Offering timely and effective intervention to young people with Anorexia Nervosa (AN) is a current priority within our national healthcare services (NHS). Treatment guidelines recommend that services should consider including multi-family therapy (MFT) in treatment pathways for young people with AN. MFT is theorised, like all family-based treatment approaches, to create change in the way families emotionally and behaviourally respond to and manage the AN. However, there is limited empirical understanding of how this intervention may create this change. This study conducted focus groups with carers who attended a pilot MFT group and clinicians who facilitated this group, to gather their perspectives of how MFT creates changes within family systems, and how this adds to existing treatment pathways for AN. Carers and therapists reported that specific aspects of the MFT programme, as well as therapeutic processes within MFT, create change in relationships between families and services, create a shift in the way carers understand the AN and in how they respond to it, and allow shared meanings of AN to be developed. The unique aspect of attending an intervention with other families with similar experiences enhances parental confidence, shifts feelings of guilt and blame, promotes hope, and challenges the way families understand and manage AN.

Multi-Family Therapy for young people with Anorexia Nervosa: Clinicians and carers' perspectives on systemic changes

Anorexia Nervosa (AN) is a serious mental health disorder, with significant psychological and physical concerns. The majority of eating disorders (ED) begin before adulthood (Bailey et al., 2014). Individuals with AN are at increased risk of mortality, disability and psychological comorbidities (Bailey et al., 2014). Individuals treated at a younger age have a better prognosis, shorter illness duration and increased rates of recovery (Hay, 2015), thus there is an impetus to provide timely, effective intervention to young people with AN.

In the United Kingdom (UK) young people with ED should be offered treatment in line with National Institute of Clinical Excellence (NICE) guidelines. The NICE first-line recommended intervention for young people with AN is outpatient family therapy. This can be single-family therapy (SFT) on it's own, or single-family therapy alongside multi-family therapy (MFT; NICE, 2017). Across the UK, most services for young people with ED routinely offer single family therapy. However, MFT is a more recent development, and is not yet embedded into treatment pathways in the same way as SFT.

Multi-Family Therapy

MFT for ED was initially developed to provide an increasingly intensive intervention to young people with an ED, without turning to hospital admission. Whilst MFT is still an outpatient programme, it is more intensive than SFT and is different in that it brings together different families with shared experiences. MFT is a four-day group programme, followed by subsequent follow-up days across several months. Approximately 5-7 families are enrolled in each group. Each day includes discussions and activities facilitated for different combinations of individuals (e.g., carer only groups, young people only groups, all attendees together).

MFT, similarly to SFT, is a systemic intervention which focuses on the relational system that a young person with ED is situated within. The theory underlying both SFT and MFT is broadly similar (Eisler, 2005). The broad framework for both of these family-based

treatments is detailed in our complementary paper; *Implementing Multi-Family Therapy within a community eating disorder service for children and young people (**Reference needed, in press**)*. In summary, both SFT and MFT are guided by an underlying understanding that families become organised around a young persons' ED, and patterns and interactions develop which maintain their difficulties. These include: family relationships and interactions becoming defined by the ED; a narrowed time-frame of the here-and-now; a lack of flexibility in family patterns; the amplification of certain aspects of family functioning (e.g. two family members becoming increasingly enmeshed); disruptions to family life-cycle needs; and a sense of helplessness.

There is a general consensus that family-based treatment models should aim to identify and change problematic patterns of beliefs and behaviours by facilitating change in: perceptions or feelings of an individual member of a system; relationships within a system; and shared meanings (Eisler, Simic, Blessitt, & Dodge, 2016). In practice, MFT and SFT aim to achieve this by using systemic techniques such as sculpt techniques (Heinl, 1987), role-play, and narrative techniques (White & Epston, 1990). These techniques help families: develop a shared understanding of the AN; increase their insight into the role the AN plays within their family system; externalise the AN; and empower them to draw on their shared strengths to overcome the difficulties they are facing.

The theory underlying both SFT and MFT is well-defined, and there is a clear idea of the systemic principles which inform the techniques used within these interventions. However, within the MFT setting, there is limited empirical evidence of how these systemic mechanisms are experienced in practice. For example, although there is a clear idea that families become stuck in detrimental, inflexible patterns which may perpetuate the AN, there is little understanding of how, or even if, MFT creates a shift or a change in these patterns. It is theorised that MFT allows families to: broaden their time-frames by seeing other families at

different phases of recovery; try out new things by understanding how others overcame problems; and gain a sense of agency over the illness by problem-solving with other families rather than relying on experts for solutions (Eisler, 2005). However, the empirical evidence to support these ideas is lacking.

Aims of the study

This study took place in a community-based ED service for young people which, until November 2015, routinely offered SFT but had never previously offered MFT. From November 2015 until June 2016 this service implemented the first pilot MFT group in the region. This study recruited carers of young people with AN who attended the MFT group, and clinicians who facilitated the group. This study aimed to explore the perspectives of carers and clinicians about how MFT contributed to changes in how families emotionally and behaviourally responded to the difficulties within their systems. The overall aim of this study was to improve general understanding of the specific mechanisms of MFT that can create change within family systems.

Method

The group

The pilot MFT group included four intensive days and six follow-up days. Each day ran from 9am – 5pm and included two ‘snack times’ and one ‘lunch time’ in which individual families sat on individual tables and facilitators supported carers to support the young person to eat. The MFT group was facilitated by two clinical psychologists and two family therapists. Five families enrolled in the group. Three individuals were recruited from inpatient services, and two from outpatient services. Three individuals attended MFT with their mother and father, one with her grandmother, and one with her mother, stepfather, and father alternately. As recommended by NICE guidelines, all families received SFT alongside MFT.

All young people were females who met the diagnostic criteria for AN (World Health Organisation 2018): they presented with eating disordered psychopathology (e.g., weight and shape concerns, fear of 'fatness'); they attempted to restrict their daily energy intake; they intended to induce and sustain weight loss; and their mean weight-for height was 85% (range 82% to 89%) which is outside the range for a healthy weight and is lower than the expected weight for their age. The young people who attended the MFT group had a mean age of 14.6 (range 14-16 years) and all identified as white British. This is representative of the region in the South-West of the United Kingdom in which this study was conducted. The sample had diverse socio-economic backgrounds. Some families reported social stressors including mental health difficulties within the wider family, financial stressors, and involvement from social care services. This study did not gather participant information about the young peoples' comorbid difficulties. Comorbid mental health difficulties and historical trauma or abuse did not preclude young people from attending the MFT group but these issues were typically addressed in ongoing SFT sessions.

Procedure

Carers focus group. Following the MFT intervention, all attendees were approached by group facilitators and provided with written information about this study. The young people all declined from participating in a focus group. Four carers, from five of the families enrolled in the MFT group, consented to take part in a focus group. This included two fathers, one mother, and one grandmother. All participants were white British. The focus group followed a semi-structured interview schedule and questions related to the carer's experiences of MFT and how it compared to other interventions received.

Therapist interviews. Three semi-structured interviews were conducted with clinicians involved in facilitating MFT. The first interview was with clinicians who facilitated the pilot MFT group that is the focus of this study (site 1). Two other interviews were held with clinicians from other community-based ED services in neighbouring regions (sites 2 and 3)

which routinely offer MFT. These clinicians are increasingly familiar with facilitating this intervention. They were interviewed with the aim of gathering richer information about MFT processes and the mechanisms that they observe within this intervention. Each interview consisted of one interviewer (the main researcher) and two interviewees (clinicians). All clinicians were female and identified as white British. Clinicians were either clinical psychologists or family therapists who were identified through the regional training network.

The carers focus group and the therapist interviews were both conducted by the main researcher, who was not involved in facilitating the MFT group. The researcher was also female and identified as white British. The main researcher did not have any prior knowledge of the participants and it was hoped that this would allow for open and honest discussion of carers and therapists experiences. The focus group and the interviews were all audio-recorded and transcribed by the main researcher.

This study received ethical approval from the University of Bath. It also received site-specific approval from the research and development teams at each participating service. All participants provided written consent to take part.

Results

This study used thematic analysis to identify, understand and report patterns in the data (Braun and Clarke, 2006). Thematic analysis identifies both inductive codes, which are grounded within the content of the data and also more theoretically driven codes, which are informed by the researcher's knowledge of relevant research and theory (Joffe & Elsey, 2014). The researcher immersed themselves in the data and moved between analytical phases of familiarising themselves with the data, searching for codes and describing themes, before deciding on final themes (Nowell, Norris, White, & Moules, 2017). A second researcher reviewed the raw data and the initial codes and themes described by the first researcher and agreed with identified themes. The first researcher was aware that they approached data

analysis with pre-existing ideas about change processes and systemic factors relevant to AN, but also tried to be aware of inductive codes that were grounded within the data.

Theme 1: Mechanisms of MFT for creating change

Therapists and carers identified key mechanisms within MFT that they believed were important for promoting change. These were: the experience of being with other families; family bonding; shifting guilt and shame; the intensity of MFT; acknowledgement of AN; improved therapeutic relationship; thinking about AN differently; and parental confidence (see figure 1).

Figure 1. Mechanisms of MFT for creating change

a) The experience of being with other families

Sharing experiences: Families emphasised one of the most important aspects of MFT was the opportunity to learn from one another, challenge each other, problem-solve together, and share experiences. Carers and therapists recognised how unique this was in comparison to other interventions and spoke about how helpful it was to share experiences.

Carer: "I'm sure people will realise 'Oh okay we are not alone, there are lots of people, all sorts of different families going through this stuff' and it really does help to share it, well it certainly did for us. And that was really the benefit of the experience."

Carer: "It was really helpful and different from anything else that we had…mainly because it was the only time we were in a position to discuss our experiences with other families."

Therapists Site 3: "I think just being in a group with other families going through the same stuff has a really powerful kind of message to them of 'they are not on their own', and also that they can do it, almost because everyone else is doing it."

There was less understanding of whether young people valued sharing experiences with others. Their perspectives are noticeably missing, which significantly impedes our insight into their experiences. However, some therapists believed that despite reluctance to engage, young people do appreciate the opportunity to meet others who share their difficulties.

Therapists Site 2: I think consistently they [the young people] all wrote down how helpful - even if they hadn't talked much - the time together had been."

Therapists Site 2: "I think one [benefit] is about being around other young people and just having that sense of 'I'm not the only that can't eat a sandwich today'…that kind of thing is helpful."

Learning from each other: Being in the MFT group also allowed families to learn from each other. Therapists believed that the messages and ideas shared amongst group attendees were experienced differently, and possibly more powerfully, than ideas and knowledge provided by facilitators. This idea is in line with learning theories, which highlight that the process of learning to problem solve and to generate knowledge within communities is different to the process of accessing formal learning via 'experts, and can enhance problem solving capabilities (Glaser, 2013). Additionally, by problem-solving together and learning from one another, carers expressed a reduced feeling of being "stuck" and a desire to "try something different." This is an important catalyst for change as systemic theory proposes that families can develop fixed, inflexible patterns of behaviours or beliefs which can perpetuate their difficulties.

Therapists Site 2: "I think that was the other strength of using parents to discuss… challenging each other about some stuff was incredibly powerful. I think because it comes from such a different place."

Carers: "In the single family situation you are all sort of set in an existing pattern of sort of ways of thinking and behaviour and if you are put in this multi-family situation you get exposed to other ideas and through talking you might come up with things that are outside the pattern that you are used so you…get some impetus to do something different or try something out."

b) Family bonding. As well as bonding with other families, one carer suggested that MFT allowed a space for group attendees to bond within their individual families, which they felt was important. Therapists acknowledged that they saw a shift in the way family members interacted with each other during the course of MFT, and in how they managed the eating

disorder. Systemic approaches acknowledge that changes in relationships and interactions within a family are central to change.

Carers: "*And there was time to do things as a family…so that develops a sort of sense of camaraderie perhaps".*

Therapists site 3: "Even if [MFT] doesn't have huge behavioural differences at that point, so it might not change the eating, the whole sort of warmth between people can change and the way that people are managing [the AN], definitely."

c) Shifting guilt and shame. Parents of a child with an ED often feel a sense of guilt about their child's difficulties. Research suggests this sense of guilt can be perpetuated in interactions with health care professionals, especially when young people are hospitalised and the responsibility of their care is temporarily transferred to hospital staff (McMaster, Beale, Hillege, & Nagy, 2004). One carer explained how MFT helped to reduce this sense of guilt, as it allowed them to recognise other carers in the same situation as themselves. Similarly, one therapist thought MFT reduced young peoples' feelings of shame as they encountered others with similar difficulties. SFT also aims to shift feelings of guilt and shame, and primarily does this by exploring alternative discourses. However, it is possible that this shift happens more quickly or more powerfully in MFT, as families spoke about being able to see how other "good parents" were also in this situation.

Carers: "I had been feeling quite guilty that… I had let X get into that situation…and so it was actually really comforting to...you sort of think 'well what's wrong with me? I am not normal I am not a good mother' and you really need to meet other people who are good parents and you can see they're good parents and the same things happened to them."

Therapist Site 2: "*We asked them to prepare something to show to the group around their journey through the illness…and by presenting that, other young people can see 'actually that bit's similar to me'…'other people have these troubles, I'm not alone'…So I think that tackles some sense of shame and blame."*

d) Intensity of MFT. The intensive nature of the MFT programme was highlighted as being an important aspect of this intervention. Therapists thought that the intensity allowed

them to gain a greater understanding of each family's individual situation, encouraged families to accept and acknowledge ED as an illness, and enhanced the therapeutic relationship between families and professionals. Furthermore, families are supported during meal times over the course of several days. This intense focus may also allow the ED treatment to become the families' highest priority for a period of time.

Therapist site 2: "I think in terms of what was really useful it is that intensity…that whole day for four days and those micro interactions around meals...being able to really see that in action was really powerful."

Carers: "There isn't really time to explore things in much depth in a short session of single family. So it was really helpful and different from anything else that we had"

Acceptance of AN: One aim of most ED interventions is for families to acknowledge the ED and accept that it is a problem for which they need to access help. Therapists felt that the intensity of MFT enabled this acceptance to happen quickly and effectively. By acknowledging that the ED is a problem, families may experience both cognitive change in how they understand the illness, as well as behavioural change in how they manage it. It is important to note that "accepting the AN" was discussed as a potential change mechanism by the therapists, but carers did not speak about this. It is possible that they did not experience a shift in their acceptance of the young person's illness.

Therapist site 1: "That was the whole fundamental premise of what we were there to talk about in an intensive way with their families -- they couldn't really hide again, they couldn't hide behind saying it wasn't an issue because that's why they were there."

Therapeutic relationship: Families with a young person with ED are typically involved with a range of professionals and services. Therapists believed that the intensity of MFT may improve the therapeutic relationships within this wider system. By spending extended time together, family members have many more opportunities to build trust in the therapeutic team, particularly because the therapy team support them during very difficult times such as meals. Carers did not speak specifically about their relationships with professionals, but generally

spoke positively of the MFT facilitators. One carer felt that her daughter "*engaged more with the team than she did during SFT."*

Therapists site 3: "I do think it helps build that therapeutic relationship with the families...I think it really boosts it because you've been on that journey with them… I think it just intensifies it and you know, okay this team is here to support us through thick and thin."

e) Thinking about the eating disorder differently. MFT employs systemic interventions to encourage family members to think about AN differently. Particular activities are designed to help families separate the AN from the child, identify how AN has affected the family, and recognise how the family structure might have become organised around AN. Therapists facilitate the sharing of each family member's perspective to enhance each individual's understanding of how the AN might be being experienced by other family members. These specific systemic techniques aim to unbalance existing interactions and patterns amongst families, and lead to the development of new ways of thinking about and responding to AN.

Therapists observed that carers began to understand their young person's experiences better and thought that the young people felt better understood by their parents. Developing shared meanings is a central goal of most systemic approaches.

Therapists site 3: "You might not see behavioural shifts but you can see processes starting and people thinking differently or understanding in a different way. You can see people shift before your eyes. You can see pennies drop, and you think woah, they've really got that."

Therapists Site 2: "I think the other impact for young people was that they felt that their parents got it."

Externalising the eating disorder. Families reported that externalising techniques (White & Epston, 1989, 1990), which aimed help them understand that the ED was an illness separate from their child, were helpful. It has previously been recognised that MFT is helpful for shifting an illness away from a person, as families become aware of common behaviours that are characteristic of AN, and are not particular to their individual child (Asen, 2002).

Changing family members' perspectives in this way can reduce blame of and frustration with the young person, allowing them to be more supportive rather than combative, thus improving those relationships and encouraging families and young people to work together against the ED.

Therapists site 3: "I guess one of the things that really happens in there is that real externalisation as well, because you are constantly talking about Anorexia…as something in the room, seven hours a day for four days."

Recognising how the eating disorder organises the family: It has been widely observed that eating disorders can 'organise' the family. A central goal of systemic practice is to recognise patterns that have developed around the ED, particularly any that might contribute to and maintain difficulties. This is thought to be a catalyst for change, as more helpful patterns of interaction can then be considered (Dallos & Draper, 2015). In MFT carers may observe similar patterns of behaviours within other families that they then recognise within their own. One carer reported that seeing another family doing a sculpt activity, in which families illustrate emotional relationships within the family (Heinl, 1987), was *"by far the most powerful bit of all the session."*

Therapists site 3: "someone said that [sculpt] was one of the most powerful things, just seeing how Anorexia had sort of scattered their family really."

Carers: "It's the classic thing of creeping changes in behaviour that you start accommodating…MFT highlighted that, and that these were sort of classic behaviours…and you kind of thought 'okay, right yes we are assisting the illness by doing this'…so that was really useful for us I think."

Sharing perspectives within the family: Both carers and therapists identified that MFT allowed carers to better understand the experience that their child was going through, and again promoted shared meanings within the family. Notably, one specific exercise was identified as being important for creating this shift, which was role-playing the voice of anorexia during a role-reversal (young person and adult) activity (Simic & Eisler, 2015).

Carer: "when I had to play the part of the young person -- and I suppose I hadn't really been forced to actually get into that head space before and to really think 'what exactly is the person going through?' -- and it was very good… I remember that and sometimes I think I can actually picture that and I say to X 'is that voice there again?"

Therapists Site 3: "there was a quote at the end where X said that she had 'finally understood what her daughter was thinking or feeling or experiencing' which I just think is really powerful isn't it."

f) Parental confidence. One of the reasons MFT is suggested to be effective is because it increases parental confidence and in turn reduces their sense of helplessness and helps them feel empowered to make further positive changes. Therapists believed they saw an increase in parental confidence across the course of the intervention, although it is important to note that carers did not reflect on this during this study.

Therapists Site 1: "The parental confidence in managing the young child, I think that was where we saw the biggest change".

Theme 2: Incorporating MFT into the AN treatment pathway

Several mechanisms appear to underpin MFT. However, it is important to understand how these mechanisms complement aspects of SFT, as MFT is always offered in adjunct to this therapy. Two key subthemes were identified in relation to how MFT fits alongside SFT (figure 2).

Figure 2. Incorporating MFT into the AN treatment pathway

Richness of MFT compared to SFT. Therapists identified that some activities used in MFT and SFT might be similar but noted how these activities were experienced differently in these two settings. They commented on how family meals could be observed within SFT but that this was more 'set up' than meal-times that naturally occur within the course of MFT. Therapists also commented on how the information they gathered about families was much richer in MFT than in SFT, again due to the fact that they were seeing families for extended periods of time and in an increasingly natural setting.

Therapists site 1: "We were able to see it in front of our eyes…we were dealing with meal times and then we would be able to deal with the whole thing and support them and actually really see it for what it was. I don't think, if you talked to a family in family therapy once a week for six months, we would ever have got that kind of rich information as what we saw in those first four days."

Therapists site 3: "You've got the power of observing meal times and snack times as well. You can do family meal but it's a little bit more stilted, it's a little less real, whereas in the group I think it is very real…and you can really challenge things which you probably can't do in the room so much at the individual family therapy".

Complementary aspects of MFT and SFT. There was widespread agreement by therapists that MFT should not replace any existing interventions within the existing AN pathway. They noted benefits of both interventions and how these worked most effectively when offered in conjunction. However, they recognised that families attending MFT may need less SFT input. Carers spoke about aspects of MFT that they found more helpful than SFT (e.g., sharing experiences) but did not discuss how MFT complemented SFT.

Therapist site 2: "There were things we picked up in MFT that we then passed back for single family therapy to work on."

Therapist site 2: "There's a danger of thinking MFT fixes everything. I don't think it does. I think it can do an intense piece of work in those first stages."

Therapist site 2: "it did reduce our numbers quantitatively of single family therapy…so single family therapy became less frequent and that's one thing we were looking at is 'will using MFT reduce the frequency of SFT?'…It absolutely did for those families."

Discussion

There is increasingly a focus on providing young people with eating disorders timely and effective intervention, to significantly reduce the long-term impact of this illness. In the UK the recommended treatment for young people with AN is family-based therapy, comprised of SFT or SFT with MFT as an adjunct. Family-based treatments for AN are underpinned by systemic theories of ED's. Systemic theory recognises common ways that family interactions

become defined by EDs and proposes common patterns that can sustain and perpetuate a young persons' difficulties (Eisler et al., 2016). Family-based treatments aim to promote change in these commonly observed patterns (Eisler, 2005). MFT is a newer family-based approach to be included within the treatment pathway for AN. There is limited understanding of how MFT may create systemic change as proposed by theoretical models. This study explored carers and clinician's experiences of MFT. It specifically focused on exploring the mechanisms which carers and clinicians felt contributed to shifts in the way families emotionally or behaviourally responded to the ED.

Therapists and carers identified several mechanisms of MFT that they felt were important for changing behavioural or emotional responses to the AN. In being around other families, carers said that they recognised how other families accommodated the AN and believed this enhanced insight into their own family's responses to the illness. Family reorganisation around an ED is a central maintaining factor of this illness (Eisler 2005), and if MFT promotes this recognition then this is likely to be key to therapeutic change. Carers also identified that seeing families at different 'stages' of recovery was beneficial (discussed in detail in our paper *'Implementing Multi-Family Therapy (MFT) within a community eating disorder service for children and young people'*). ED's can disrupt typical life cycle processes (Carter & McGoldrick, 2005), and seeing other families move through different life stages can foster hope, and broaden the here-and-now focus that often develops when a young person has an ED.

Furthermore, carers spoke about the experience of learning from other families, and therapists felt that this was a powerful way for families to generate ideas and overcome difficulties. Systemic theories of ED's describe how families can feel helpless about how to support their child (Eisler, 2005), and carers described how learning from other families helped them to feel more impetus to 'try other solutions' in the face of difficult situations. In addition,

families spoke about the 'normalising' and 'destigmatising' impact of being around other families and how this helped to shift feelings of guilt. This is in line with findings from a similar study conducted in Sweden (Engman-Bredvik, Carballeira Suarez, Levi, & Nilsson, 2015), suggesting that this is an important factor of MFT.

The intensity of MFT was also identified as being central to change. Inpatient interventions are intensive, but have been criticised for 'sidelining' parents, which not only diminishes their confidence in caring for their child but also potentially damages their relationship with services (Scholz, Rix, Scholz, Gantchev, & Thömke, 2005). Therapists in our study observed that MFT promotes parental self-efficacy and improves the therapeutic relationship with services, although it is important to acknowledge that this was not discussed by carers. Therapists support the family during an intense four-day period, and therapists thought that families increasingly felt the therapists understood their difficulties and were there to support them. Families accessing services for AN become part of a wider system, and systemic theory would suggest that relationship changes in this wider system are likely to effect overall change.

Compared to SFT, therapists commented on the richness of the information they gained from families during MFT. This again could effect change within the wider system, as therapists understood families better and shared meanings were developed. Furthermore, therapists felt the intensity of MFT enforced carers to acknowledge and accept the ED, which could in turn give them impetus to challenge it and reduce their sense of helplessness.

Carers and therapists believed MFT allowed families to view AN differently. In turn, it is theorised that this could lead to changes in how carers respond to the AN and potentially alter unhelpful patterns of beliefs and behaviours within the system. Carers reported that specific activities within the MFT programme (e.g., role-play) enabled them to externalise the AN and to better understand perspectives of other family members. It is theorised that

externalising techniques reinforce the idea that families need to come together to 'resist' the ED, and therefore creates a shift in how they begin to manage the ED (Eisler, 2005). Supporting families to think about the AN differently will be a central component of all family-based therapies, however therapists felt that MFT allowed families to recognise that some behaviours were shared by other young people and characteristic of the illness, which may have enhanced the process of externalisation. This is in line with findings from a similar study, which also noted how helpful it was for carers to identify common behaviours across young people (Voriadaki, Simic, Espie, & Eisler, 2015).

Limitations

The most notable limitation of this study is that there is limited understanding of how young people themselves experienced MFT. This is common to research into MFT and future studies would do well to focus on this area. Moreover, this was a pilot study with a small sample, limiting the conclusions that can be drawn about the specific aspects that carers and clinicians think underpin the effectiveness of MFT. It is possible that other clinicians or carers would have alternative views regarding the aspects of MFT they felt contributed to systemic changes. Future research should aim to include a larger number of families who have attended MFT groups to improve understanding of the aspects of MFT that they find most helpful for shifting their behavioural and emotional responses. Furthermore, this study briefly considered how MFT can complement SFT (as recommended in treatment guidelines) and discussed how it might enhance some of the aspects which both therapies aim to do (e.g., help families to recognise patterns within their system). However, no other therapy modalities were discussed within the scope of this paper. Future research could usefully consider how MFT compares to other 'non-dominant' modes of therapy for this population (e.g., individual interventions). Lastly, it is beyond the scope of this paper to understand how the systemic changes discussed by the participants in this study translate to AN-related outcomes such as weight regain or

reduced ED psychopathology. A recent study demonstrated that significantly more individuals who received SFT with MFT showed clinical improvements in regards to weight, ED psychopathology and mood than those who attended SFT alone (Eisler, Simic, Hodsoll, et al., 2016). This indicates that future research needs to explore and investigate how MFT-driven systemic changes may contribute to AN-related changes.

Conclusion

This project identified specific aspects of MFT that clinicians and carers believe contribute to subtle but important changes in the way individuals respond to and manage AN within a family. Specific activities within MFT, as well as processes within this therapeutic approach, create change in the relationships between family members and between families and services, and develop a shared understanding of AN within these systems. Being amongst families with shared experiences is thought to challenge factors that contribute to AN by: promoting recognition of how family patterns develop around AN; enhancing parental efficacy; reducing feelings of shame and guilt; and reducing a sense of helplessness. Further research is needed to extend this research and understand how these factors relate to AN outcomes in young people.

References

Asen, E. (2002). Multiple family therapy: an overview. *Journal of Family Therapy*, *24*(1), 3–16. https://doi.org/10.1111/1467-6427.00197

Bailey, A. P., Parker, A. G., Colautti, L. A., Hart, L. M., Liu, P., & Hetrick, S. E. (2014). Mapping the evidence for the prevention and treatment of eating disorders in young people. *Journal of Eating Disorders*, *2*(1), 5. https://doi.org/10.1186/2050-2974-2-5

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. Qualitative Research in Psychology, 3(2), 77–101.

Carter, B., & McGoldrick, M. (2005). Overview: The expanded family life cycle. Individual, family and social perspectives. In B. Carter & M. McGoldrick (Eds.), *The expanded family life cycle. Individual, family and social perspectives.* (Third., p. 1–26.). Boston, MA: Allyn and Bacon.

Dallos, R., & Draper, R. (2015). *An introduction to family therapy: Systemic theory and practice. Journal of Family Therapy* (Vol. 22). Open University Press. https://doi.org/doi:10.1036/9780335264551

Eisler, I. (2005). The empirical and theoretical base of family therapy and multiple family day therapy for adolescent anorexia nervosa. *Journal of Family Therapy*, *27*(2), 104–131. https://doi.org/10.1111/j.1467-6427.2005.00303.x

Eisler, I., Simic, M., Blessitt, E., & Dodge, L. (2016). *Maudsley Service Manual for Child and Adolescent Eating Disorders*. Retrieved from https://www.national.slam.nhs.uk/wp-content/uploads/2011/11/Maudsley-Service-Manual-for-Child-and-Adolescent-Eating-Disorders-July-2016.pdf

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*(1), 422.

https://doi.org/10.1186/s12888-016-1129-6

Engman-Bredvik, S., Carballeira Suarez, N., Levi, R., & Nilsson, K. (2015). Multi-family therapy in anorexia nervosa—A qualitative study of parental experiences. Eating Disorders, 24(2), 186–197. doi:10.1080/10640266.2015.1034053

Glaser, R. (2013). Learning theory and instruction. International Perspectives On Psychological Science, II: The State of the Art, 341.

Hay, P. (2015). Course and Outcome of Eating Disorders. In *Encyclopedia of Feeding and Eating Disorders* (pp. 1–4). Singapore: Springer Singapore. https://doi.org/10.1007/978-981-287-087-2_123-1

Heinl, P. (1987). The interactional sculpt: examples from a training seminar. Journal of Family Therapy, 9, 189–198.

Joffe, H., & Elsey, J. W. (2014). Free association in psychology and the grid elaboration method. Review of General Psychology, 18(3), 173.

McMaster, R., Beale, B., Hillege, S., & Nagy, S. (2004). The parent experience of eating disorders: interactions with health professionals. *International Journal of Mental Health Nursing*, *13*(1), 67–73. https://doi.org/10.1111/j.1447-0349.2004.00310.x

National Institute for Health and Care Excellence (NICE). (2017). Eating disorders: recognition and treatment. Retrieved August 17, 2017, from https://www.nice.org.uk/guidance/NG69

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic Analysis: Striving to Meet the Trustworthiness Criteria. International Journal of Qualitative Methods, 16(1).

Scholz, M., Rix, M., Scholz, K., Gantchev, K., & Thömke, V. (2005). Multiple family therapy for anorexia nervosa: Concepts, experiences and results. *Journal of Family Therapy*, *27*(2), 132–141. https://doi.org/10.1111/j.1467-6427.2005.00304.x

Simic, M., & Eisler, I. (2015). Multi-Family Therapy. In K. L. Loeb, D. Le Grange, & J. Lock (Eds.), *Family Therapy for Adolescent Eating and Weight Disorders: New Applications*. New York: Routledge.

Voriadaki, T., Simic, M., Espie, J., & Eisler, I. (2015). Intensive multi-family therapy for adolescent anorexia nervosa: Adolescents' and parents' day-to-day experiences. *Journal of Family Therapy*, *37*(1), 5–23. https://doi.org/10.1111/1467-6427.12067

White, M., & Epston, D. (1989). *Literate Means to Therapeutic Ends.* Adelaide: Dulwich Centre Publications.

White, M., & Epston, D. (1990). *Narrative Means to Therapeutic Ends*. New York: W.W. Norton.

World Health Organization. (2018). International statistical classification of diseases and related health problems (11th Revision). Retrieved from https://icd.who.int/browse11/l-m/en

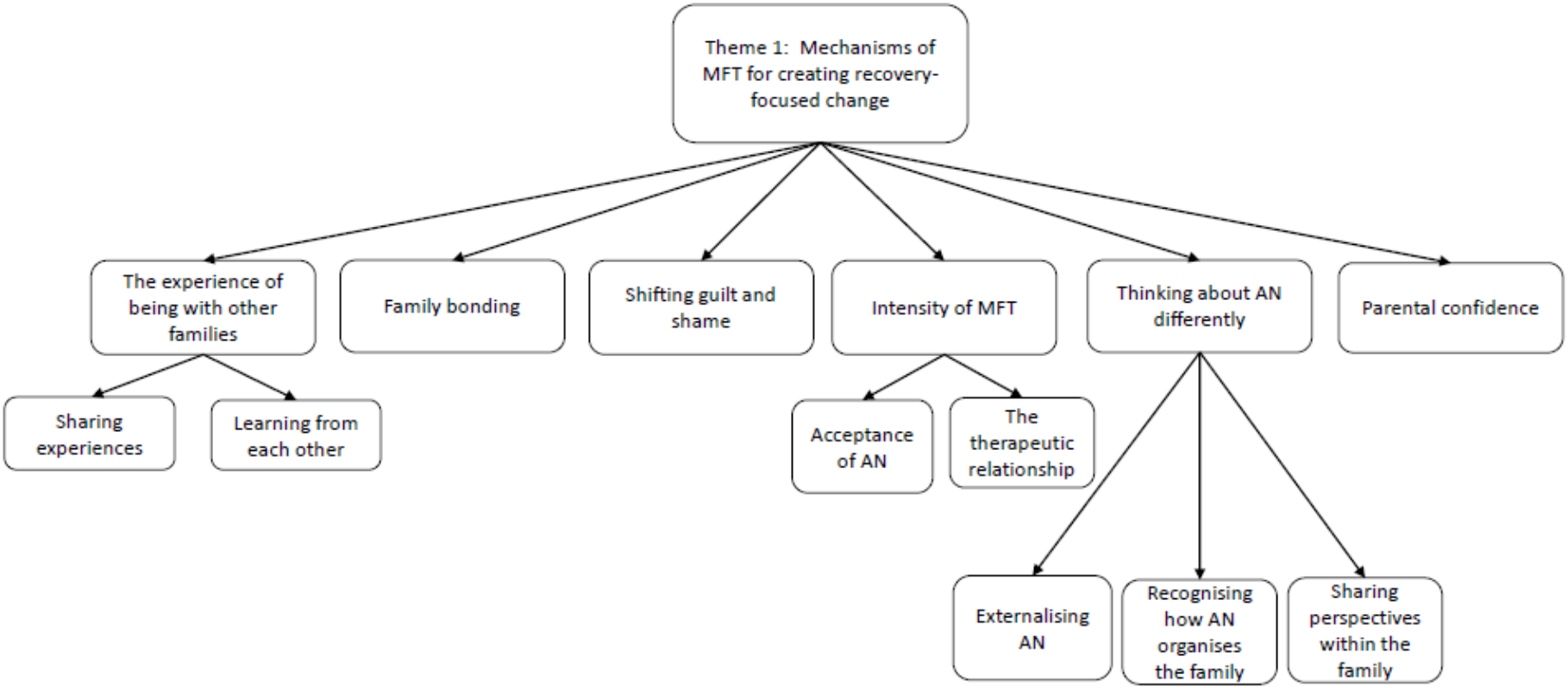

Figure 1. Mechanisms of MFT for creating recovery-focused change

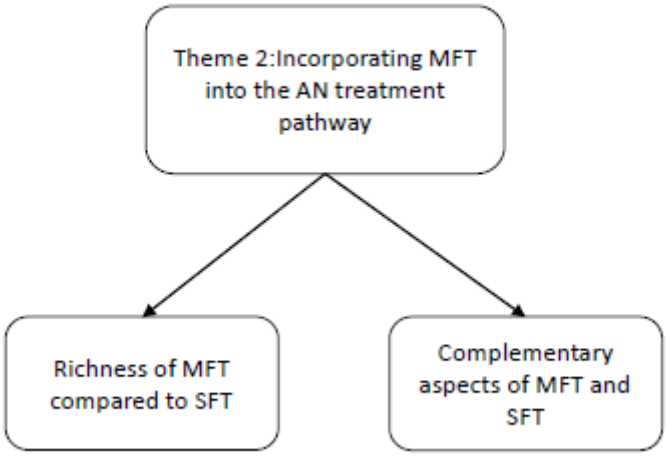

Figure 2. Incorporating MFT into the AN treatment pathway