016). Attachment-based family therapy as an adjunct to family-based treatment for adolescent anorexia nervosa. *Australian & New Zealand Journal of Family Therapy*, 37(207–227), <https://doi.org/10.1002/anzf.1152>.
- Wetherell, M. (1998). Positioning and interpretative repertoires: Conversation analysis and post-structuralism in dialogue. *Discourse and Society*, 9(3), 387–412. <https://doi.org/10.1177/0957926598009003005>.
- Wetherell, M. (2007). A step too far: Discursive psychology, linguistic ethnography and questions of identity. *Journal of Sociolinguistics*, 11(5), 661–681. <https://doi.org/10.1111/j.1467-9841.2007.00345.x>.
- Wetherell, M., & Potter, J. (1988). Discourse analysis and the identification of interpretative repertoires. In C. Antaki (Ed.), *Analysing Everyday Explanation. A Casebook of Methods*. (pp. 168–183). London: Sage.

Conti et al.

- Wetherell, M., & Potter, J. (1992). *Mapping the Language of Racism. Discourse and the Legitimation of Exploitation*. London: Harvester Wheatsheaf.
- White, M. (1997). *Narratives of Therapists' Lives*. Adelaide, S.A.: Dulwich Centre Publications.
- White, M. (2007). *Maps of Narrative Practice*. New York: Norton.
- White, M. (2011). *Narrative Practice: Continuing the Conversations*. New York: W.W. Norton.
- White, M., & Epston, D. (1990). *Narrative Means to Therapeutic Ends*. New York: Norton.

Appendix 1: Interview questions

A selection of questions was used with each participant and questions scaffolded between –

- Experience (e.g., Can you tell me about ... ?)
- Meaning (What does ... mean to you?)
- Identity (e.g., How does ... have you seeing yourself as a person?)
- Positioning on experience/identity conclusion (e.g., Is this OK for you or not? Why?)

Section 1: Interview questions for experiencing person, brother, mother, and father (interviewed separately)

a) Interview augmented with a timeline for narrative

When did anorexia start to have an impact on your/your child's/your sibling's life? What was this like for you as a person? And as a child/parent in your family? How did this have you seeing yourself as a person? Was this helpful or not? Why?

What does you/your child/your sibling having experienced anorexia mean to you as a person/parent/sibling?

Has your life changed with your/your child's/your sibling's experience of anorexia? What have you got in touch with yourself as a person/parent/sibling?

Additional questions for experiencing person. Can you tell me your story of anorexia?

Can you tell me a bit about your relationship with anorexia now? How does this affect your life? Relationships? How you see yourself as a person/child?

Do you consider your relationship with anorexia to be problematic for you now? If so, how? If not, why?

Additional questions for parents. Can you tell me your story of anorexia as a family?

When did you notice anorexia starting to have an influence over your child's life? What was this like for you as parents? How did this have you seeing yourself as parents? Was this helpful or not? Why?

Do you consider your child's relationship with anorexia to be problematic for them now? If so, how? If not, why?

What does your child having experienced anorexia mean to you as a parent?

Have your lives changed with your child's experience of anorexia? What have you got in touch with yourselves as a person/parent?

b) Experiences of MFT/FFT

How did you come to be involved in MFT/FFT?

Can you tell me about your experiences of MFT/FFT?

What was most helpful about MFT/FFT? Why? What was least helpful about MFT/FFT? Why?

Did your family complete the MFT/FFT? Why or why not?

Did MFT/FFT assist you/your child/your sibling to shift their relationship with anorexia?

Can you tell me about what you understand as the circumstances that led you/your family to no longer continue with MFT/FFT?

Do you think it was a positive or negative decision for your family to cease MFT/FFT?

How did participating in the MFT/FFT affect how you see yourself as a person/parent/sibling? Is this helpful or not? Why?

Did you have any fears/concerns about what might happen if your family discontinued MFT/FFT?

What were you hoping for as your family made the decision to cease MFT/FFT?

What do you want to not forget about yourself/your parents/your family from the MFT/FFT?

What might be important/advice you might give to another person/parent/sibling/family to know as they commence MFT/FFT?

What would you like more of in future treatments for anorexia? What would you like less of in future treatments for anorexia nervosa? What does this say to you about what matters for you/your child/your family?

Do you have hopes for future treatment/therapy in terms of the sort of work you would like to engage in? What does this say to you about what you value as a person/child/parent/family?

Additional questions at the end of each interview. What has stood out for you from our conversation today?

What might be important for us not to forget as we analyse the data from this interview?

Section 2: Interview questions for family (if interviewed together)

a) Meaning of experience of anorexia to family

What does having experienced anorexia mean to you as a family?

How have your lives changed with the experience of anorexia? What have you got in touch with yourselves as a family?

b) Experiences of MFT/FFT

Is there anything about your experiences of MFT/FFT that you would like to talk together now about as a family? (questions focused on scaffolding between experience and identity).