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Family Based Treatment for Adolescents with Eating Disorders: A Clinician's Perspective

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Abstract

The purpose of this study was to explore the nuances of Family-Based Treatment (FBT) in a clinical setting, as well as the areas of growth and development within the use and implementation of this treatment modality as it relates to adolescents with eating disorders. Qualitative interviews were conducted with four mental health clinicians who primarily use FBT in their work with adolescents with eating disorders. Through the use of grounded theory methodology, each interview was audio-recorded, transcribed, and coded over the course of a month to produce four main themes. The most common themes within the interview transcripts included: 1) FBT process, 2) FBT supports the family system, 3) FBT commitment, and 4) FBT development. Through the use of these four themes, the current research study further highlighted the importance of incorporating the family system into the recovery process of their adolescent with an eating disorder and revealed the important distinctions that are contained within this treatment modality.

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Introduction

Anorexia nervosa is a common psychological disorder with an estimated prevalence rate of 48% among girls ages 15-19, and it is 9 to 10 times more common in girls than boys (Lock & Le Grange, 2013). While eating disorders can occur across the lifespan of development, 10,000 teenagers between the ages of 13 to 18 will show signs of eating disorder patterns that will often go undetected or misdiagnosed (Fursland, Bryne, Watson, La Puma, & Byrne, 2012). Research on eating disorders is often focused on women and girls, yet, it is important to note that males also struggle with eating disorder tendencies with a prevalence rate ranging from 5% to 15% (Curry & Ray, 2010).

Eating disorders are defined as a psychological illness that have a variety of serious medical consequences that can often contribute to a variety of short- and long-term consequences (Lock & Le Grange, 2015). Anorexia nervosa, bulimia nervosa, binge-eating disorder, and avoidant/ restrictive food intake disorder are four types of eating disorders that can create harm to the body (Lock & Le Grange, 2015). Of these many harmful eating disorders that cause psychological distress, anorexia nervosa has the highest mortality rate than any other psychological disorder (Fursland et. al., 2012). Those who are affected by anorexia nervosa often present behaviors of denial and minimize their eating disorder symptoms. These same thoughts and behaviors are often recognized among others suffering from bulimia nervosa, binge eating disorder, and eating disorders not otherwise specified. While eating disorders continue to be a prevalent diagnosis seen amongst individuals, effective forms of treatment remain to be further developed and discovered (Krautter & Lock, 2004).

Developing a successful form of treatment is often challenged by the thoughts and behaviors of those diagnosed with an eating disorder (Forsberg, LoTempio, Bryson, Fitzpatrick,

Le Grange, & Lock, 2014). While having an eating disorder is often classified as an individual's internal conflict, it can often impact the relationships of those around them, including friends, coworkers, and in particular, members of their family (Downs & Blow, 2013). While these relationships are meant to provide a strong support system for those struggling through eating disorder symptoms, their attempts to help can often cause further conflict and stress in a person's life (Downs & Blow, 2013).

One factor that has been attributed to the increase of eating disorders is the growth in technology and the use of online pro-eating disorder support groups. The development of pro-eating disorder (pro-ED) websites provide support to individuals in maintaining their eating disorder patterns. The content of these websites through "text, images, audio, or video" is used to encourage "knowledge, attitudes, and behaviors to achieve terribly low body weights" (Borzekowski, Schenk, Wilson, & Peebles, 2010, p. 1). The continual growth of these websites creates problems within the eating disorder community. Rather than searching for a treatment, young individuals are exposed to a culture that values the "thin ideal" as opposed to a healthy eating lifestyle. According to Gailey (2009), the internet is a place that "offers anonymity for those who face severe isolation and stigma from society, their families, and friends" (p. 2). The use of these online support groups continues to support an individual in the maintenance of their disorder and reveals the prevalence and persistency of this disorder. The enduring nature of eating disorder behaviors is cause for concern among practitioners as effective forms of treatment are yet to be discovered.

Family-based treatment (FBT) is an emerging form of treatment that incorporates the family system into the healing process of those with an eating disorder. This family-based approach was created to place treatment responsibility not only on the individual but also on the

family (Bean, Louks, Kay, Cornella-Carlson, & Weltzin, 2010). FBT consists of three phases: 1) parents re-feed their adolescent and prevent unhealthy eating disorder behaviors, 2) control of eating is slowly given back to the adolescent and recognized improvements are being made, and 3) the family works towards the restoration of healthy relationships and "autonomy for the adolescent" (Girz, Robinson, Foroughe, Jasper, & Boachie, 2013, p. 2).

Studies have revealed that incorporating the family into eating disorder treatment significantly improves severe eating disorder symptoms (Bean et. al., 2010). Because eating disorders are so prevalent amongst adolescents, it is important that proper forms of treatment are being utilized and implemented among clinicians. While there are four main types of eating disorders (anorexia nervosa, bulimia nervosa, binge-eating disorder, and avoidant/ restrictive food intake disorder), this present study will focus largely on the implications of Anorexia Nervosa. Though eating disorders are also prevalent in males, this current study will also focus on the eating disorder patterns within adolescent women. In this present study, the use of FBT in a clinical setting is examined in order to better understand the process of treatment through the perspective of the clinician. To better understand the nuances of FBT in a clinical setting and explore the areas of growth and development with the FBT modality, this study seeks to answer the following research questions: From an FBT clinician's perspective, what is the process of implementing FBT with adolescent clients living with anorexia nervosa? What components of FBT have clinicians found to be both effective and challenging in their work with adolescents experiencing anorexia nervosa? What new areas of growth and development are occurring within the practice of using FBT?

Literature Review

Impact of Anorexia Nervosa

Anorexia nervosa greatly impacts the physical and mental functioning of individuals struggling with this disorder (Lock & Le Grange, 2015). Due to the physical challenges of anorexia nervosa, it is believed to be one of the most serious health problems influencing adolescent girls today with a prevalence of anorexia as high as 2-5% with 90% of these cases being girls or women (Griffin & Berry, 2003). Anorexia nervosa is defined as "an eating disorder characterized by impaired visual body perception, fear of adiposity, and therefore chronically decreased caloric intake, resulting in self-induced starvation" (Vignini, D'Angelo, Nanetti, Camilloni, Cester, Faloia, Salvolini, & Mazzanti, 2010, p. 1). The mental and physical damages caused by anorexic symptomology creates severe and damaging implication to the health and wellness of each adolescent diagnosed with this disorder. Lock and Le Grange (2015) state that "no other psychological illness affecting children and adolescents involve pathological thoughts, behaviors, and emotions that lead to such serious short- and long-term medical complications" (p. 80).

Of these medical complications, the starvation tendencies of anorexia alter the body's natural mental and physical capacities within the developing body of an adolescent. According to the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association [APA], 2013) diagnostic criteria for anorexia nervosa states that those with this disorder display low body weight in the context of age, sex, developmental trajectory, and physical health. In addition to this requirement, those with anorexia often have an intense fear of gaining weight, which may result in a lack of recognition of the seriousness of their current low body weight (APA, 2013).

Physical implications: Cardiovascular damages. The life threatening conditions caused by anorexia nervosa greatly increases the likelihood of developing complication in every organ system in the growing, developing body of an adolescent (Katzman, 2005). Of these organ systems, the cardiovascular system is one that endures many medical difficulties as a result of the progressive nature of anorexia nervosa. Of these difficulties, anorexia nervosa is characterized "by a high degree of undernutrition and chronic energy deficiency. The prolonged starvation, the low energy intake, and the pathological weight loss in patients cause profound modifications in body composition" (Vignini et al., 2010, pp. 5- 6). Research has shown that those suffering with anorexia nervous display significantly lower heart rates and lower left ventricular forces. (Katzman, 2005). The lower left ventricle of the heart is the main pumping chamber that sends oxygen and other nutrients out to the other organ systems within the body (The Mayo Clinic, 2015). Starvation, low energy, and significant weight loss that occur as a result of anorexia limits the hearts ability to effectively care for the other systems within the body of an adolescent (Mitchell & Crow, 2006).

While anorexia is recognized as a psychological disorder within the DSM, the physical implications that occur as a result of this disorder increase the severity of this diagnosis and increase the need for effective treatment interventions. Sinus bradycardia is another one of these physical implications that may result from excessive anorexic tendencies and characteristic. Sinus bradycardia is defined as "a heart rate <50 beats per minute during the day or <45 beats per minute at night" (Katzman, 2005, p. 2). In this case, an adolescent facing these cardiac conditions would require hospitalization in order to monitor the heart and gradually bring the adolescent back to a weight that will stabilize the heart. An increase of syncope also presents dangers to adolescents with persistent anorexic characteristics as their blood pressure and heart

rates continue to change. Syncope is defined as a loss of consciousness that is a result from these changes in heart rate and blood pressure (Katzman, 2005).

Adolescents facing anorexia nervosa often do not recognizing the damaging effects that are taking place within their body. Within the cardiovascular system, adolescents with anorexia will often experience low energy as a result of lower heart rates, changes in blood pressure, and risks of syncope. These changes in the cardiovascular system can drastically damage the body of an adolescent as it effects various other systems within the body.

Psychological implications: Brain changes. The malnutrition that is experienced as a result of anorexia nervosa creates significant complications to the structure of function of brain activity within an adolescent. One study revealed that there is a relationship between prolonged starvation habits in those with anorexia nervosa and global brain volume deductions (Titova, Hijorth, Schioth, & Brooks, 2013). This research suggests that while malnutrition occurs in the body of those with anorexia nervosa, malnutrition also takes place in the brain's ability to process and make sense of information. Those with anorexia have shown deficiencies "in cognitive domains such as attention, memory, visuospatial abilities, and executive function" (Andres-Perpina, Lozano-Serra, Piug, Miguel, Lazaro, & Castro-Froniels, 2011, p. 1). The deficiencies that take place within these functions of the brain can often make it difficult for adolescents to seek help and intervention.

A study designed to understand the cognitive impairment of adolescents with anorexia found that those with this diagnosis had increased levels of obsessiveness and anxiety (Andres-Perpina et. al., 2011). The change in these levels contributed to slower cognitive processing as certain detail tasks were unachievable by those who had anorexia nervosa (Andres-Perpina et. al., 2011). While the structure and function of the brain may perform differently in different

adolescents with anorexia, it is important to note that changes do in fact take place that can impair a child's ability to function in a healthy and successful way. Slow processing speed is one such impairment that is often recognized in adolescents who are diagnosed with anorexia nervosa (Andres-Perpina et. al., 2011). Another research study produced results that states "females with adolescent-onset anorexia nervosa revealed significant abnormalities in brain structure and function compared to health female controls" (Chui, 2007, p. 77).

Research has discovered the drastic impacts that anorexia nervosa can have on the developing brain. Connan, Campbell, Katzman, Lightman, and Treasure (2003) explain that a major phase of brain development involves the development of the frontal and limbic areas in the brain that takes place during puberty. Their research revealed that a disruption to this process of brain development "could contribute to the impairment of emotional recognition and cognitive set shifting reported in those vulnerable to anorexia nervosa (Connan et. al., 2003, p. 4).

Social implications: Social comparison. According to the social comparison theory, "people compare themselves with other people in order to evaluate themselves on a given dimension, and/or to enhance their self-image, and/or to inspire themselves toward self-improvement" (Trottier, Polivy, & Herman, 2007, p. 2). Adolescents currently are at a pivotal stage in their development and are often at a higher risk of comparing their body image with those around them (Trottier et. al., 2002). Eating problems within adolescents are more likely to develop disordered eating problems as a result of pubertal change and fat development (Lock & Le Grange, 2013). According to Lock and Le Grange (2013), "girls who felt most negatively about their bodies at puberty were at highest risk of developing eating difficulties" (p. 4).

Similarly, social comparison has been used to understand the influence of eating symptoms within an attachment framework (Ty & Francis, 2013). Ty and Francis (2013)

conducted a study that linked insecure attachment to eating disorder symptoms through a social comparison model. Their study revealed that "social comparison, based upon both physical and personality features, can increase the likelihood of body dissatisfaction and disordered eating behaviors" (Ty & Francis, 2013, p. 15). Comparing thoughts based upon what is seen or what is heard can negatively influence an adolescent's view of self.

When comparisons are made, adolescents are more likely to withdraw and internalize the thoughts and feelings of worthlessness that may contribute to the eating disorder itself (Treasure, Corfield, & Cardi, 2012). According to Treasure, Corfield, and Cardi (2012) as anorexic tendencies increase, so too do characteristics such as shyness and isolation. They write that social difficulties such as "loneliness, shyness, feelings of inferiority, and a tendency to engage in solitary pursuits predict the onset of the illness" (Treasure et. al., 2012, p. 2). Understanding these social implications can greatly impact the treatment process as positive social supports begin to be developed and created.

Treatment Options

Eating disorder treatment continues to be a widely discussed topic amongst clinicians working with adolescents with anorexic behaviors and habits. With many various treatment modalities and components available to clinicians, finding the best approach to working with adolescents with eating disorders can often be a challenge. Cognitive Behavior Therapy (CBT), Dialectical Behavior Therapy (DBT), and Eye Movement Desensitization and Reprocessing (EMDR) are a few approaches that are commonly used in the treatment of eating disorder symptoms. Exploring a few of these treatment approaches will help this present study make sense of the current forms of treatment that are used when working with adolescents with eating disorders.

CBT. Cognitive Behavior Therapy (CBT) continues to be a growing form of treatment for adolescents diagnosed with Anorexia Nervosa. CBT is commonly recognized as being an effective form of treatment that is highly suitable for a broad range of adults and adolescents struggling with an eating disorder (Fursland et. al., 2012). Developed my Aaron Beck in the 1960, CBT has developed into an evidence-based treatment modality that "is based on a conceptualization, or understanding of individual patients (their specific beliefs and patterns of behavior)" (Beck, 2011, p. 2).

The foundation of CBT functions out of the understanding that dysfunctional thinking is an outcome of the disorder itself. This dysfunctional thinking often influences the way in which a person feels, behaves, and understands the world around them (Beck, 2011). Beck (2011) writes that "when people learn to evaluate their thinking in a more realistic and adaptive way, they experience improvement in their emotional state and in their behavior" (p. 3). The goal of therapy under CBT principles is to help a client understand the complex interactions that take place between the biological, environmental, and cognitive-behavioral elements that contribute to the disorder itself (Wright, Basco, & Thase, 2006). Understanding this relationship will help an individual make better sense of their behavior and become more aware of the errors they may be making in their thinking.

Through the cognitive-behavior model, anorexia is often understood to be an emotional distress in an individual's life that results in abnormal behavior (Bowers & Ansher, 2000). Using a CBT lens, errors in cognition are recognized in the thought process of individuals suffering from anorexic beliefs and characteristics. These vulnerable individuals "develop the idea that weight loss will somehow alleviate psychological distress and dysphoria" (Bowers & Ansher,

2000, p. 2). Treatment is often centered on individually working through these irrational thoughts in order to improve anorexic thoughts and behaviors.

When working with adolescents, studies have revealed that incorporating CBT can greatly improve the eating disorder symptomology of an individual. One study examined the effectiveness of CBT on forty-nine adolescent patients with anorexia nervosa. Forty sessions of CBT were implemented over 40 weeks and revealed significant improvements in an individual's weight and eating disorder psychopathology (Grave, Calugi, Doll, & Fairbur, 2012). CBT is designed to be a treatment approach that is structured and time-limited as well as flexible and individualized to each client (Fursland et. al., 2012). Another study revealed that through the implementation of CBT showed that patients were less concerned about approval from others to evaluate their own self- worth (Bowers & Ansher, 2000). Thus, improvements in weight, appearance, and approval were made.

DBT. Dialectical Behavior Therapy (DBT) is another form of treatment of eating disorders that emphasizes the teaching and implementations of learned skills to replace behaviors that are creating difficulty in everyday life functioning (Pederson, 2012). Though similar to CBT, DBT incorporates dialectical philosophies into the treatment process that investigates the relative truth of opinion, principles, and guidelines that make up a person's life (Pederson, 2015). Modern DBT therapists will often incorporate mindfulness, skills training, and validation in order to seek out behavioral improvements in their client's life.

Pederson (2015) writes that "DBT interventions center on functional analysis. Functional analysis is concerned with understanding the function of clients' behaviors and those behaviors' relationship to others and the environment" (p. 134). Those with an eating disorder can incorporate the skills that they gain in DBT to process their thoughts and feelings regarding their

eating disorder symptomology in relation to the environments in which they continually interact with. In addition to skills learning, DBT therapists emphasize acceptance, being non-judgmental, and validating the feelings of those with an eating disorder (Pederson, 2012).

A quantitative study was designed to evaluate the effectiveness of DBT for treating eating disorders episodes as well as co-occurring depression symptoms in those with an eating disorder (Lenz, Taylor, Fleming, & Serman, 2014). This study revealed that there may be evidence suggesting that DBT could be successful in decreasing eating disorder episodes among women with an eating disorder diagnosis (Lenz et. al., 2014). In addition to this understanding, Lenz, Taylor, Fleming, and Serman (2014) believe that "it may be possible that decreases in comorbid depression symptoms through the implementation of DBT may prevent self-injurious behaviors and lethality among individuals with an eating disorder" (p. 7). DBT therefore could be implemented as an appropriate intervention for adolescents who are not only struggling with eating disorder behaviors but also those struggling with feeling of worthlessness and depression. Similarly, a description study revealed that DBT can be a helpful approach to treating multidiagnostic clients who also have been diagnosed with an eating disorder (Federici, Wisniewski, & Ben-Porath, 2012). Federici, Wisniewski, and Ben-Porath (2012) believe that incorporating the full DBT model has significant potential to produce promising results in those who struggle with eating disorder symptoms.

EMDR. Eye movement desensitization and reprocessing (EMDR) is a developing form of treatment that is typically implemented on clients who have experienced some form of trauma. Through the implementation of EMDR, "the clients focus on emotionally disturbing material in sequential doses while simultaneously focusing on an external stimulus" (Field & Cottrell, 2011, p. 2). The aim of EMDR is to allow an individual to replace negative cognitions, such as 'I am

useless,' with more positive thoughts, such as 'I am in control' (Field & Cottrell, 2011). Using this type of approach with individuals diagnosed with eating disorders can help replace irrational thinking regarding their self with more rational thoughts and ideas.

Through a neurological perspective, EMDR operates through the understanding that "emotions are stored in the right hemisphere" of the brain and eye movements "simulate the movement of information through the corpus callosum from the right hemisphere of the brain to the left hemisphere" (Protinsky, Sparks, & Flemke, 2001). Through this process, disturbing thoughts, feelings, and images can begin to be processed using both hemispheres. Protinsky, Spark, and Flemke (2001) shared an example of how EMDR was successfully implemented on a client with poor eating disturbances. Through the techniques of eye movements, this single case example showed significant results in reducing intensity of emotion and inhibiting the poor eating behaviors (Protinsky, Sparks, & Flemke, 2001).

A similar study used the EMDR treatment modality to support their hypothesis that EMDR is successful in improving eating disorder characteristics and symptoms. A single subject case study used EMDR and a variety of pre- and post-tests in order to measure the changes in body image disturbance and low self-esteem (Dziegielewski & Wolfe, 2000). After 43 days of observations, researchers found that incorporating EMDR into treatment proved to be a successful tool in improving body-image disturbance and increasing self-esteem within this client (Dziegielewski & Wolfe, 2000).

The implementation of CBT, DBT, and EMDR have been shown to be positive forms of treatment when working with clients with various eating disorders. Each of these approaches to treatment are shown to have significant results in decreasing eating disorder characteristics and symptomology. While each of these forms of treatment can have lasting impacts on the clients

they serve, these three approaches fail to recognize the importance of incorporating the family system into the treatment process. CBT, DBT, and EMDR are three approaches to treatment in which their main focus is on the individual struggling with the eating disorder diagnosis; they pay little attention to the surrounding systems that can be used to aid in the healing process of an eating disorder. For this reason, this present study will focus on the implementation of the family system into the treatment process of adolescents with Anorexia Nervosa.

Incorporating the Family System

When working with adolescents struggling with an eating disorder diagnosis, understanding the family system can be an important piece in the treatment of eating disorder characteristics. Low self-esteem, low body satisfaction, and low self-confidence are typically internal struggles that externally affect those around them, in particular family members (Downs & Blow, 2013). According to Le Grange and Eisler (2008), the first half of the twentieth century believed that the family system was a primary hindrance in the treatment and healing of an eating disorder. In working with therapists, parents would often report feeling blamed and defensive in regards to their child's health and well-being (Downs & Blow, 2013). Lock and Le Grange (2015, p. 42) captured the severity of disengaging parents and other family members from treatment in the following quote:

> Many current approaches either exclude or blame parents, explicitly or implicitly, causing parent to be confused about whether and how they can help their child with an eating disorder. In addition, because of the severity of both the psychiatric and medical problems of anorexia nervosa, hospitalization or residential care is often recommended. This requires separating the child with anorexia nervosa from the parent and other family members.

When a family member suffers individually though their eating disorder, parents and other family members may also be negatively impacted by the severity of their disorder—feeling confused and helpless to know how to best support their loved one.

In a separate study, Eilser (2005) revealed that this theoretical understanding was largely focused around the causation of eating disorders. In order to recognize improvements in eating disorder symptomology, Eilser (2005) suggests that the focus of treatment should seek to understand "how families become organized around a potentially life-threatening problem" (p. 1). Families taking on an active and engaged role in the treatment process of their adolescent is believed by researchers to contribute largely to the solution rather than the problem (Downs & Blow, 2013).

A research study conducted by Sim and Matthews (2012) examined parents' and caregivers' perceptions of the anorexia nervosa disorder of their child. This study revealed that "parents who reported more understanding of their child's illness endorsed increased feelings of efficacy in parenting and an improved alliance with their child's other parent" (Sim & Matthews, 2012, p. 8). The significant outcomes of this study help support that importance of incorporating the family system into the treatment process. Developing parent awareness can significantly improve family dynamics by decreasing family conflict, worry, and symptoms of depression that could develop if parents' perceptions of the mental illness were misguided (Sim & Matthews, 2012).

Maudsley Family-Based Treatment. Incorporating the family system into the treatment process is the foundation of the Family-Based-Treatment (FBT) modality when working with adolescents with anorexia nervosa. Under the beliefs of behavioral, family systems, and structural family therapy theories, FBT derives from the idea that the family can serve as a

resource in discovering effective solutions to the problem of anorexia nervosa (Loeb, Lock, Greif, & Le Grange, 2012). Beginning at the Maudsley Hospital in London, England in the 1980s, FBT developed by incorporating the family system into the process of re-nourishing their child (Couturier, Isserlin, & Lock, 2010). FBT was first utilized as an intensive, outpatient treatment option in which "patients with an onset of illness before age 18, and duration of illness less than three years" began to see more improvements through family intervention than individual treatment (Couturier, et. al., 2010, p. 2).

The Maudsley method of FBT is a developing method in the treatment of anorexia nervosa in which the family begins to be viewed more positively and can contribute significantly to their adolescent's weight restoration and normalize eating patterns (Le Grange & Eisler, 2008). Through this approach, parents take on a unified stance with their child to encourage adolescent cooperation while eliminating the anorexic symptomology (Le Grange & Eisler, 2008). While involvement from the family system is a key component in the FBT modality, research suggests that early intervention can predict better outcomes in adolescents with anorexia nervosa (Lock, Le Grange, & Crosby, 2008).

Elements of Maudsley's Family-Based Treatment. *Phase 1.* In the case of anorexia nervosa, the first phase focuses on the unification of parent relationships in order to empower them to take control and restore their child back to an appropriate and healthy weight (Downs & Blow, 2013). During this phase of treatment, FBT clinicians will work hard to support the parents in their effort to bring their child towards weight restoration (Le Grange & Eisler, 2008). In order for clinicians to provide this supportive role, parents are encouraged to monitor and control the adolescent's food intake each day (Le Grange & Eisler, 2008). This requires parents and family members to take an active role in monitoring the adolescent's snacks and meals while

restricting physical activity or any other behaviors that could lead to further weight loss (Le Grange & Eisler, 2008).

Refeeding techniques are often provided by the clinician during the first phase of the FBT process. The goal during the first phase is to help each family member learn to take charge of their child's poor eating habits. According to Loeb and Le Grange (2009), "the therapist helps parents develop and refine their techniques in an in-session family meal, a goal of which is for parents to convince their child to consume a least one more bite than s/he was originally willing" (p. 2). It is important to note that once a child regains the appropriate weight, "conflict around eating is significantly reduced, control over food consumption is transferred back to the adolescent in phase two of treatment" (Loeb & Le Grange, 2009, p. 2).

During phase one of FBT, one study examined the importance of family interactions around meal times and how these interactions impacted eating disorder symptomology among adolescents (Godfrey, Rhodes, & Hunt, 2013). Their results found support suggesting a relationship between family meals and eating behaviors (Godfrey, et. al., 2013). This relationship revealed that negative mealtime interactions were associated with disordered eating behaviors (Godfrey, et. al., 2013). According to the researchers, this suggests that "interactions during family mealtimes play an important role in distinguishing families with a child with disordered eating behaviors" (Godfrey, et. al., 2013, p. 16). In comparing different groups, one study found that those in the group who struggled to eat were able to eat one mouthful more than they were willing (Godfrey, Rhodes, Miskovic-Wheatley, Wallis, Clarke, Kohn, Touyz, & Madden, 2006). Their research believed that through coaching parents in FBT strategies and techniques, parents could convince their child to eat more than they would have normally (Godfrey, et. al., 2006).

Phase 2. Once a healthy and appropriate weight is restored to the adolescents, the adolescent and their family begin to move into phase two with the help of the clinician. During this phase the adolescent begins taking charge of their own eating habits as they start eating on their own (Downs & Blow, 2013). Le Grange and Eisler (2008) state that the second phase of treatment cannot begin until "the patient has reached ~90% of ideal body weight, is eating without resistance, and the mood of the family is more upbeat" (p. 13). While this process takes place upon regaining an ideal body weight, the second phase often proceeds at the pace of each individual family (Le Grange & Eisler, 2008).

According to Downs and Blow (2013), the main goal of phase two is to continue with many of the steps that are taking place in phase one such as keeping parents in charge of the feeding process. Within phase two, clinicians and family members begin searching for evidence that the adolescent can take on the responsibility of independent eating. Once this responsibility is given back to the adolescent, the FBT process can begin to transition into the third phase of treatment.

Phase 3. The third phase begins in FBT once the adolescent is able to maintain a healthy body weight while independently taking over the responsibility of the feeding process. It is within the third phase of FBT that clinicians begin to address topics centered on termination of services as well as general concerns regarding adolescent development (Loeb & Le Grange, 2009). As an adolescent and family progress through the FBT process, techniques and skills to work through the eating disorder symptoms, such as re-feeding, begin to progress expected during the third phase (Downs & Blow, 2013). Once the adolescent gradually regains their control, "the therapy shifts from a focus strictly on the eating disorder itself to a more general focus on other concerns" (Downs & Blow, 2013, p. 7).

FBT in practice. Current research has strongly supported the impact of implementing the family into the treatment process with adolescents with anorexia nervosa. A study conducted by Couturier, Isserlin, and Lock (2010) examined FBT through a variety of pre- and post-tests and gathered results regarding effectiveness, fidelity, and acceptability. Their results revealed that FBT is an effective treatment approach for adolescents facing anorexic symptoms. They shared that "this treatment is effective in this population not only for weight restoration, but also in improving some of the psychological symptoms such as dietary restraint, interoceptive deficits and maturity fears" (Couturier, et. al., 2010). Similarly, another study examined the successful application of FBT for a 17-year-old identical twin who was presenting with symptoms of anorexia nervosa (Loeb, Hirsch, Greif, & Hildebrandt, 2009). After a six month follow-up with this single case client, researchers found that eating disorder symptoms remained stable after time away from treatment thus further supporting the effectiveness of FBT (Loeb, et. al., 2009).

Research has also found that FBT is an effective approach across many different settings and can produce positive results over long- and short-term treatment plans. For example, one study examined outcomes and change in adolescents in a day hospital program implementing FBT (Girz, et. al., 2013). Within this study, researchers found that adolescent eating disorder symptoms, depression, and anxiety decreased between 3 and 6 months after the initial assessment took place (Girz, et. al., 2013). These results help support their hypothesis that FBT is an approach that can be adapted in order to be implemented within a hospital setting for adolescents. Similar research also revealed the long-term impact of FBT in an outpatient family program by following up with various families after five-years of treatment (Eisler, Simic, Russell, & Dare, 2007). Results further supported the "long-term efficacy of family therapy in

adolescents with anorexia nervosa and highlights that those who respond well to family therapy generally stay well" (Eisler, et. al., 2007).

While research continues to provide significant results regarding the impact of FBT in reducing adolescent anorexic pathology, little research has provided an understanding of FBT through the clinician's perspective. Though various treatment modalities are often used in treating eating disorder symptoms, FBT provides a unique opportunity to incorporate the family system into this process when treating an adolescent. Though the literature has shown measurable improvements on eating disorder symptomology through the use of FBT, further research could explore the insight from a clinician's perspective regarding the implementation of FBT and the nuances they have discovered incorporating FBT with their clients.

Exploring the application of FBT in a clinical setting can provide further insight into the nuances of this treatment modality and further explore the gaps in the literature regarding areas of growth and development through the incorporation of the family system in the therapy setting. This present study will seek to address these gaps in the literature with the following research questions: From an FBT clinician's perspective, what is the process of implementing FBT with adolescent clients living with anorexia nervosa? What components of FBT have clinicians found to be both effective and challenging in their work with adolescents experiencing anorexia nervosa? What new areas of growth and development are occurring within the practice of using FBT?

Conceptual Framework

Ecological Systems Theory

In order to best understand FBT through a clinician's perspective, this study will incorporate the ecological systems theory to make sense of the role of the FBT clinician when working with families and adolescents with anorexia nervosa. Through this lens, the ecological systems theory understands the relationships between people and their environments as an active and enduring interaction (Miley, O'Melia, & DuBois, 2013). This interaction between people and their environments is not separate but exists together in order to better understand the other (Miley, et. al., 2013). To better understand an individual through the ecological systems approach, Siporin (1980) writes:

> People and their physical-social-cultural environment are understood to interact in process of mutual reciprocity and complementary exchanges of resources, through which processes the systemic functional requirements are met, dynamic equilibrium and exchange balance are attained, and dialectical change takes place (p. 4).

Each system that is working is constantly impacting other various systems while being impacted by the outside systems themselves. Siporin (1980) describes this idea in the following quote:

> Ecological theory thus deals with the web of life, at the interfaces between systems and subsystems, so that is relates to open, self-organizing, self-regulating, and adaptive complexes of interacting and interdependent subsystems (p. 4).

Incorporating the ecological systems perspective often understands a person to be a complex individual that is constantly influencing and being influenced by the systems in which they live. As a clinician operating through this ecological systems lens, understanding an individual cannot fully be achieved without also considering the systems in which they live and

interact with (Miley, et. al., 2013). The role of the clinician, through an ecological perspective, is to better identify and makes sense of the reciprocal interactions between the person and their environment (Miley, et. al., 2013).

Within the ecological perspective, dysfunctional and maladaptive behaviors do not apply (Miley, et. al., 2013). Instead, behaviors are said to be understood when considered in context to the other working systems within the adolescent's life (Miley, et. al., 2013). Though the family system once was blamed for their child's eating disorder symptoms, FBT clinician have recognized the important role that the family system can have in the recovery process for their adolescent struggling with anorexia nervosa (Le Grange & Eisler, 2008). The ecological systems theory understands that "a change in one part of the system creates a change in another part of the system, which, in turn, changes the functioning of the entire system" (Miley, et. al., 2013, p. 35). Through this fundamental principle of the ecological systems theory, FBT clinicians utilize this lens to describe the way that problematic behavior can be reduced through the incorporation of positive, healthy, and engaged families within the treatment process.

Clinicians using FBT in their work with adolescents understand the important role that the family system can play in the recovery process of their child suffering from an eating disorder. The ecological systems perspective recognizes that many systems are in constant interaction in the life of the adolescent. If these interactions are not positively influencing the adolescent, problems can occur and behavioral dysfunction can begin to take place (Miley, et. al., 2013). Of these many mutually interacting systems, the family system is often one that is ongoing and impacts the life of the adolescent. Through an understanding of the family systems

and the positive ways it can help serve in the treatment process, the FBT clinician can begin to incorporate the family into the treatment process to promote recovery.

Method

Research Design

Within this study, a qualitative descriptive research design was utilized to answer the following research questions: From an FBT clinician's perspective, what is the process of implementing FBT with adolescent clients living with anorexia nervosa? What components of FBT have clinicians found to be both effective and challenging in their work with adolescents experiencing anorexia nervosa? What new areas of growth and development are occurring within the practice of using FBT? Data was collected by conducting a variety of semi-structured interviews of FBT clinicians who are currently incorporating this treatment modality into their work with adolescents with anorexia nervosa.

Sample

For this qualitative research study, the researcher utilized convenience and snowball sampling in order to recruit potential FBT clinicians working with adolescents with anorexia nervosa. A convenience sampling, according to Padgett (2008), is the idea of "selecting respondents based solely on their availability" (p. 53). The researcher made contact with various FBT clinicians through the Maudsley Parents website in which FBT providers were listed by each state. Recruitment for these participants was initiated by the researcher using publicly listed contact information for FBT clinicians with practice emphasis in adolescents with anorexia nervosa. The researcher also asked participants and others who have experience with FBT and eating disorders to assist the research in identifying other potential participants. This type of

recruitment is known as a snowball sample in which "a few cases of the type we want to study lead us to more cases, and so on" (Monette, Sullivan, DeJong, & Hilton, 2014, p. 147). Four semi-structured interviews were conducted between January 13th, 2016 and February 10th, 2016. All respondents were female. Two of the clinicians were Licensed Independent Clinical Social Workers (LISCWs), one was a Licensed Psychologist (LP), and one was a Licensed Professional Clinical Counselor (LPCC). Three of the four clinicians worked for the same eating disorder treatment center, and one clinician worked in private practice. The clinicians had between 4 and 10 years of FBT experience and training.

Protection of Human Subjects

Prior to conducting the interview, the researcher participated in the Collaborative Institutional Training Initiative Program (CITI training) to increase understanding, knowledge, and awareness in the protection of human subjects and incorporate this awareness into the study. Before the study began, the respondent was given a consent form approved by the St. Catherine University Institutional Review Board (IRB). The respondent was informed of the purpose of the study as well as the procedures that would take place throughout the entire process. The respondent was told that they would be participating in a 45-60 minute interview and would be asked various questions pertaining to the topic of adolescents with eating disorders while being audio-recorded. The data they provided was then analyzed by the researcher and committee members to check for reliability. The researcher ensured the respondent that there would be no risks to participating in this voluntary study. The information they provided would remain confidential and each participant would have the ability to choose where the interview would be held and at what time. Many of the questions that were asked of the participants were generally

related to their work implementing FBT in their work with adolescents, professional and therapeutic development, and client success (see Appendix A).

Once the consent form was reviewed and understood by each participant, the form was then signed by each participate as a way of agreement to participate in the study. The researcher informed each participant that at any time they were free to not participate in answering a certain question or end the interview completely with no consequences. In order to maintain confidentiality, the participant's information and the data collected from the interview was stored on a password protected computer until the project was finished, at which point their data was to be destroyed.

Procedure

This semi-structured interview proceeded after the consent form was signed by the respondent. The interview was conducted using a set of structured questions that were approved by the IRB. Open-ended questions were used in order to gain helpful information and encourage honest dialogue between the respondent and the researcher. Closed-ended questions were used as a way to probe for more information when the interviewee felt it was necessary to expound upon the information that was given. This allowed the respondent to further develop their thoughts and provided useful information regarding the research topic. The interview lasted approximately 45-60 minutes and was then transcribed into text to be later analyzed.

The interview questions were designed to begin broadly, addressing general topics relating to eating disorders, FBT, and the impact of this treatment modality through a clinician perspective. These general questions helped develop a framework to better understand the topics of FBT and its use and importance within a clinical setting. The questions following narrowly addressed specific topics pertaining to the research topic such as clinicians' perspective, nuances

with FBT, and growth and development with FBT. The general questions provided necessary information to better understand the importance of FBT and help make sense of the information that was provided in the responses to more specific questions.

When the interview was complete, the researcher's contact information was given to the participants if any questions developed following the interview. Lastly, the researcher asked if each participant would like to see the final copy of this research once the study was complete.

Data Analysis

To analyze the data collected, principles of grounded theory were used as a strategy to best interpret the information that was given. Grounded theory "entails inductive coding from the data, memo writing to document analytic decisions, and weaving in theoretical idea and concepts without permitting them to drive or constrain the study's emergent finding" (Padgett, 2008, p. 32). For this reason, data was drawn from the interview once transcribed by the researcher. A process of open coding was used to note the major concepts that were pulled from interview. Concepts were drawn from the interview and noted, or coded, next to the text. Patterns within the codes were then grouped into themes to better make sense of the concepts that were addressed within the interview. Once themes were established, the transcript was reviewed again in order to ensure that the research question was being addressed through the codes and themes that emerge from the interview. For the purpose of this study, the researcher alone transcribed and coded the data.

Results

Overall findings suggested that though FBT is a manualized form of treatment, it can be used across various settings to effectively meet the needs of the family systems and strengthen family relationships. According to the respondents, the families that are committed and willing

to engage in FBT often see recovery within their adolescent. After the data was transcribed and coded, four themes and eleven subthemes were established by the researcher upon coding the interview transcripts. These four themes included: FBT process, FBT empowerment, FBT commitment, and FBT development.

FBT Process

Each respondent discussed their own use and implementation of the FBT process in their work with adolescents with eating disorders. While some interpretations varied, three subthemes were established from the FBT process theme: 1) incorporating the family system, 2) creativity in practice, and 3) participation. The respondents discussed the value of incorporating the family system as well as the importance of participation among the family members. The respondents also addressed the ways in which they leave room for creativity within their implementation of FBT to meet the unique needs of each individual family.

Incorporating the family system. Incorporating the family system was identified through the coded patterns that appeared during the course of many interviews. The respondents explained that the process of FBT requires the family system to be utilized and incorporated in order for recovery to be effective. Furthermore, the respondents all recognized the value that the family system can have when working with adolescents with anorexia nervosa. The subtheme of incorporating the family systems is exemplified when one respondent stated, “the family system is the recovery, and I mean that is the key. I would say akin to FBT and research, is saying that having a good support system is key.” Another respondent further stated:

> Looking at what meals are like for them at home. What is their normal meal time that can look really different depending on the family? Maybe their normal meal time is eating subway in the car on their way to soccer practice. Or like, everyone has their different- I

> think when the model is laid out it's like 'oh yeah, sure everybody sits down with their entire family and they cook dinner,' and I don' think that is really realistic for a lot of families. So really what is your normal? And let's get back to that. You don't have to change your normal.

The respondents here recognized the importance of incorporating the family system into the process of FBT in a way that feels normal for that family. For this clinician, the process of FBT was discovering ways in which the family could smoothly transition into the treatment process in a way that does not cause too much disruption for the family system. One respondent further illuminated the subtheme of incorporating the family system when she stated:

> Depending on where they live, like I've said, they are here all the time. That is best case scenario. We have parent programming once a week. Only parents come in and we have a process group for them where we give them lots of skills. Then we have twice a month we have family programming. […] We teach families, sibling, parents, and lots of skills. We teach them about eating disorder, because a lot of them come in here and have no idea what's going on. But then also, as much as possible, especially if they are doing FBT we try to get the whole family system in here.

The subtheme of incorporating the family system developed as a result of the coded patterns that were found through the interview. By using the family within the treatment process, the respondents found FBT success when the individual uniqueness of the family system was used and implemented during the recovery process.

Creativity in practice. Within the process of FBT, respondents found that incorporating creativity during treatment correlated with adolescent recovery and success. Respondents found that each family system is distinctive from other families and requires a certain amount of

creativity when implementing FBT. The idea of creativity within the process of FBT was highlighted in the quote below:

> I'm very creative with family, meaning bring in grandparents, bring in aunts and uncles, and godparents, and the neighbor lady that helps out, I mean whoever it is who is going to help oversee this. I do feel strongly that siblings should not be in an authoritative position, as in overseeing the meal. They should be in a partner position with the client.

Creativity was also recognized in the use of technology when one respondent stated:

> I have had a family where the kid eats in front of her computer at lunch and video record everything, and they came up with on their own. I don't know if I would have suggested it. And I was like 'eh, that works.' I have very rarely that when given the task of refeeding haven't figured out a creative way to do it. And that's where I am not so rigid that is just has to be you know a guardian, that is where we have really brought in who else we can bring in like school nurses and teachers.

Similarly, one participant understood the importance of using the family's "normal" routine as a way to incorporate creativity in the FBT process. One participant illuminated this idea in the following statement:

> I think then parents come in here too and they are worried like, 'are you going to feed her steak every day,' we've been vegetarians for 10 years. Their own food values. They believe in local, sustainable food and that is something that is really important to them. […] It is just about going back to what was normal for them before.

Incorporating creativity during the FBT process allowed each respondent to meet the individual needs of the family system. The respondents appeared to utilize all aspects of the adolescent's support system in order to effectively carry out FBT. Creativity was also described by the

respondents during each phase of the FBT process. Clinicians would incorporate the FBT process into the family's everyday normal activities in order for effective outcomes to take place.

Participation. The subtheme of participation was a common theme regarding the process of FBT among respondents. Clinicians often explained that in order for the process of FBT to be effective for adolescents, there had to be a strong element of participation from the supporting family system. The following quote from one respondent highlighted the importance of participation within the FBT process:

> We know that with the disease of anorexia, that they [adolescents] are not going to refeed themselves, so if there is not action then where is the refeeding happening if the family is not going to do it. This type of treatment isn't going to be effective. […] I won't take them unless the family will do it.

Additionally, one respondent replied by saying:

> People come off as pretty perplexed in the beginning [of FBT], but generally when I get the parents on board and talk about it [FBT] and help explain it, they can get on board and figure things out pretty quickly.

Another respondent used an analogy to describe the importance of participating in the process of FBT in the following statement:

> I use the analogy, if your kid had cancer, you wouldn't say, let's start chemo in a few months when we have more time. It is not convenient and it is going to interrupt your life. This is a terminal illness and you are going to do that. I think families really keeping that focus- this is not just something we are doing for the fun of it. This is serious and we are going to be consistent with treating this seriously. That really helps kids to.

Respondents recognized that the FBT process would not be as beneficial for the recovery of the adolescent if the parents or caregivers would not participate within that process. Furthermore, one respondent highlighted that the process of FBT is not convenient for the family system and would require participation even through the inconvenience. The codes and themes found within the interview transcript of incorporating the family system, creativity in practice, and participation were then combined and considered subthemes all relating to the theme of the FBT process.

FBT Supports Family System

Each respondent identified the ways in which the FBT process empowers the family system to work together in order to successfully support the adolescent with an eating disorder. From the theme, FBT supports the family system, three subthemes were identified as relating to and supporting the theme of family support: 1) empowerment, 2) ambivalence, and 3) trust. Each respondent discussed that ways in which incorporating FBT techniques helped support and strengthen the family system as a whole entity. Through the subthemes of empowerment, ambivalence, and trust, FBT can begin to support and strengthen the family system.

Empowerment. When incorporating FBT techniques in their work with the family system, each respondent recognized the ways in which empowerment helped support and strengthen the family system. Through the subtheme of empowerment, parents who once felt controlled by their child's eating disorder began to take back a sense of control within the treatment process. The following quote supported the subtheme of empowerment as it impacted and influenced the family system:

> You are working with the people who know and love the client the best. This is where the use of siblings is amazing because they have a very important role, and the empowerment

> of parents. Almost every parents that walks in my door feels awful, 'what did I do?' 'How could I have not have seen this?' They are coming to me "what should I do?" and I am like you know how to feed your kid […] you are the expert on your kid. I am the expert in this field, sure and we are going to partner together but you know your kid, and we are going to figure it out. How can I partner and re-empower you as a parent again?

Another respondent recognized the impact that family empowerment can have on the recovery of an adolescent in the statement below:

> The empowerment of the family system is a really powerful thing. To be able to hold a family, to be able to say this is a bump in the road but we know how to get over it, it actually teaches them how to address other things.

And another replied stating:

> I think it goes back to the fact that the kid is struggling and is losing control and for parents to step up and sometimes siblings too, and look at is as a family disorder and be a team. I think even though the kids won't say this, I think that it provide them with a lot of comfort and safety. Feeling like they can do it because everyone is in it together.

Each respondent recognized the ways in which FBT clinicians empower the family system to work together as a team to support their adolescent with an eating disorder. As FBT incorporated the use of the family system, the system as a whole began to develop a sense of empowerment to overcome the eating disorder together.

Ambivalence. Eliminating ambivalence was another common subtheme among respondents as they identified ways in which FBT supported and strengthened the family system. While respondents recognized the ambivalence of the adolescent, many respondents acknowledged that FBT began to eliminate and reduce that ambivalence as parents became

involved within the treatment process. The subtheme of eliminating ambivalence was highlighted in the following quote:

> I think when parents aren't here and they are not taking control, I think that the kids have a longer time to muddle over things. There is more ambivalence and more anxiety. I think it takes them longer to work through all of that, rather than the kids who are doing FBT and the whole family is in it together and they don't have to worry about that part.

Additionally, another respondent further illuminated ambivalence when she said:

> The thing with family based, which is part of why it is so effective, is that people are ambivalent to recovery, ambivalent about various things. When you get the kid that is ambivalent about weight gain, but the parents are not, you have two people who are not ambivalent at all and they are worried and they want to do it. So, if they can battle their kid's resistance then I think it is effective.

When asked about the main strength of the FBT process, one respondent further supported the subtheme of eliminating ambivalence in order to support and strengthen the family system:

> I go back to the parents aren't ambivalent. I mean you have just no ambivalence. They are ready to be effective. Where as with any treatment, where it is just the individual in treatment, there is a function to the illness, change is hard, and family change is hard too, but that is not where they start, they start with we are going to make our child well and they are super motivated to do that.

As FBT incorporated the family system into the treatment of their adolescent with eating disorders, the respondents identified the ways in which FBT eliminated ambivalence within the family system to help support their adolescent. While the child may be ambivalent to their eating

disorder, respondents found that parents who were able to engage within the treatment process, reducing ambivalence, were more effective.

Trust. Respondents recognized the ways in which families that engaged in the FBT process developed stronger trusting relationships within the family. Many of the respondents found that as families participated in FBT, adolescents developed a stronger relationship with their parents as they partnered together towards recovery. The following respondent's quote illuminated the trust that is developed as the family began to feel support through the FBT process:

> Really FBT helps kids have a lot of trust in their parents. They think, 'my parents can help me, they can make me better, they know what they're doing.' Which, I think is really helpful for all adolescents in general. Having that relationship especially having gone through something difficult. They know they can do this and can go to them. I think that is really helpful down the road.

Another participant stated, "It is almost like by parents being here and being present and doing what they need to do for their kid, it seems like it gives the kid more of the ability to have some trust in their family." Trust continued to be seen as a subtheme throughout each interview. Through trust the following participant recognized the impact that it can have not only on the family but also on the adolescent when she stated, "I think they go away from FBT with a stronger relationship with their parents and a stronger sense of worth just knowing that people are going to be there for them."

Through the subtheme of trust, respondents found that FBT supported the family system in the ways in which trusting relationships are formed between family members. Through the

responses of each respondent, the idea of trust was a common subtheme as it relates to the theme of, FBT supports the family systems. The subthemes of empowerment, ambivalence, and trust were understood as all relating to the theme of FBT supports the family system.

FBT Commitment

While the previous theme recognized many of the strengths within the FBT process, respondents also discussed the challenges in which families must overcome when engaging in FBT. The theme of FBT commitment was common among respondents as they described the importance in family commitment in order for recovery to take place for the adolescent and family. From the theme of FBT commitment, three subthemes were identified as necessary characteristics in order to commit within the FBT process: 1) communication, 2) conflict management, and 3) willingness.

Communication. Communication was a common subtheme relating to the commitment that is required within FBT. Respondents identified communication as a necessary characteristic in order for FBT to be most effective and successful for adolescents. Respondents understood that a lack of communication created barriers to fully engaging and committing to the process of FBT. The following quote supported the subtheme of communication as it related to FBT commitment:

> There was a lot of getting mom and dad on the same page, and they got really creative about how to do that. I think eating disorders are a great triangulation. 'Mom wouldn't let me eat this, dad already gave me a snack.' So it is a lot of communication.

Additionally, one respondent expressed the importance of parent communication when she said, "I think the kid could, if the parents were to be able to be on the same page and have trust in the

process, I think no matter what kid it was it would eventually work out." Another participant further highlighted the importance on communication with FBT when she stated, "I always think as therapists our job is to make ourselves obsolete, right? I mean, ultimately its communication functioning within their relationships. So again, I feel that you're facilitating that in the treatment right from the beginning."

Respondents recognized that as parents effectively communicate with one another and are on the same page, the process of FBT began to be more effective. Challenges began to occur when parents no longer openly communicate with one another. The subtheme of communication was common among respondents as they recognized the challenges of families committing to FBT.

Conflict Management. Throughout many of the interviews, the subtheme of conflict management was another way in which FBT required commitment from the families supporting their adolescent through the recovery process. Many respondents discussed the ways in which FBT brought up conflict as the adolescent began to heal from their eating disorder. Respondents have recognized that families who can effectively manage this conflict often effectively engage in FBT. The subtheme of conflict management was recognized by the participant in her statement:

> FBT brings out conflict in many ways that families have never seen. So if there is a system that really can't tolerate that climate of conflict, it may not be safe to do that. […] But there has been situations that over time a family cannot manage their own reactivity, and that would be the other time where FBT wouldn't work.

Another participant highlighted the use of FBT as an approach to teach conflict resolution in her statement:

> It [FBT] teaches families conflict resolution and emotion regulation. While I don't want to stereotype too much, it is pretty fair to say many kiddos that come through here tend to be overachieving, good kids, that aren't necessarily getting in trouble, and the first time they really rebel is with food. So, it is teaching a family how to be able to handle that kind of conflict. […] I will have a lot of families that have never had a problem, ever had an illness, and never had a sickness. […] I think that's another piece of FBT is that is teaches families how to do conflict resolution in a safe way, how to triage what is important.

Another respondent replied:

> Parents who upfront learn how to manage conflict and then if they can tolerate their kid being upset with them will do better. That's the number one thing. They're like, 'she doesn't want to, she's mad at me,' or 'he says he would rather die than eat, so why would we feed him.' So people who can, a family systems that can learn how to or already know how to work through that kind of conflict do much, much better.

Respondents found that FBT brought up a variety of conflicts as adolescents began working through treatment. The subtheme of conflict management related to the theme of FBT commitment in the ways in which parents had to effectively learn to manage and tolerate conflict. Each respondent found challenges in their experience with FBT when family systems struggled to manage the conflicts that developed for their adolescent.

Parent willingness. The subtheme of parent willingness was a common theme in regards to FBT commitment. Respondents often found challenges within the process of FBT when parents were not willing to fully commit to the treatment. Respondents recognized that FBT is a lot of work that requires the willingness of parents in order for recovery to take place. The following quote promoted the subtheme of parent willingness:

> We know that with the disease of anorexia they [adolescents] are not going to refeed themselves. So if there is no act then where is the refeeding happening if the family is not going to do it? This type of treatment isn't going to be effective. So I guess as we are talking about who I will screen out, I won't take them unless the family will do it.

The important of parent willingness was also expressed within the following quote:

> The other thing that sometimes happen are if the parents are kind of, they hear me, but they don't necessarily buy in. That generally it's just a phase, she'll snap out of it, and so that another things that happens. Or there is a certain denial, 'well you know she is just actually really athletic.' So there is just this certain level that the parents really haven't brought into the crisis.

When asked about certain family systems in which FBT was more effective, one respondent continued to highlight the importance of parent willingness in the following quote:

> Family systems, or parents I would say, who are willing to listen and willing to actually try what we are telling them. It is very hard when parents are very emotional. They have to kind of be able to set their emotions aside.

Each respondent reflected on the need for parents to have willingness to engage in the FBT process in order to be fully committed. Respondents recognized that incorporating the

parents in FBT took a certain amount of work that required willingness in order to be effective. The subthemes of communication, conflict management, and parent willingness were identified as being related to the theme of FBT commitment. The respondents recognized that the family systems must be able to communicate effectively, manage difficult conflict, and be willing to engage in services in order to fully commit to the process of FBT.

FBT Development

In coding and identifying themes within the interview transcripts, the respondents demonstrated a common theme of FBT development. Many respondents offered an understanding regarding where they hoped to see FBT growing and developing based on their own experience of implementing FBT. Two subthemes were identified as relating to the theme of FBT development: 1) resources, and 2) implementation. Many respondents identified FBT development taking place within each of these subthemes.

Resources. Many respondents recognized FBT challenges in families that did not have the necessary resources to fully engage in FBT. For this reason, respondents identified an increase in resources for families participating in FBT treatment could effectively improve the recovery of their adolescent. The subtheme of resources as it relates to FBT development was understood in one participant's quote:

> I would also like to see how can it continue to grow and develop and I don't know what or how, but again there are certain families that you know literally they just can't do it. So could there be in-home family therapy, or skills workers, or something to help assist with that?

Another replied by stating:

> Then some families in an ideal setting a family will take a week off of work and the kid won't go to school for a week and you will spend that first week just eating. Um, and some families don't have the vacation to do that or the resources, or the means. And so, those are some of the challenges.

One participant recognized the need for skill use in order to effectively support parents through the FBT process in the following statement:

> How can we give parents the skills to help deescalate their emotions when they are at the table and things are really hard? Just getting them language of which to do that and skills says okay let's take a break from eating and work on these skills. I think that can be really beneficial.

The common subtheme of resources was discussed among respondents in regards to the growth and develop of FBT. Many respondents recognized the need for additional resources in order for families to effectively participate and engage in FBT treatment. Not only could personal resources help family through the FBT process but also outside resources in order to help support the family systems as they move through the process of FBT. As a result of these ideas from the interviews, the subtheme of resources was created relating to FBT development.

Implementation. The subtheme of implementation was another common theme relating to FBT development according to respondents. Many believed that FBT could be beneficial if the implementation of this treatment continued to be explored and researched in new and creative ways. The following quote provided an example of ways in which the implementation of FBT could further be explored:

> I think that treatment programs should be family treatment programs, like residential settings. I also think that therapist should go to family houses. If you are going to do FBT you should go for a week, have a room there, and every meal and every snack you are sitting there. I think it would be a lot faster and a lot more successful.

Additionally, one respondent stated, "I hope that they will continue to research it [FBT], some of these questions like how does it look five, ten years later. Is it successful long-term?" Similarly, another respondent discussed the need for FBT to be researched not only with adolescents but also with adults. The following statement highlighted this idea:

> I love the idea of FBT being more and more applicable to older adults. And a lot of people are like no you would never do that and I'm like I don't care if you are 19. No one, well very few people, are finically independent. You still have ways.

The implementation of FBT could also be explored by incorporating other forms of treatment. The following respondent supported the implementation of FBT and DBT in the following quote:

> I think it would be really great to figure out a way to implement FBT with DBT. Especially because those kids may be with some personality disorder stuff that may be coming up. Traits or chronic suicidal ideation. How can we get kids and families those DBT skills along with the refeeding instead of having to pick which one?

Each respondent identified different ways in which they hoped to continue to see the growth of FBT continue to take place and identified various ways of implementing FBT in order for this growth to take place. Through the use of increased resources to families and continued

research and new implementation, the respondents believed that FBT could continue to be used as a successful treatment modality when working with adolescents with eating disorders.

Discussion

Interpretation of Findings

The four themes and eleven subthemes described above provides a clear understanding into the context of the interviews that took place. The respondents built upon each theme as a way of making sense of and articulating the themes and subthemes that followed. For example, FBT process was one of the first themes that emerged from the content of the interviews. Each respondent identified ways in which their use and implementation of FBT impacts the adolescents and families that they serve. Through the subthemes of incorporating the family system, creativity, and participation, the respondents recognized the way in which they use the participation of the family system as the expert when working through the treatment process. The respondents also stressed the importance of seeing each family and individual and unique in order to effectively incorporate the family systems in the FBT process.

The second theme of ‘FBT supports the family system’ builds upon the context surrounding the theme of ‘FBT process.’ The respondents made it clear that through the process of FBT, the family systems begins to feel united, supported, and empowered to work as a team towards recovery of their loved one. The respondents highlighted the subthemes of empowerment, ambivalence, and trust as relating to ways in which FBT supports the family systems through the process of recovery. The respondents identified the ways in which FBT empowers the family through recovery, challenges and overcomes ambivalence, and builds trusting and supportive relationships within the family.

While each respondent recognized the ways in which the process of FBT provides support to the family system, they also stressed the importance of commitment within the third theme. FBT commitment was a theme that continued to build upon the themes of FBT process and FBT supports the family system. Without commitment, the respondents found that barriers and challenges developed within the recovery process. Through the subthemes of communication, conflict management, and parent willingness, the respondents revealed that without these family characteristics and abilities, families often struggled through the FBT process. In order for growth and development to take place within the adolescent, the respondents recognized the need for communication, the ability to manage conflict, and a willingness to provide support to their child.

The previous three themes of 'FBT process,' 'FBT supports the family system,' and 'FBT commitment' provides further context when understanding the final theme of 'FBT development.' Each respondent's own experience using and implementing FBT, identifying its strengths and challenges, allowed the respondents to recognize ways in which they would like to continue to see FBT grow and develop as more research is conducted. Common subthemes of resources and implementation were identified as relating to the theme of FBT development. Each respondent recognized the need to provide families with the necessary resources for FBT development to take place. Additionally, each respondent affirmed development as they provided new ideas for implementing FBT in practice. Though the understanding of the previous themes and subthemes, a cohesive understanding of the FBT process through a clinician's perspective can be made.

Connections with Literature

The finding of the first theme, FBT process, helps further support the findings that are seen within the context of the literature. Each respondent recognized the process of FBT treatment through their experience included incorporating the family into treatment, being creative with each unique and individual family, and required participation in order to effectively engage in services. Those families that were unable to engage fully into the treatment process often took longer in treatment and longer to recover.

The literature recognizes the important role that the family system can play in the recovery process of an adolescent diagnosed with anorexia nervosa. Through parent involvement, the severity of symptoms among adolescents with an eating disorder significantly improves over time (Bean et. al., 2010). The literature, as well as the respondents, further recognized the unique characteristics that each family systems bring into the treatment process of FBT. According to Le Grange and Eisler (2008) families not only differ in the way they respond to their adolescent with an eating disorder, but they also differ in the way they utilize and implement family interventions. As a result, the literature and the respondents stress the importance of adjusting to the norms of the family systems to successfully incorporate FBT and see success within the adolescent.

The second theme, FBT supports the family system, was widely recognized within the literature and by the respondents interviewed. Many respondents found that FBT empowered the family system, challenged ambivalence, and increased parent-child relationships. This idea is supported within the literature: parents who developed a greater understanding into their adolescent's illness improved their confidence to parent and improved the relationships within the family system (Sim & Matthews, 2013).

Similarly, many of the respondents found that families who engage in FBT will often feel more empowered to work together to effectively support their adolescent through the recovery process. According to Rhodes, Brown, and Madden (2009), the utilization of FBT serves "a more active function, helping to mobilize parents to take a firm, calm, and united leadership position in managing their child at home" (p. 11). Both the literature and the content of each interview provided further insight into the ways in which FBT helps support the family system through the recovery of their adolescent with an eating disorder.

FBT commitment was the third theme that was recognized by the literature and the respondents as a necessity in order to engage in and implement FBT. Many respondents recognized the challenges they are faced with when families are not fully engaged in treatment. Despite the efficacy of implementing the family system within the treatment of adolescents with eating disorders, FBT is believed to be a challenging and rigorous experience for the parents (Binford Hopf, Le Grange, Moessner, & Bauer, 2013). FBT is not only empowering towards the family systems but is "also time-consuming and labor-intensive" (Binford Hopf et. al., 2013, p. 1). As a result of the intensity of FBT and the burden that this eating disorder can have on the entire family, "therapists […] are often confronted by parents who are suffering from high levels of psychological distress" (Holtkamp, Herpertz-Dahlmann, Vloet, & Hagenah, 2005, p. 1). These ideas were further supported by the respondents as they recognized the need for effective communication, the ability to manage conflict, and a willingness to engage in FBT services.

The final theme, FBT development, widely connects with the literature and is further intensified through the responses contained within the interviews. The respondents recognized the need to provide families with additional resources in order to improve FBT and continue to see growth and development within the treatment modality. Similarly, Rhodes, Brown, and

Madden (2009) believe that providing additional support to families through the use of "mentor programs, parent support groups, or the inclusion of a wider network of family members and friend in treatment" could impact the recovery of an adolescent (p. 12).

In addition to increased resources for families, the respondents and the literature suggests the need for FBT to continuously be researched in order to discover news ways on implementing this modality within various contexts, situations, and settings. Each respondent felt that FBT development could take place through incorporating creativity within the manualized treatment model of FBT. Downs and Blow (2013) further support this idea as they recognize the need for FBT development regarding late-onset eating disorders. Further research could help shed light into different stages of eating disorder symptoms and the impact the family system could have in this recovery process as well.

Strengths and Limitations

This study contained several strengths that helped support the overall findings regarding FBT as a treatment modality for adolescents recovering from an eating disorder. One such strength was the depth of content that each qualitative interview provided within this study. The semi-structured approach to research helped deliver a clear picture into the use and implementation of FBT through a clinician's perspective. Each respondent answered the structured questions and were able to freely move the conversation in different directions as needed. This allowed for rich content to form from the interviews and created a better sense and understanding regarding the nuances of FBT.

In addition to the depth of content contained within each interview, the number of years that each participant has working as a FBT clinician helped strengthen the results contained

within this study. Each participant had between 4 to 10 years of FBT experience and training in order to effectively implement this treatment approach with adolescents. The collective experience that was contained among each respondent helped provide reliable and valid information pertaining to the topic of implementing FBT.

Various limitations also arose during the implementation of this study. This semi-structured interview format made it challenging to stay focused on topics that were most relevant to the research questions. The personal and professional experience of the respondents often allowed for the discussion to widely focus on client examples and situations rather than the process and implementation of FBT. While it is important to understand FBT through case examples of specific clients, this study's main focus was on the process of implementing FBT through a clinician's perspective. Respondents would often get lost in their stories and forget to address the main purpose of each question.

In addition to the structure of the interview, another such limitation was the number of respondents who participated in this study. The findings are limited and unable to be generalized due to the four interviews that were conducted and interpreted. Of the four FBT clinicians who participated in this study, all four were female and three clinicians worked within the same agency. The lack of diversity within the sample may be limited, and therefore unable to be generalized to all FBT clinicians. In addition to this limitation, the study was also limited in its access to these FBT clinicians. Based on the Maudsley FBT website, many clinicians work outside of the state of Minnesota. The accessibility of FBT clinicians in Minnesota posed challenges hearing from and gaining participation. More interviews and information would need to be gathered in order to make generalizations regarding the research topic.

Implications for Social Work Research and Practice

There are several implications to social work practice contained within the research presented. One such implication is the use of the family system as a support when caring for their adolescent with an eating disorder. The use and implementation of the family system in the treatment process of FBT incorporates the theoretical perspective of the ecological systems theory and the person-in-environment theory that is grounded in social work practice. Through these theoretical perspectives, social workers understand clients as interconnected with various external forces-including the family. In the life of an adolescent, the family system is one of the largest systems in which the adolescent engages in on a daily basis. Through the use of the ecological perspective, it is important for social workers to begin recognizing and utilizing the unique characteristic of each family to incorporate effective FBT.

Further social work research could be utilized to expound upon the findings presented within this study. One topic that continually was discussed during the course of the interview was the importance of normalizing FBT to meet the individual needs of each adolescent and family. Research has revealed that individualizing FBT based on the unique and dynamic characteristic of each family may help sustain behavioral changes in adolescents with various eating disorders (Goldschmidt, Saelens, Best, Stein, Epstein, & Wilfley, 2014). Each respondent within this study recognized the importance of incorporating manualized FBT within their practice setting but identified ways in which they adapt the model to make it more applicable to each family system. Further research could be developed in order to better understand how to effectively individualize FBT in order to meet the needs of each family.

Social work ethical standards and principles, such as the dignity and worth of the person, recognizes and respects the individual differences of all people. When considering the process FBT, it is important for social workers to continue to research the ways in which FBT and the

implementation of the family system could be used in various contexts and settings. The respondents recognized many ways in which FBT could continue to develop and be researched in order for other populations of people to be reached.

Conclusion

The results of this study helped exemplify the ways in which FBT can be used to impact the recovery process of an adolescent with an eating disorder through the perspective of the clinician. Based on clinician's responses, four themes were discovered: 1) FBT process, 2) FBT supports the family system, 3) FBT commitment, and 4) FBT development. These four themes helped support the use of FBT in working with adolescents with eating disorders and helped further highlight the important role that the family system can play in the process of recovery. While FBT is seen as a strength as it utilizes that family system, many clinicians also recognize the challenges and barriers that this treatment modality can have when families are not committed to the process of FBT. This study helped further reveal the significant growth and development that can take place in an adolescent's recovery when families are willing to fully engage in the process of recovery and commit to FBT.

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Appendix A

Qualitative Interview Questions

1. Please state your name, license/title, and how long you have been using FBT in your work with adolescents.
    a. Describe your role in working and interacting with adolescents?
2. What does your implementation of FBT in therapy look like based on your experience?
    a. In what ways would you say this experience is different from others who utilize FBT?
3. How do you incorporate the family system into the treatment process with your clients?
    a. What value do you see in utilizing the family system in your work with adolescents?
    b. Are there certain family systems in which FBT is more effective?
4. When considering the clients that you treat, what do you see, if any, as the most common strength of the treatment process?
5. How does the family system support the use of FBT in the recovery of their adolescent with anorexia nervosa?
    a. What may be the challenges?
6. Statistics reveal that FBT has a 50% success rate that is higher than any other form of eating disorder treatment, what do you see as a reason why this success may be taking place?
    a. What are some characteristics of clients who are successful?
    b. What are some characteristics of clients who were unsuccessful?

c. In your own experience, how does FBT positively impact an adolescent's recovery from anorexia?

7. In your professional opinion, where do you see the use of FBT developing from here?
    a. What components of FBT positively impact clients with a comorbid diagnosis?