

What are the Experiences of Family-Based Therapy Among Adolescents Affected by Eating Disorders? A Qualitative Systematic Review

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ABSTRACT

Aims: To understand experiences of young people who received Family Based-Therapy for disordered eating.

Background: The research gap is that little is known about how young people experience models of rehabilitation, and in particular family-based therapy. The focus of the family-based therapy aims to provide support to ensure medical stabilisation, develop brief coping strategies for patients and their families, and provide aftercare planning.

Design and Methods: A qualitative systematic review using meta-aggregation was conducted using Joanna Briggs Institute (JBI) guidance for qualitative evidence synthesis. Five databases and one register were searched on 27 March 2023 to identify relevant studies. The review process followed a registered review protocol and reported according to Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) guidelines. The studies were checked according to pre-determined inclusion/exclusion criterion, data extraction and methodological quality assessment was conducted in parallel.

Results: 16 publications were included. A total of 60 unequivocal and 99 credible findings supported the development of thirteen categories, which were then synthesized into three domains. Broadly, the lived experience of adolescents receiving family-based therapy method identified 'psychological distress', 'relationship breakdown' and 'the role of the therapeutic alliance and the healthcare system'. Adolescents articulated that their experiences were predominately negative within family-based therapy. The gaps included failings to address the psychological concerns of the adolescent, due to the perceived focus being solely on weight restoration.

Conclusion: Commonly, adolescents felt powerless and voiceless through this model of care, and the breakdown of the therapeutic alliance negatively impacted their wellbeing. Policy makers, health care professionals and researchers are making slow progress towards acknowledging the unique needs of adolescent living with eating disorders, as underscored in this review.

Patient Contribution: Healthcare professionals are encouraged to reflect on the findings of this research to inform holistic models of person-centred care.

Keywords: Family-Based Therapy; Eating Disorders; Qualitative; Systematic Review; Adolescence

Introduction

Worldwide, 70 million people live with an eating disorder and the prevalence has risen steadily in the last decade from 3.4% to 7.8% (Ritchie & Roser [1]). The prevalence of eating disorders ranges from 0.1 to 1 percent by country, with females more likely to experience an eating disorder than males. Globally, eating disorders tend to be

more common in the ages between 15 and 24 years old (Australian Institute of Health and Welfare, [2]). Young people aged 11 to 17 years remain one of the most prevalent groups experiencing this condition, with higher rates among females (Sparti, et al. [3]). Disordered eating is a psychological and physical condition that is characterised by disturbed eating behaviours which impairs health, wellbeing, and

psychosocial functioning (Yager [4]). Globally, eating disorders are diagnosed according to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (Mitchison, et al. [5]). The DSM-5 classifies eating disorders which are characterised into the subcategories of anorexia nervosa, avoidant/restrictive food intake disorder, binge eating disorder, bulimia nervosa, pica, and rumination disorder (Yager [4]). Eating disorders have been identified to cause severe medical complications including cardiovascular, pulmonary, gastrointestinal, and electrolyte complications requiring medical intervention (Ritchie & Roser, [1]).

The four major physiological effects of eating disorders linked directly to this condition include, kidney failure, heart failure, osteoporosis, and infertility issues (Sparti, et al. [3]). In the adolescent demographic, adult growth and development is also inhibited. Eating disorders have one of the highest mortality rates of any mental illness and expensive to manage (Aouad, et al. [6]), primarily as 90% are all inpatient admissions for anorexia nervosa (Sparti, et al. [3]). In addition, the report identify that inpatient treatment relapse rates and re-admission rates are extremely high ranging from 33 and 60% (Sparti, et al. [3]). The research gap is that little is known about how young people experience models of rehabilitation, and in particular family-based therapy. Research has shown that family-based therapy has been the primary intervention for the treatment of disordered eating behaviour (Forsberg, et al. [7]). The focus of the family-based therapy aims to provide support to ensure medical stabilisation, develop brief coping strategies for patients and their families, and provide aftercare planning (Freizinger, et al. [8]). According to this model of family-based therapy, at discharge, the family would receive a meal plan, and would be supported by an outpatient treatment program to oversee the patient's recovery supported by the family. Including an emergence of the use of multi-family therapy, which draws on the principles of family-based therapy and involves 5-7 families engaging in an intensive counselling over several months (Zinser, et al. [9]).

Patients who have received family-based therapy, multi-family therapy and/or inpatient specialist care are most likely to achieve remission at one-year follow-up (Nilsen, Hage, et al. [10]). There has been a focus on the experiences of families engaging in a family-based therapy model of care, however, the evidence into the child and adolescents experiences of this model of care are yet to be critically synthesised (Freizinger, et al. [8]). Other studies (Kadur, et al. [11]) have explored healthcare professionals' interactions with this model which has highlighted negative interactions between patients and healthcare professionals which has led to fear and frustration, missed appointments and poorer outcomes in family-based therapy. Therefore, the current qualitative systematic review aims to address this evidence gap by critically synthesizing qualitative experiences of children and adolescents during family-based-therapy and/or multi-family therapy. Specifically, this qualitative systematic review aims to understand the lived experiences of young people with eating

disorders who have received family-based therapy or an adaptation of this model, as directly described by them.

Methods

Design

A qualitative systematic review was conducted using the Joanna Briggs Institute qualitative systematic reviews methodology (Lockwood, et al. [12]). This qualitative systematic review has been reported in accordance with the Preferred Reporting Items for Systematic Reviews (PRISMA) guidelines (Page, et al. [13]). This review followed a pre-registered systematic review available from the PROSPERO International Register of Systematic Reviews (blinded for peer review).

Eligibility Criteria

Types of Studies:

Inclusion

- Articles published in English.
- Studies that explored the experiences of adolescents receiving family-based therapy for a diagnosed eating disorder.
- Studies that reported findings from adolescents, parents, family, or clinicians, providing that they reported the adolescents experience separately.
- All qualitative studies irrespective of research design.
- Case studies were considered.

Exclusion

- Quantitative study designs, editorials, conference abstracts and commentaries.

Types of Participants:

Inclusion

- Study participants who were diagnosed with an eating disorder according to DSM-IV or DSM-V criteria (Mitchison, et al. [5]).
- Articles exploring participants experiences of family-based therapy for the therapy primarily without adjunctive treatment component (Baudinet [14]).
- Articles that directly discussed 'adolescents' or 'young people'.
- Articles that discussed all types of eating disorders who received same model of care.
- Both female and male participants.

Exclusion

- Articles focusing explicitly on parents or clinicians' perspective.
- Articles focusing on obesity with the underpinning rationale that obesity is not diagnosed as a disordered eating condi-

tion in the DSM-5 (Mitchison, et al. [5]).

- Studies that provide no detail about the context of family-based therapy.

Literature Search

Five databases and one register were searched on 27 March 2023 to identify relevant studies. These were APA PsycINFO (via EBSCOhost), CINAHL (via EBSCOhost), Cochrane CENTRAL Register of Controlled Trials, Medline (via EBSCOhost), and Scopus, and Web of Science Core Collection, see Supplementary Material 1). Relevant systematic reviews were scrutinised for potentially relevant studies for screening and experts invited to submit relevant articles. The search architecture was designed by an expert librarian, utilising the efficient search method for systematic reviews developed at Erasmus Medical Centre (Bramer [15]). The management of citations was conducted using Endnote software. The search used a combination of keywords and subject headings to increase the sensitivity and inclusiveness of the searches and capture the “Sample” – children and adolescents affected by disordered eating and “Phenomenon of Interest” – experiences of family-based therapy.

Data Collection and Analysis

Following the database searches, all identified citations were exported to EndNoteX20 and uploaded into Covidence Systematic Review Software for the removal of duplicate records and the record screening process. The titles and abstracts were independently screened by two reviewers according to the pre-determined eligibility. The full-text articles were retrieved and carefully assessed against the inclusion and exclusion criteria. Any disagreements were discussed until a consensus was reached.

Data Extraction and Management

The data was independently extracted from the studies using data extraction tools that were developed to capture two levels of information. The first table included the study and sample characteristics (data methods and analysis, country, theoretical model / framework, phenomena of interest, setting, context, sample size and description of main results). The second table of data extraction related to the qualitative findings presented within the articles. The data extractions were checked for accuracy by a second author.

Assessment of Risk of Bias in Included Studies

Methodological quality of eligible studies was assessed using the Joanna Briggs Institute appraisal checklist for qualitative research (Stern, et al. [16]). This tool was selected as it was developed by the internationally recognised JBI and approved by the JBI Scientific Committee following extensive peer review. The JBI critical appraisal checklist for qualitative research consists of ten screening questions to determine empirical status as well as risk of bias. Each item was rated against “yes”, “no”, and “unclear” as it pertained to the qualita-

tive study criteria. Items that were rated as unclear triggered a further search for additional supporting articles.

Data Synthesis

The Joanna Briggs Institute method of meta-aggregation (Lockwood, et al. [12]) was used to extract, synthesise, and categorise the data. This three-step approach to thematic analysis initially involved extracting the authors interpretation of the results verbatim and documenting these as findings. Direct illustrative quotes were then used to inform each finding. This afforded an accurate and reliable presentation of results and eliminated the risk of re-interpreting the included studies. Findings and supporting illustrations were assessed for congruence and given a credibility ranking of either “unequivocal” (clear association between the finding and illustration and not open to challenge), “credible” (plausible and logically inferred from data however they are interpretive and open to challenge) or “not supported” (findings not supported by data) (Lockwood, et al. [12]). Following careful and repeated assessment of the compiled data, two or more findings were grouped into categories accompanied by an explanatory statement. Further synthesis of these categories produced overall synthesised findings.

Results

The remaining 24 publications were retrieved in full, of which sixteen studies met the eligibility criteria for inclusion in the final analysis, see Figure 1. The studies were diverse in origin and primarily conducted in Australia (Cont, et al. [17-21]), except for four studies conducted in the United Kingdom (Coopey, et al. [22-25]), three in Norway (Nilsen, et al. [10,26,27]), two in France (Baumas, et al. [28-29]), one in China (Ma [30]) and Canada (Dimitropoulos [31]), see Table 1. All studies utilised semi-structured interviews to collect qualitative findings, with all participants interviewed separately from family members or clinicians. All studies reported the adolescent experience separately; however, nine of the sixteen studies subsequently reported the patient’s parent, family member or clinician experience. Ten studies recruited participants diagnosed with anorexia nervosa, four studies involved participants with bulimia nervosa and two studies involved participants with eating disorders not otherwise specified. All studies received family-based therapy/Maudsley method or an adaptation of this model, for example, group therapy. The sample size of participating adolescents varied from n=1 to n=37 (total of n=208 adolescents). This review represented mostly females, with only ten male participants represented, and three studies did not specify the gender of the participants. Participant characteristics including culture, and other co-morbid conditions at the time of treatment were inconsistently reported. The methodological quality of each study was assessed concurrently with the data extraction process, see Table 2.

Table 1: Characteristics of the Included Studies.

Study	Methods for data collection and analysis	Country	Theoretical model/framework	Phenomena of interest	Setting/context/culture	Participant characteristics, Diagnosis, and sample size	Description of main results
Baumas, V. et al (2021)	<p>Data Collection:</p> <p>The present pilot exploratory qualitative study included two focus groups conducted using a semi-structured approach: one with the adolescents and another with one or two of their parents.</p> <p>Data Analysis</p> <p>Qualitative analysis: The two FG's audiotapes were anonymously transcribed, and a thematic interpretation, which is an inductive analytic approach, was chosen to explore their content.</p>	France	Qualitative Framework	The aim of the Focus Group was to identify the various changes perceived because of the treatment, but also the factors that lead to these changes according to the families.	<p>Setting: Multi-family therapy comprises 10 sessions over a year. Each session lasts three hours and involves initially five to seven families including the patients, their parents and non-systematically their siblings. Each session occurred face-to-face.</p> <p>Context: This study was approved by the French National Agency for Health and Medical Drugs (ANSM) and by the local Independent Ethics Committee. Information about the present study and the goals of the FG was verbally explained at the last session of the MFT group. The data gathered were confidential and identifying information have been anonymized.</p> <p>Treatment: Multi-family therapy guided by the Maudsley method</p> <p>Culture: French Participants</p>	<p>Participants</p> <ul style="list-style-type: none"> • A1-Female(16yrs) • A2-Female (14yrs) • A3- Male (19yrs) <p>Six Parents were included in this study including four mothers and two fathers, there demographics are not stated.</p> <p>Diagnosed Eating Disorder</p> <p>All three patients recruited (two girls and a boy) were aged 14 to 19 years and treated in outpatient care or hospitalized for Anorexia Nervosa</p> <p>Sample Size:</p> <p>3 Adolescents & 6 parents, Sibling participation, although noted was not directly stated in this study.</p>	<p>Qualitative analysis revealed that while both adolescents and parents had difficulties relating the changes, they observed in the last year to MFT, they were able to say that the group cohesion had several positive effects and that their family dynamics had improved. In the light of analysis, the adolescents perceived more improvements related eating disorders symptoms than their parents did, while parents were concerned about a negative effect of MFT on their children.</p> <p>Major themes that were highlighted in this study included the impact on the family unit, benefits of working within a group, impact on the disease and conflict</p>

<p>(Conti et al., 2017)</p>	<p>Data Collection: Semi-structured interviews. Audio-taped, transcribed verbatim and de-identified with pseudonyms.</p> <p>Data Analysis: Critical discursive analysis</p>	<p>Australia</p>	<p>Not reported</p>	<p>Qualitative case study analysis focusing on the experiences of both the adolescent and her family receiving Family-based therapy (FBT) or Maudsley family therapy model (MFT).</p>	<p>Setting: Interviews occurred face-to face individually with each family member, then interviewed as a whole family.</p> <p>Context: After being approved by the Human Committee at Western Sydney University, the family responded to an advertisement distributed through health professional networks. Participants were to have received the Maudsley model or Family based therapy (MFT/ FBT) for anorexia nervosa and be aged within the adolescent demographic (not defined).</p> <p>Treatment: Maudsley Family therapy or Family-based therapy</p> <p>Culture: Not reported</p>	<p>Participants:</p> <ul style="list-style-type: none"> • Hayley (patient receiving treatment) age at commencement of treatment: 11. Age at interview:13 • Margaret (Mother) age not reported • Jack (Father) age not reported • Richard age at commencement of Hayley’s treatment 13, age at interview: 15 <p>Diagnosed Eating Disorder: Anorexia Nervosa</p> <p>Sample Size: One family consisting of two parents and one sibling, plus one adolescent child diagnosed with anorexia nervosa</p>	<p>Three themes identified each with 10 sub-categories. These include;</p> <ul style="list-style-type: none"> • Trying and ‘failing’: impacts of MFT/ FBT on family alliance. <ul style="list-style-type: none"> ○ Conflict ○ Blame, suffering and failing ○ Hidden family stories • ‘Failing’ and standing for self and others: Roles and identity formation <ul style="list-style-type: none"> ○ How did it get to this stage? On my watch ○ I felt wretched but I knew my daughter ○ Distraction vs trust ○ Loss and reclaiming of identity and voice • What can be learnt for future therapies for adolescent AN <ul style="list-style-type: none"> ○ Significance of mobilising family commitment in therapy ○ Structural adherence to model vs tailoring to the family’s unique reality ○ Addressing emotions and prioritising the adolescent’s voice <p>From these sub-categories and themes, only four sub-categories focused on the qualitative data of the adolescent, these include conflict, hidden family stories, loss and reclaiming of identity and voice, significance of mobilising family and commitment in therapy, addressing emotions and prioritising the adolescent’s voice, the remainder were family focused.</p>
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<p>(Conti et al., 2021)</p>	<p>Data Collection: Semi-structured interviews. Audio-taped, transcribed verbatim and de-identified with pseudonyms.</p> <p>Data Analysis: The analysis was data-driven and inductive with all themes generated from the data set.</p>	<p>Australia</p>	<p>Qualitative Framework</p>	<p>The aim of this study was to explore how participants experiences and identity negotiations might inform future augmentations and transformative treatments for adolescent anorexia nervosa.</p>	<p>Setting: Interviews occurred in person or online/telephone</p> <p>Context: Participants were invited to discuss their experiences of FBT and generate context of individual experiences and ideas to improve the intervention. Participants responded to advertisements via Australian clinicians, after indicating interest via a Facebook advertisement. Participants must have received family-based treatment and have a diagnosis for anorexia nervosa</p> <p>Treatment: Family Based therapy</p> <p>Culture: Not reported</p>	<p>Participants: Fourteen participants who reported being diagnosed with AN and treated with FBT on average 4 years earlier. Gender was not identified in the sample</p> <p>Diagnosed Eating Disorder: Anorexia Nervosa</p> <p>Sample Size: 14</p>	<p>Analysis traced these participants' experiences of key dimensions of the FBT intervention and ways they engage in identity negotiations within these treatment contexts, including the reclaiming of identity and voice in matters related to their treatment.</p> <p>Primary Themes</p> <ul style="list-style-type: none"> • Therapeutic Focus • Identity Negotiations <p>Subthemes</p> <ul style="list-style-type: none"> • Focus on the invisible (psychological distress): Thirteen of the 14 participants argued that there was a lack of treatment focus on their experiences of psychological distress during FBT, ten of the participants who reported dropping out prematurely highlighted that failure to address emotional stress was a major contributor to this decision • Focus on the visible (ED symptoms): Ten participants' narratives indicated that the early treatment focus of FBT, where their parents took responsibility for their eating, was experienced as a relief, albeit it was also a distressing experience. • A life worth saving: Interwoven in participant narratives was a process of ascribing meaning to their parent's commitment to their recovery. • Negotiating personal agency and voice: All the participants, at some point in their narratives, talked about struggles to negotiate personal agency and voice in their treatment, particularly in the first phase of FBT where their parents were allocated responsibility for their eating restoration.
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<p>Coopey & Johnston (2022)</p>	<p>Data Collection: Participants engaged in semi-structured interviews designed to explore themes relating to the young person's experience of treatment and of change. The interview guide was cocreated with an expert by experience.</p> <p>Data Analysis: Interpretative Phenomenological Analysis (IPA) is a qualitative research method that focuses on examining how people make sense of their lived experiences.</p>	<p>United Kingdom</p>	<p>Not Reported</p>	<p>The principal objective of this research was to explore young people's experience of FT-AN and MFT in an inpatient setting to better understand the sense they make of the treatments provided and, from their perspective, treatment acceptability.</p>	<p>Setting: Interviews occurred in person, in a semi structured design. The interviews varied in duration, ranging from 24 to 76 min with a mean duration of 37 min.</p> <p>Context: Participants were recruited from the AN pathway; whilst on this, individuals would receive manualised FT-AN and five days of MFT. Four of those days were held on consecutive weeks, with the fifth being held nearer to discharge. The MFT was a closed group with a maximum of eight families, facilitated by two clinicians. Individuals were referred to the inpatient unit via their community team as they were judged to be unable to remain at home due to the severity of their presentation.</p> <p>Treatment: Family Therapy for Anorexia Nervosa or Multi-family therapy</p> <p>Culture: Not specified</p>	<p>Participants:</p> <p>Morty (Male)</p> <p>Meghan (female)</p> <p>Lilly (female)</p> <p>Lucy (female)</p> <p>Molly (female)</p> <p>Ages ranged from 10-18, mean age was 14.6. Pseudonyms were allocated to participants to maintain confidentiality. The nature of the study meant that no additional demographics were collected.</p> <p>Diagnosed Eating Disorder</p> <p>The participants had either a diagnosis of Anorexia nervosa or a diagnosis largely characterised by features of Anorexia Nervosa, such as Other Specified Feeding and Eating Disorders.</p> <p>Sample Size: 5</p>	<p>Four superordinate themes and ten subthemes were developed from the data. The four superordinate themes were: 'Process of Understanding', 'Reviving Connection', 'Emerging from the eating disorder and 'Development of I'.</p> <p>There appeared to be two overarching concepts: the role of the individual and the role of others, that helpfully framed the results. The superordinate themes: 'Emerging from the eating disorder' and 'Development of I' focused on the development of the individual. Conversely, the superordinate themes: 'The Process of Understanding' and 'Reviving Connection' were centred on the relationships existing within the family system. The results could help inform future service developments regarding inpatient provision and service design.</p>
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<p>Dimi- tropolis et al (2017)</p>	<p>Data Collection & Data Analysis:</p> <p>The research team conducted data collection and analysis simultaneously in an iterative process. This iterative process is characterized by the systematic generation of comparisons, which allows for the identification of similarities and differences among concepts formed. An open-coding system was developed inductively through a line-by-line analysis of each transcript. Constant comparative analysis allowed the research team to both review the themes generated from the interviews and determine new areas to be explored in additional interviews with participants.</p>	<p>Canada</p>	<p>Comparative analysis</p>	<p>The aim of this study was to identify types of family support desired by young adults with eating disorders during the transfer of care from paediatric to adult eating disorders programs.</p>	<p>Setting:</p> <p>Interviews occurred in person, in a semi structured design. Interviews were approximately 1 hour in length and were carried out at a time that was convenient for participants.</p> <p>Context:</p> <p>A convenience sample of 15 participants was recruited over a 2-year period. All participants had received an ED diagnosis from a licensed psychologist or psychiatrist at the time of admission into a paediatric EDP and/or prior to being placed on a waitlist for an adult EDP. Eligible participants had transferred out of a paediatric EDP within 2 years.</p> <p>Treatment:</p> <p>Family driven in a paediatric setting vs adult model of care</p> <p>Culture: Not reported</p>	<p>Participants:</p> <p>All participants in the study were female, with an average age of 19.1 years (SD = 1.5). Among our sample, a range of ED subtypes were represented: 7 individuals had AN restrictive sub-type, 5 individuals had AN binge-eating/purging type and the remaining 3 had BN. The average reported age of onset for their EDs was 14.7 years of age.</p> <p>Diagnosed Eating Disorder: Anorexia Nervosa or Bulimia Nervosa</p> <p>Sample Size:</p> <p>15 participants</p>	<p>The study aimed to understand and describe the experiences of young adults with eating disorders who transferred from paediatric to adult care, with a particular focus on the challenges and facilitators associated with accepting support from family members. Two key themes were identified within this study.</p> <ol style="list-style-type: none"> 1. A description of some of the family-related difficulties that arise during the transition phase from the perspective of the young adult is provided. 2. The ways in which participants conceptualize familial support as either helpful or unhelpful to recovery are outlined.
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<p>Escoffie et al. (2022)</p>	<p>Data Collection:</p> <p>Information about the qualitative experiences of MFTBN was gathered using a combination of focus groups (~60 m) and individual interviews (~45 m), conducted face-to-face in the clinic by author alone. All were semi-structured and followed similar topic guides, that focused on (a) experience and expectations of treatment, (b) reflections on what felt more and less helpful in supporting recovery, (c) the impact of MFT-BN on specific domains</p> <p>Data Analysis:</p> <p>Transcripts of the interviews and focus groups were analysed using reflexive thematic analysis. All authors (participated in data analysis and approached it from a critical realist epistemological position, from which meaning and experiences are considered subjective and influenced by social and cultural context. The analysis was more theoretical than inductive as it was driven by FT-BN theory around hypothesised change mechanisms.</p>	<p>United Kingdom</p>	<p>Reflexive thematic analysis</p>	<p>Multi-family therapy (MFT-BN) is a new treatment for adolescent bulimia nervosa with emerging empirical support. It extends the bulimia nervosa focussed family therapy model, by offering treatment in a group setting. Up to nine families work together with a team of clinicians over the course of 20 weeks. No qualitative study to date has investigated the experience of MFT-BN. This study aimed to explore this from the adolescent and parent/caregiver perspective</p>	<p>Setting: Interviews occurred in person, in a semi structured design. All using a combination of focus groups (~60 m) and individual interviews (~45 m)</p> <p>Context: Participants from two consecutive MFT-BN groups facilitated at the Maudsley Hospital in London, UK, were invited to participate in either a focus group or individual qualitative interview about the experience of MFT-BN. Of the 19 eligible participants (from 9 families), 15 (8 parents, 1 older sibling, 6 adolescents) consented and participated. Audio-recordings of interviews and focus groups were transcribed verbatim and analysed using reflexive thematic analysis</p> <p>Treatment:</p> <p>Multi Family Therapy based off the concepts of family-based therapy</p> <p>Culture:</p> <p>Two participants identified as Asian/mixed Asian, one mixed race, and three as white British.</p>	<p>Participants:</p> <p>Adolescents who participated in this study were aged between 13 and 17 at assessment (mean=15.17, sd=1.17). Four were diagnosed with BN and two with Atypical BN. Five identified as female and one as male. All were cis gendered. Mean duration of eating difficulties prior to assessment at MCCAED was 15.40 months (sd=18.26, range=6-48, median=7). To ensure anonymity of the sample, no further demographic information was collected for this study. No demographic information beyond gender was collected for parent/caregivers.</p> <p>Diagnosed Eating Disorder: Bulimia Nervosa</p> <p>Sample Size</p> <p>The total eligible sample included 19 people (7 mothers, 2 fathers, 1 older sibling, 9 adolescents) from 9 families (group 1, n=5 families; group 2, n=4 families)</p>	<p>Three main themes were identified: (1) seeing and being seen, (2) holistic shift, (3) the unspoken. Participants reported overall shifts in cognitions, emotions, behaviours, and relationships both individually and within the family because of attending MFT-BN. Meeting other families with similar struggles and sharing experiences, skills and learning helped reduce isolation and promote change. There was also a sense from participants that some things did not, or could not, be spoken about in the group context and that more direct and challenging conversations might have been helpful at times</p>
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<p>Konstantellou et al. (2019)</p>	<p>Data Collection: Thirteen young people with a restrictive ED were recruited from multi-family therapy groups run within the Maudsley Centre for Child and Adolescent Eating Disorders at the South London and Maudsley NHS Foundation Trust. Three focus groups were conducted asking young people to discuss their views, experiences and coping strategies when faced with uncertainty.</p> <p>Data Analysis: Data were analysed using interpretative phenomenological analysis (IPA). IPA is concerned with in depth explorations of individuals' subjective experience on a given phenomenon, how they make sense of it and what meaning they attach to it. IPA was chosen for the present study as the main aim is to understand how young people with a restrictive ED experience and manage uncertainty moving beyond a descriptive level and reaching a more psychological understanding. Interviews were transcribed verbatim by the first author and cross-validated by the second author.</p>	<p>United Kingdom</p>	<p>interpretative phenomenological analysis</p>	<p>Research is consistently reporting elevated levels of intolerance of uncertainty (IU) in individuals with an eating disorder (ED). Less is known about the phenomenology of uncertainty for this clinical group. The present study aims to advance our understanding of the relationship between IU and restrictive EDs by providing insight into young people's subjective experiences of uncertainty.</p>	<p>Setting: Three focus groups were run, two of which consisted of five young people while the third one three young people. The composition of young people in all three focus groups was similar in terms of their age, diagnosis, and illness duration. The facilitator made notes on non-verbal information and group dynamics. All focus groups lasted approximately 45 min.</p> <p>Context: Thirteen young people with a restrictive ED were recruited from multi-family therapy groups run within the Maudsley Centre for Child and Adolescent Eating Disorders at the South London and Maudsley NHS Foundation Trust. Three focus groups were conducted asking young people to discuss their views, experiences and coping strategies when faced with uncertainty.</p> <p>Treatment: Multi-Family Therapy programme for AN (MFT-AN)</p> <p>Culture: Not reported</p>	<p>Participants: Young people were recruited from pre-existing groups as part of the Multi-Family Therapy programme for AN (MFT-AN) delivered by the Maudsley Centre for Child and Adolescent Eating Disorders, South London, and Maudsley NHS Foundation Trust. Inclusion criteria involved having a diagnosis of AN (DSM-IV) or Eating Disorder Not Otherwise Specified restrictive subtype (EDNOS-R; DSM-IV) established at initial clinical assessment by the clinical team and aged between 12 and 18 years. A total number of 13 young people took part in the study</p> <p>Diagnosed Eating Disorder: 10 participants had restrictive anorexia Nervosa and 3 participants had eating disorders not otherwise specified restricting subtype</p> <p>Sample Size: A total number of 13 young people took part in the study.</p>	<p>Data were analysed using interpretative phenomenological analysis which yielded five superordinate themes: (1) young people perceived uncertainty as something negative; (2) high levels of anxiety and stress were identified as primary responses to uncertainty; (3) ED behaviours were given a functional role in reducing uncertainty; (4) need to control various aspects of young peoples' lives was of high importance; (5) young people discussed how they struggled to find ways to cope with uncertainty and often used behaviours associated with the eating disorder psychopathology as coping strategies. Several subordinate themes were highlighted in each of the primary five theme</p>
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<p>Ma (2012)</p>	<p>Data Collection: The recovered young person and the family were invited to participate in the post-treatment interview on a voluntary basis, with the interview lasting for an hour and being audio-taped for verbatim transcription</p> <p>Data Analysis: Content analysis was adopted to identify the clinical themes. All transcriptions were analyzed to identify the main themes evolving around the addressed issues. Themes generated from the data gathered from the videotape reviews and from the post-treatment interviews were compared and examined to identify their similarities and differences.</p>	<p>China</p>	<p>Case Studies</p>	<p>The purpose of this article is to report the results of a qualitative study conducted in Shenzhen, China that aims (1) to identify the symptomatic cycle of family interactions that have maintained the symptoms of the disorder; (2) to find out if the family therapist has, in her facilitative role, effected the contextual change in the family and to track the process of the therapeutic change; and (3) to understand the roles of the family and the therapist in effecting such changes.</p>	<p>Setting: Five families were drawn from a larger treatment project of Chinese families with ED (n = 20) attending a family treatment centre of a Shenzhen hospital from January 2004 to December 2008. Recovery from the disorder was indicated by an increased body weight and body mass index (BMI), resumption of menstruation in the case of the female patients, improvement in psychological well-being, and perceived family functioning. One-and-a-half-hour family therapy sessions were conducted at the centre in Putonghua, the national language of China, on biweekly basis.</p> <p>Context: Case studies (Yin, 1994) were used as the research method for this study. Case studies refer to "an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident. This study is part of the research aiming to assess the applicability of family therapy for Chinese patients suffering from ED in Shenzhen, China. Ethical approval was obtained from the University Research Ethics Committee.</p> <p>Treatment: Family Based Therapy</p> <p>Culture: Chinese participants</p>	<p>Participants: The three female patients and one male were diagnosed with AN, and one female suffered from bulimia. The average number of family therapy session these patients had attended was 13.6, with the duration of treatment lasting from 6 months to 2 years. Ages of participants have been noted twice within this article (13yrs + 15yrs), nil full demographic data has been presented on the participants.</p> <p>Diagnosed Eating Disorder: Anorexia Nervosa and Bulimia</p> <p>Sample Size: 4 participants</p>	<p>Two emerging themes in relation to the perceived changes were identified: (1) the perceived contextual changes, including the involvement of the previously disengaged father in the care of the young person suffering from an eating disorder to disrupt the symptomatic cycle in the family, and the change in the parenting methods, and (2) the different roles played by the emaciated young person, the parents, and the therapist in healing.</p>
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<p>(Medway et al., 2019b)</p>	<p>Data Collection: Semi-constructed face-to-face interviews, which were approximately 1 hour in duration. Interviews were audio-taped, and participants were asked open ended questions from when they first noticed symptoms of their eating disorder to the period post FBT.</p> <p>Data Analysis: Narrative inquiry method</p>	<p>Australia</p>	<p>Not reported</p>	<p>The aim of this study was to explore the role that FBT plays in fostering adolescent development beyond the markers of weight and eating disorder symptomatology. The study aimed to explore the lived experience of adolescent development, as defined, and told retrospectively, by young people</p>	<p>Setting: Young people and parents completed separate semi-structured face-to-face interviews, which were approximately 1 hour in duration. Interviews were audio-recorded. Participants were prompted to tell their story from when they first noticed symptoms of AN, through their period of being unwell, receiving FBT and the period since FBT.</p> <p>Context: Participants were identified from records of families who had received outpatient FBT at the Eating Disorder Service at the Children’s Hospital at Westmead, NSW, Australia. Participants’ files were used to verify their completion of an adequate number of sessions of phases two and three. Eligible families were sent an invitation letter from the Eating Disorder Service coordinator, followed by a phone call inviting them to participate.</p> <p>Treatment: Family-Based therapy</p> <p>Culture: Not reported</p>	<p>Participants: 12 young people 11 were female and the mean age of disease onset was 14. Participants had ceased FBT on average 4 years prior to participation.</p> <p>Diagnosed Eating Disorder: Anorexia Nervosa</p> <p>Sample Size: 12</p>	<p>This study aimed to explore the perspectives of young people and their parents regarding the developmental impact of AN, and the role of FBT in addressing developmental challenges. Young people (N=12) who ceased FBT a minimum 1 year prior, completed face-to-face semi-structured interviews, and data were analysed using a narrative inquiry method. All the participants described AN as highly disruptive to adolescent development, with phase one of FBT accentuating this experience. In phases two and three, FBT helped facilitate adolescent development in three keyways: Supporting return to adolescent pursuits, facilitating autonomy, and providing freedom to develop post-FBT.</p>
<p>(Mogorovich & Caltabiano, 2018)</p>	<p>Data Collection: Telephone interviews using a semi-structured questionnaire</p> <p>Data Analysis: Not reported</p>	<p>Australia</p>	<p>Not reported</p>	<p>The aim of this study was to explore the young people and their families’ experiences of the illness, and their access to and satisfaction with the services received. Of particular interest was their view of the working alliance with their therapist/s. Participants were interviewed by telephone using a semi-structured questionnaire</p>	<p>Setting: Telephone interview using a semi-structured questionnaire</p> <p>Context: Context in obtaining participants is not reported</p> <p>Treatment: Family based treatment or the Maudsley method</p> <p>Culture: Not reported</p>	<p>Participants: 14 young people participated in a telephone interview using a semi-structured questionnaire. The young people had been diagnosed with AN, all 14 young people were females, with ages at the time of the interviews ranging from 16 to 23</p> <p>Diagnosed eating disorder, Anorexia Nervosa</p> <p>Sample size:14</p>	<p>This study provided information about the therapies the respondents received during their attendance to CYMHS, about clinical issues, as well as about their experiences and perceptions of the services received. Typically, the respondents had encountered difficulties regarding early detection, appropriate intervention, and access to specialist services. The young people were open about their denial of the illness at initial presentation to CYMHS, and how they struggled with fear and guilt.</p> <p>Many of the respondents were engaged in treatment with CYMHS for over a year, and more than half had had a hospital admission. The participants who received the Maudsley treatment reported that they found it effective with significant improvement in physical markers such as weight restoration. As interviewees were volunteers, the sample’s representativeness is limited.</p>

<p>Nilsen et al (2019)</p>	<p>Data Collection: Thirty-seven semi-structured interviews of former adolescent inpatients were conducted. Participants' post-treatment reflections were inductively analyzed by applying a thematic analytic framework.</p> <p>Data Analysis: All 37 participants were included in the qualitative thematic analysis to allow as much diversity in views as possible. Transcripts were analysed according to six phases. The analysis was mainly informed by an inductive and semantic approach. Inductively analysing the transcripts meant that we aimed at staying sufficiently long with the raw material to "truly" grasp the meaning of the accounts. Applying a semantic approach implied that the explicit and surface meanings were primarily considered, rather than inferring beyond the content conveyed in the accounts, as would be the case with a more interpretative, implicit approach</p>	<p>Norway</p>	<p>Thematic analytic framework</p>	<p>This study aimed to understand how young persons with lived experience from a family-based inpatient treatment setting, where the adolescents were admitted together with their parents, viewed therapeutic aspects related to staff-patient collaboration and staff-related behaviours.</p>	<p>Setting: Twenty-six of the interviews were conducted on-site at the hospital, seven at the participant's home, three by telephone, and one in-person elsewhere. All interviews (including telephone interviews) were audiotaped. The qualitative interviews lasted between 30 and 100 min.</p> <p>Context: Thirty-seven (64%) of 58 invited former inpatients (33 females/4 males), provided written consent to participate in this sub-study. For the sole participant under the age of 16 (i.e., age of consent) at follow up, parental consent was also provided.</p> <p>Treatment: Family-based Inpatient treatment</p> <p>Culture: Not reported</p>	<p>Participants: There were no significant differences on clinical and demographic variables when comparing participants with non-participants. All had a primary diagnosis of AN and were admitted together with family members between 2008 and 2014. Prior to the family-based admission, all participants had received outpatient treatment at their local child and adolescent clinic.</p> <p>Diagnosed Eating Disorder: Anorexia Nervosa</p> <p>Sample Size: 37 Participants</p>	<p>Based upon user perspectives from a treatment setting highly influenced by a family therapeutic approach, findings revealed that former inpatients prefer tailored treatment and a collaborative approach. Eight subthemes constituting two main themes emerged:</p> <ol style="list-style-type: none"> 1) There are no ready-made solutions. Staff should facilitate collaboration by tailoring treatment toward the young person's perspectives, 2) Emphasizing skills that matter. Staff should display a non-judgmental stance, educate patients, stimulate motivation, enable activities, and prevent iatrogenic effects during the stay.
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<p>Nilsen et al (2021)</p>	<p>Data Collection:</p> <p>All former eating disorders 393 patients (N = 58) who had received family-based inpatient treatment between 2008–2014 were invited to participate in the study. Former patients who consented to participate (N = 37) took part in a semi-structured interview. Qualitative interviews were conducted by either a senior researcher, a clinical psychologist, one psychiatrist or a psychiatric nurse. Twenty-six of the interviews were conducted on-site at the hospital, seven at the participant’s home, three by telephone, and one in-person elsewhere. All qualitative interviews (including telephone interviews) were audiotaped and transcribed verbatim, and lasted between approximately 30 and 100 minutes</p> <p>Data Analysis:</p> <p>Data were analyzed by utilizing the framework of Thematic Analysis (TA) by Braun and Clark. Main themes were derived from the entire data set; hence all thirty-seven interviews were included to allow as much diversity in views as possible.</p>	<p>Norway</p>	<p>Thematic Analysis</p>	<p>With its “insider focus,” this study contributes to knowledge on how family based inpatient treatment is perceived from a user perspective. The current study has value for both advancing the development of family-based inpatient treatment, and by adding patient perspectives to the ongoing effort of providing family-based approaches at higher levels of care.</p>	<p>Setting:</p> <p>Qualitative interviews were conducted by either a senior researcher, a clinical psychologist, one psychiatrist or a psychiatric nurse. Twenty-six of the interviews were conducted on-site at the hospital, seven at the participant’s home, three by telephone, and one in-person elsewhere. All qualitative interviews (including telephone interviews) were audiotaped and transcribed verbatim and lasted between approximately 30 and 100 minutes.</p> <p>Context:</p> <p>In May of 2008, the adolescent inpatient unit at the Regional Department for Eating Disorders in Oslo restructured the standard treatment program from traditional individually based admissions, to provide family-based inpatient treatment. Without adhering to a manualized FBT program, the guiding treatment principles were inspired by outpatient FBT, with its focus on enabling parental authority and responsibility. The predominant treatment focus corresponds to the first phase in outpatient FBT.</p> <p>Treatment: Family Based Therapy</p> <p>Culture: Not Specified</p>	<p>Participants:</p> <p>The duration of ED prior to the admission was on average 2.7 years (range; 0.5–6.0, SD = 1.8), and mean age at admission was 15.8 years (range; 12.4–19.5, SD = 1.8). The majority (33/37) were admitted voluntarily. Mean length of stay was 20.8 weeks (range; 3–58, SD = 13.5), including planned leaves from the ward as part of the treatment program. None of the participants dropped out of treatment. The mean number of years from discharge to the follow-up interview was 4.5 years (range; 1.3–7.0, SD = 1.7). The mean age at follow up was 20.2 years (range; 15.8–25.3, SD = 2.6). Sixty-two percent (N = 23) reported that they had experienced no hospitalizations post the family-based admission. Thirty eight percent (N = 14) had received additional inpatient treatment during the follow-up period. At follow up, the majority (65%) had achieved normal body weight.</p> <p>Diagnosed Eating Disorder: Twenty-two participants did not meet the criteria for any DSMV ED-diagnosis, 8 met criteria for AN, 2 for BN and 5 for OSFED.</p> <p>Sample Size: 37 participants</p>	<p>The analysis yielded 4 main themes, constituted by in all 8 subthemes. The main themes were; 1) Enabling new ways of understanding and relating, 2) Enhancing or maintaining negative power dynamics, 3) Vulnerable transitions, and 4) Sibling relationships and different ways of involvement. With its “insider focus,” this study contributes to knowledge on how family based inpatient treatment is perceived from a user perspective.</p>
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<p>Nilsen et al. (2021)</p>	<p>Data Collection:</p> <p>Interview guides were developed separately for patients, parents and siblings by a group of experienced clinicians led by a senior researcher [IH]. Interview guides were piloted and revised before the final completion. Despite subtle differences, all interview guides were semistructured and organized into three broad sections to cover perspectives related to the pre-admission phase, admission, and post discharge. Patients and siblings were interviewed individually. Parents were given the opportunity to choose whether they wanted to be interviewed separately or together.</p> <p>Data Analysis:</p> <p>Starting out our analysis was inspired by a multiperspectival interpretative phenomenological analysis (IPA) framework. After analyzing the individual interviews case-by-case, we used substantial time to explore whether we could find any thematic development that supported a shared family narrative, that is, we searched for themes potentially shared within the family as a whole, and also for similarities and discrepancies between families.</p>	<p>Norway</p>	<p>Interpretative phenomenological analysis (IPA) framework</p>	<p>The aim was to investigate family members' perspectives following a family-based inpatient treatment program for adolescent anorexia nervosa and to discuss clinical implications for treatment providers.</p>	<p>Setting:</p> <p>In 2008, the EDU changed the treatment program in order to provide a family-based inpatient treatment program. This restructuring was guided by a) the promising evidence-base from research on outpatient family-based therapy for AN, b) the wish to prevent separating the ill child from caregivers during hospitalizations and c) the specific legal situation in Norway, where children have a legal right to be accommodated by a parent during hospitalization. Since then, up to 5 families have been treated at the same time.</p> <p>Context: Interview guides were developed separately for patients, parents, and siblings by a group of experienced clinicians led by a senior researcher [IH]. Interview guides were piloted and revised before the final completion. Despite subtle differences, all interview guides were semi structured and organized into three broad sections to cover perspectives related to the pre-admission phase, admission, and post discharge.</p> <p>Treatment: Family-based therapy</p> <p>Culture: Not reported</p>	<p>Participants:</p> <p>Post-treatment perspectives from eight former inpatients and their family members were included (8 former patients, 14 parents, and 10 siblings).</p> <p>Mean age at admission was 15 years (range: 12-18) and mean age at follow up was 19 years (range: 16-21). Mean length of stay was 21.4 weeks (range: 8-58), including planned leaves as part of the treatment program. All patients had an admission diagnosis of AN. No statistically significant differences existed between the 8 participants and the 29 non-participating patients for the following variables: age at admission, duration of ED before admission, length of stay, weight and BMI percentile at admission and discharge, time elapsed between discharge and follow up and EDE-Q global score at follow up.</p> <p>Diagnosed Eating Disorder:</p> <p>Anorexia Nervosa</p> <p>Sample Size: 8 Adolescents</p>	<p>Five main themes were identified: 1: Expectations and evaluation of needs. Entering treatment from different vantage points, 2: Interactions with peers during the admission as highly beneficial or problematic, 3: Perspectives on staff expertise and the eating disorder unit's structure, 4: Influencing within family relationships in different ways, and 5: Being admitted is at best only half the job: reflections on leaving the eating disorder unit.</p> <p>As this article focused on parental perspectives, only the adolescent illustrations were collected.</p>
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<p>(Sibeoni et al., 2020)</p>	<p>Data Collection: This qualitative study, using semi-structured interviews, took place in France. Data collection by purposive sampling continued until we reached theoretical sufficiency.</p> <p>Data Analysis: Thematic</p>	<p>France</p>	<p>Not reported</p>	<p>The aim of this study was to explore the experience of therapeutic alliance in inpatient treatment among adolescents with anorexia nervosa, their parents, and their psychiatrists.</p>	<p>Setting: Data came from semi-structured interviews with an open-ended approach. The interviewers used an interactive conversational style and a list of areas of experience to be explored with adolescents, parents, and psychiatrists. The participants were the experts on their own experience, and the interviews were conducted in a way that offered them the opportunity to recount it.</p> <p>Context: This exploratory multicentre study took place at the Department of Adolescent Psychiatry at the Argenteuil Hospital Centre, in the outpatient unit receiving adolescents with AN who had previously been hospitalized in specialized departments in the Ile de France region, and at the Rouen University Hospital Centre, the regional referral centre for the most severe cases of AN, those not responding to first-line treatment by their local mental-health professionals</p> <p>Treatment: Not reported</p> <p>Culture: French Citizens</p>	<p>Participants: 15 teenage girls aged between 13-17years. The Average length of engagement of treatment was between 2-8 months.</p> <p>Diagnosed Eating Disorder: Anorexia Nervosa</p> <p>Sample size: 15 teenage girls</p>	<p>Forty-one participants were included, 15 teenaged girls, 18 parents and 8 psychiatrists. Analysis showed two themes: (1) what facilitates an alliance in treatment - with four facilitators: (a) human qualities, (b) an active role in the treatment, (c) taking time and (d) taking care of the entire family and (2) what impedes an alliance in treatment with four obstacles: (a) being too close or too distant, (b) focusing on weight, (c) control and constraints and (d) psychiatrization.</p>
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<p>Voriadaki et al (2015)</p>	<p>Data Collection:</p> <p>The study was approved by the Joint South London and Maudsley and the Institute of Psychiatry National Health Service Research Ethics Committee. Participants were first approached at the MFT introductory evening (Day 0) held a week prior to the 4-day treatment block and gave their written informed consent to join the study. A mixed methodology was used, which involved multiple methods of data collection to provide an in-depth account of the process of treatment. This included using rating scales, daily journals, focus groups and researcher observation, in an effort to capture the participants' experience to the highest possible degree.</p> <p>Data Analysis: The qualitative approach used in this study was interpretative phenomenological analysis, which acknowledges that an in-depth understanding of the participant's experience involves the researcher's ability to interpret the data. Data from each instrument or method were analysed separately and emerging themes were clustered by day (1 to 4) and subgroup (adolescents' or parents' experience). Then, themes and clusters of themes that had emerged from each data source were combined in a search for meaningful connections and re-clustered by day, given that there were themes that emerged more on some days than others and the aim of the study was to capture these day-to-day changes</p>	<p>United Kingdom</p>	<p>Interpretative phenomenological analysis</p>	<p>The present pilot study aims to contribute to our understanding of the process of change that takes place in MFT for adolescent AN. To this end, the experiences of a group of six families during a 4-day MFT course are closely examined from day to day and connections are explored as to how changes in cognitions, emotions or behaviour are related to particular aspects of the treatment and interventions used</p>	<p>Setting: The MFT treatment consists of 10 full days of treatment over a period of 9 months. The first 4 days of MFT treatment are always consecutive days in the same week. The study focused on this part of the treatment because our clinical experience suggests that these intensive 4 days lead to the greatest amount of change in a short period. For practical reasons it was also not possible to extend the study over the whole period of treatment. The group studied ran from Monday to Thursday (Day 1-4), from 10 am to 4 pm.</p> <p>Context: The study was approved by the Joint South London and Maudsley and the Institute of Psychiatry National Health Service Research Ethics Committee. Participants were first approached at the MFT introductory evening (Day 0) held a week prior to the 4-day treatment block and gave their written informed consent to join the study. A mixed methodology was used, which involved multiple methods of data collection to provide an in-depth account of the process of treatment. This included using rating scales, daily journals, focus groups and researcher observation, in an effort to capture the participants' experience to the highest possible degree.</p> <p>Treatment: Multi-family therapy</p> <p>Culture: Five families were White British and one was Asian British.</p>	<p>Participants:</p> <p>Participants were recruited from one MFT group that took place at the Child and Adolescent Eating Disorders Service at the Maudsley Hospital in London. This MFT group consisted of six families. All the parents (six mothers and four fathers), together with five of the six adolescents who participated in the group, were recruited into the study. The parents of one adolescent did not give their consent for her to participate in the study but consented to take part themselves and for the researcher to attend the group as an observer.</p> <p>Diagnosed Eating Disorder: All five adolescents were girls aged 15 to 16 years who were clinically assessed and met DSM-IV criteria for AN</p> <p>Sample Size: 5 adolescents</p>	<p>There were 4 main themes for this study, that align with the day of therapy being received by participants. Within each main theme there was a total of 12 subthemes. As this study focused on the perspectives of parents and adolescents, the adolescent perspective were evident in;</p> <ul style="list-style-type: none"> Enhanced motivation, optimism and hope. Adolescents felt sympathy and guilt for the frustrating position of the parents. Feelings of hope for the future on the part of the adolescents tempered by a sense of entrapment Increased emotional expression. Mutual support versus isolation. Adolescents complained about changes, but remained motivated.
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<p>Wallis et al (2017)</p>	<p>Data Collection: A Constructionist grounded theory design was employed with purposive sampling. Sixteen young people between 12 and 18 years with a good outcome in FBT and twenty-eight of their parents participated. Young people and their parents took part in separate interviews at the end of treatment. Each interview was transcribed and analysed to identify a unifying phenomenon across the data to elicit a theory that explained the data and then integrated into existing theory.</p> <p>Data Analysis: Each interview was analysed using grounded theory principles. Analysis was progressive using a constant comparative method. Initial codes from the interviews were clustered and a second level of focused coding completed to develop a core category and explanatory framework.</p>	<p>Australia</p>	<p>Constructionist grounded theory methodology</p>	<p>The aim of this study was to understand the impact of FBT on family relationships and investigate this process of change for families with a good outcome to generate new theoretical insights to guide future enhancements to treatment interventions.</p>	<p>Setting: In-depth, face-to-face interviews were conducted with each young person and their parent(s) separately. Interviews lasted between 30 and 60 min and were audio recorded and transcribed verbatim.</p> <p>Context: Families who completed the 20-session protocol with weight greater than 85% EBW were invited to participate during the RCT follow-up period until data saturation occurred. To be included at least one parent and the young person needed to complete the interview, 6- months or more after completing treatment. The coordinator of the RCT provided information about the research to interested adolescents and their parents meeting inclusion criteria. Of the 17 families approached none declined, however one young person decided not to be interviewed and this family was withdrawn leaving 16 participants.</p> <p>Treatment: Family Based Therapy</p> <p>Culture: Not Specified</p>	<p>Participants: Sixteen adolescents aged between 12 and 18 years and 28 parents who had completed outpatient FBT participated in the study. Fourteen families had two parents, one was a single parent, and one had a parent pass away during follow up. All participants met the criteria for DSM-IV Anorexia Nervosa</p> <p>Diagnosed Eating Disorder: Anorexia Nervosa</p> <p>Sample Size: 16</p>	<p>Prior to treatment families' experienced significant conflict, disconnection, and isolation. The FBT structure, therapist direction, and the specialist medical setting created a process of relational containment. This enabled parents to trust the process of FBT and develop confidence in their executive role in the family. In turn this allowed the adolescent with anorexia nervosa to trust their parents, feel more secure and gradually engage in the treatment process themselves. Improvements in closeness, communication and adolescent sense of self were reported after FBT.</p>
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Table 2.

Qualitative Study	S1*	S2*	S3*	S4*	S5*	S6*	S7*	S8*	S9*	S10*
Baumas, V. et al (2021)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Conti, J., et al. (2017). "Somebody Else's Roadmap': Lived Experience of Maudsley and Family-based Therapy for Adolescent Anorexia Nervosa." Australian & New Zealand Journal of Family Therapy 38(3): 405-429.	U	Y	Y	Y	Y	U	Y	Y	Y	Y
Conti, J., et al. (2021). "'I'm still here, but no one hears you': a qualitative study of young women's experiences of persistent distress post family-based treatment for adolescent anorexia nervosa." Journal of eating disorders 9(1): 151.	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Coopey & Johnston (2022)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Dimitropoulos et al (2017)	Y	Y	Y	Y	Y	U	Y	Y	N	Y
Escoffie et al. (2022)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Konstantellou et al. (2019)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Ma (2012)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Medway, M., et al. (2019). "Adolescent development in family-based treatment for anorexia nervosa: Patients' and parents' narratives." <i>Clinical Child Psychology and Psychiatry</i> 24(1): 129-143.	Y	Y	Y	Y	Y	Y	Y	U	Y	U
Mogorovich, G. and N. J. Caltabiano (2018). "Therapeutic Alliance and Anorexia Nervosa Treatment Outcomes: Experiences of Young People and Their Families." <i>Community Mental Health Journal</i> 54(8): 1259-1265.	U	U	Y	U	Y	N	N	N	Y	Y
Nilsen et al (2019)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nilsen et al (2021)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Nilsen et al (2021)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Sibeoni, J., et al. (2020). "Obstacles and facilitators of therapeutic alliance among adolescents with anorexia nervosa, their parents and their psychiatrists: A qualitative study." <i>Clinical Child Psychology and Psychiatry</i> 25(1): 16-32.	Y	Y	Y	Y	Y	Y	Y	U	Y	Y
Voriadaki et al (2015)	Y	Y	Y	Y	Y	N	Y	Y	N	Y
Wallis et al (2017)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Note: Check List Questions*:

S1: Is there congruity between the stated philosophical perspective and the research methodology? S2: Is there congruity between the research methodology and the research question or objectives? S3: Is there congruity between the research methodology and the methods used to collect data? S4: Is there congruity between the research methodology and the representation and analysis of data? S5: Is there congruity between the research methodology and the interpretation of results? S6: Is there a statement locating the researcher culturally or theoretically? S7: Is the influence of the researcher on the research, and vice-versa, addressed? S8: Are participants, and their voices, adequately represented? S9: Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body? S10: Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

*Three levels of assessment quality scores

Yes (Y) (CLEAR)
Unclear (U)
No (N)

Lived Experiences of Adolescents (Synthesized Findings)

Overall, there were 60 unequivocal and 99 credible findings (see Supplementary Table 1) and thirteen categories which were synthesized into three domains overviewing the lived experiences of ado-

lescents receiving family-based therapy/ Maudsley method, see Table 3. The synthesized findings related to "psychological distress", "relationship breakdown" and "the role of the therapeutic alliance and the healthcare system".

Supplementary Table 1: Qualitative Study Findings and Illustrations.

Authors	Findings	Illustrations (Page Number)	Evidence	Unequivocal	Credible	Unsupported	Revised Finding Number
Baumas, V. et al. (2021)	Impact on the Family unit	p.5	Adolescent 1: "With my sister we laugh all the time, we have regained the complicity we had before, that is nice."	X			1
	Impact on the Family unit	p.5	Adolescent 3: "We are more affectionate. But not only in the words, well, in the words too. We have never been the type of people to say things to each other." Improvement of their parents' well-being	X			2
	Impact on the Family unit	p.6	Adolescent 1: "My mother, she has not really changed her behaviour except that she is more relaxed, she is not scared all the time anymore. [. .] My father is also more relaxed. He thinks about other things than me. They are no longer just the parents of a sick child.	X			3
	Impact on the Family Unit	p.5	Adolescent 1: "I understood that it must be hell to have a child who does not eat anymore."	X			4

	Impact on the Family Unit	p.5	Adolescent 3: (talking about his sibling): "I mainly noticed that during therapy's sessions, they spoke to me more freely, and they identified themselves a lot with others. It was cool. Not necessarily in terms of how they behaved afterwards, but during the sessions they were involved"	X			5
	Benefits of Group Work	p.5	Adolescent 2: "Seeing other people who were in the same situation as I was, it helped me. It helped me to talk with them."	X			6
	Impact on the disease	p.5	Adolescent 1: "Now I am able to focus on something other than weight, sport, and food."	X			7
	Impact of the Disease	p.5	Adolescent 1: "A year ago I was shy. In the eyes of others I had to be perfect, I controlled everything I said, I could not cross any line, now I do not care. I can party, I can dance, I can let loose with my friends, there is no more problem. Even with people I do not know."	X			8
	Impact of the Disease	p.5	Adolescent 2: "I feel much better, I am less sad, I cry less, I see life in a less negative way. In the last year, there have been many changes."	X			9
	Conflict with the model	p.5	Adolescent 1: "At one point, when I was finally getting out of it, and there was a therapy session, and there were other people who said they wanted to stop eating carbohydrate, I felt bad. [. . .] Finally, I got out of it, and I think that it made it stronger, because there were comments like that. But it hurt me a little	X			10
	Conflict with the Model	p.5	Adolescent 1: "Sometimes it was a bit frustrating because we could start to speak about an issue that we wanted to talk through, or we really wanted to get into more family centred issues. But as we were in a group and we were not there to talk about ourselves, well, we cut it short."	X			11
Authors:	Findings (Themes in Paper)	Illustrations (Page Number)	Evidence	Unequivocal	Credible	Unsupported	Revised findings number
Conti, J., et al. (2017)	Trying and 'failing': impacts of MFT/FBT on family alliance. <ul style="list-style-type: none"> Conflict 	409-410	Hayley: [...] it didn't focus on my emotions and what was going on in my head and focused on, and the Maudsley approach was happy to sort of put those thoughts at bay so long as the food went in. And when I cried or when I screamed, I don't think my parents really understood how hard it was, what I was feeling, what I thought about myself. Like they obviously knew it was hard, but I think maybe they thought I was being difficult. So, this sort of battle between me and my parents didn't really cause healthy relationships".	X			12
	Trying and 'failing': impacts of MFT/FBT on family alliance. <ul style="list-style-type: none"> Hidden & Family Stories 	411-412	Hayley: [...] I used to be crying on a daily-basis um and just felt like no one understood and felt like when mum and dad were doing this family-based therapy if I got anxious and started crying then they'd get mad at me for crying and then they'd say, like they'd call me, just, they'd call me mean things but I know they didn't mean it but everyone just got (pause) it wasn't a good dynamic but it's got much better.		X		13

	<p>'Failing' and standing for self and others: Roles and identity formation</p> <ul style="list-style-type: none"> Loss and reclaiming of identify and voice 	416-417	<p>Hayley: [...] Every time like everything around food that I said, they thought it was the eating disorder.</p>	X			14
	<p>'Failing' and standing for self and others: Roles and identity formation</p> <ul style="list-style-type: none"> Loss and reclaiming of identify and voice 	416-417	<p>Hayley: I think I had enough to convince myself that the eating disorder is lying to me and that like up there was just that sort of spark of hope and determination which really helped me to imagine life without it.</p>	X			15
	<p>What can be learnt for future therapies for adolescent AN</p> <ul style="list-style-type: none"> Significance of mobilising family commitment in therapy 	418	<p>Hayley: [...] although it [MFT/FBT] was very unenjoyable, I don't think I would have been able to gain that weight and get to the medically stable point if it had sort of been all up to me. I don't think I was in a mentally ok place to, even if I was having really helpful cognitive therapy. I think at that point I still definitely needed my family support because otherwise I think, even if it was unintentionally, I would've just slipped back. So having their support and knowing that I wasn't going to (pause), knowing that it wasn't sort of all on my shoulders, that they were helping me, to get the food in and to physically be healthy was good. [...] I had a really nice therapist, and knowing that (pause) I didn't always have to have a sort of battle in my head - "Should I have this or not?" "Should I be having something with lower calories than this?" Knowing that that sort of decision making wasn't up to me, um, ah, gave me a little bit of relief. [...] I think I also (pause) knowing that my parents cared for me and were prepared to take me to whatever treat- meant or you know, spend as much as they needed to get me back, so that helped me to know I wasn't on my own."</p>		X		16
	<p>What can be learnt for future therapies for adolescent AN</p> <ul style="list-style-type: none"> Addressing emotions and prioritising the adolescent's voice 	419	<p>Hayley: [...]my current therapist and I see a dietitian as well, it wasn't like, it wasn't like as soon as I saw them everything was great but [...] generally helped me to understand if there's a meal and I get anxious around it or nervous or start to cry or any of those signals, instead of just going "I'm scared of the food," she sort of helped me to think "well why are you scared of the food? What does that mean?" and helped me to think rationally and enjoy food more and trust her and the dietitian, [...] I've gained weight and much as healthy as I've ever been and there was much less arguments.</p>	X			17

Authors	Findings (Themes in Paper)	Illustrations (Page Number)	Evidence	Unequivocal	Unsupported	Revised findings number
Conti, Joyce et al. (2021)	Therapeutic Focus <ul style="list-style-type: none"> Focus on the invisible (psychological distress) 	7	Harley: Because they never really addressed the underlying problems, it was all so much harder than it probably should have been, because I was still battling with the thoughts and battling with the guilt and all that.	X		18
	Therapeutic Focus <ul style="list-style-type: none"> Focus on the invisible (psychological distress) 	7	Beth: [...] [...] I never really got a chance to properly, like talk out, like my anger, like with people. Like I never got to just express how I was really feeling, which is probably why I was so angry, because it was all, like building up inside, because I never got to express how I was feeling.	X		19
	Therapeutic Focus <ul style="list-style-type: none"> Focus on the invisible (psychological distress) 	7	Kate: [...] I never got to the point where I could really end my life but there were feeling just wanting it to end because it's easier than the voices that are in your head.	X		20
	Therapeutic Focus <ul style="list-style-type: none"> Focus on the visible (ED symptoms) 	6	Kaylee: [...]The whole control aspect, it was, my parents had full control which made me feel real safe.			21
	Therapeutic Focus <ul style="list-style-type: none"> Focus on the visible (ED symptoms) 	6	Kate: It was helpful...that saved my life. 100%. Going to that first appointment, they put me on eating plan. [...] I'm glad that they got someone to be my eyes in that sense because I would not be here today.	X		22
	Identity Negotiations <ul style="list-style-type: none"> A life worth saving 	10	Maisy: [...] my parents [...] were always there telling me that I would get through this and that I was a strong person and – and that no one was ever going to give up on me.	X		23

	Identity Negotiations <ul style="list-style-type: none"> A life worth saving 	11	Hayley: I think I don't want to forget um, (pause), ah how much care I have seen shine through people in this, like my parents have been support- I've the whole time and shows how great they are.	X		24
	Identity Negotiations <ul style="list-style-type: none"> Negotiating personal agency and voice 	8	Phoenix: Because at one stage I felt like a monkey in a cage and had no control. My parents were doing everything for me.			25
	Identity Negotiations <ul style="list-style-type: none"> Negotiating personal agency and voice 	8	Lydia: I think to a certain degree, the treatment team had drilled into them [parents] that um I was not a person, I was an eating disorder and giving the reins to an eating disorder.	X		26
	Identity Negotiations <ul style="list-style-type: none"> Negotiating personal agency and voice 	9	Nora: [...] just the fact that you had an eating disorder meant they were dismissive of anything you say, they believed anything you say was completely motivated by the eating disorder [...] I was very distressed by that because I thought I'm still me, I'm still here, I can recognise that I have anxiety and unhelpful thoughts but I can still communicate as a person. [...] I'm still me.	X		27
Authors	Findings	Illustrations (Page Number)	Evidence	Unequivocal	Unsupported	Revised Finding Number
Coopey & Johnson (2022)	Process of Understanding: Understanding your not alone	p.4	Lilly " think it was nice to talk to other people, other parents, er, they knew they weren't alone and they gave them the tools to progress".			28
	Process of Understanding: Understanding your not alone	p.4	Morty " groups and stuff for like parents to understand and stuff ... it helps like with my parents and stuff to understand and helps me to like try and deal with things a bit better".			29
	Process of Understanding Understanding your not alone	p.4	Molly "It was almost Multi-Family Therapy was less for us, more for our parents, or at least that's what we felt."	X		30
	Process of Understanding Others Understanding	p.4	Lilly "I think that they'd say that [pause] their [pause] view of anorexia has changed probably ... They see it as more a mental illness"		X	31
	Process of Understanding Others Understanding	p.4	Lucy "Erm [pause] helped them understand the emotions associated with it [pause] and how it's not one-sided ever. It's always two sides".			32

Process of Understanding I am Understood	p.4	Morty "...I think she also thought like, about like I was choosing to be unwell and stuff but yeah."		X	33
Process of Understanding I am Understood	p.4	Lilly "Er, they know how to manage my meltdowns... and they know how to properly support me at mealtimes"			34
Process of Understanding I am Understood	p.4	Molly described them as: "a lot more accepting"			35
Reviving Connection Altering the System	p.5	Molly "...having someone a third-party label it... makes it much easier to have conversations...I don't sometimes have to say what I really think but they still understand what's going on."			36
Reviving Connection Altering the System	p.5	Lucy "... having a voice from someone else...you need someone else to kind of have an input."			37
Reviving Connection Altering the System	p.5	Meghan "... we did a role play ... we were the parents [okay] and I think that sort of opened it up for a lot of us, sort of actually seeing sort of what it must be like in your parents' perspective..."			38
Reviving Connection Altering the System	p.5	Molly "a lot more aware of each other"		X	39
Reviving Connection Taking it forward	p.5	Meghan "...not just like me and my family, my family's got closer with each other as well..."			40
Reviving Connection Taking it forward	p.5	Molly "... being able to have more conversations, have like brother as an ally rather than someone to compete against."			41
Reviving Connection Taking it forward	p.5	Molly "...building on creating almost a new element of family is really difficult and still is..."		X	42
Emerging from the eating disorder. Understanding the immersion	p.6	Molly "it got to a point where I wanted to get better and I knew I couldn't do that at home".	X		43
Emerging from the eating disorder. Understanding the immersion	p.6	Lucy "I wasn't really making enough progress in the community. So it was, yeah, I was sent there"			44

Emerging from the eating disorder. Understanding the immersion	p.6	Morty "they've helped with like, er, trying to get, er, back into like eating different foods.	X		45
Emerging from the eating disorder. Understanding the immersion	p.6	Meghan "...I look back and realise how bad I used to actually ...I'm eating now, but like a couple of months ago, I probably wouldn't eat anything at all."	X		46
Emerging from the eating disorder. The eating disorder was damaging	p.6	Lilly "what it would look like it would be like spikey..." "We're definitely not as close..., I really took it out on her."			47
Emerging from the eating disorder. The eating disorder was damaging	p.6	Molly "just the relief ... you're not forcing your parents into that situation anymore is incredible... it's really difficult because you're constantly lying"			48
Development of I Adapting to the new norm	p.6	Lucy "It was hard...I just think being like taken away from your home is really difficult".			49
Development of I Adapting to the new norm	p.6	Molly "...you've just suddenly moved into like a new place and you're living with people [inaudible], so I was very scared when I first got here.". D			50
Development of I Adapting to the new norm	p.6	Meghan "...it was scary... then you make friends and ... close relationships with people, [pause] it's not as bad"			51
Development of I Adapting to the new norm	p.6	Morty "it just feels a bit more like, just a bit more like you get used to it...."			52
Development of I Adapting to the new norm	p.7	Lucy "I think, as time went on, it became more and more valuable and different activities we did",			53
Development of I The process of evolving	p.7	Lucy ... throughout my stay I became more [pause] involved in the session",			54
Development of I The process of evolving	p.7	Morty ...I've got more, er, calm with, er, sort of being in hospital, I guess..., the therapy like sort of changed how like I sort of felt as well...".			55

	Development of I The process of evolving	p.7	Lilly "My mental state is much different to the state it was in, feeling less upset, less tearful"			56
	Development of I The process of evolving	p.7	Meghan "...it's not just figuring out my problems, ... I feel like [pause] I'm more confident, just as a social [yeah] person as well as before I came in here as well."			57
	Development of I Finding my voice	p.7	Meghan "... I wouldn't dare to say anything before [yeah], I was very a keep to myself type of person, I can't really do that here [laugh]"			58
	Development of I Finding my voice	p.7	Lucy "... one of the things we did talk about in family therapy was how to deal with other people...now I can deal with it. So, I think that - talking about it did help."			59
	Development of I Finding my voice	p.7	Morty "maybe it's just because, er, I've been with loads of people on the ward and talking to them, maybe I'm a bit more used to talking."			60
Authors	Findings	Illustrations (Page Number)	Evidence	Unequivocal	Unsupported	Revised Finding Number
Dimi- tropoulos et al. (2017)	Theme 1: Family-related challenges as- sociated with transition	p.259-260	B4 When I left [paediatric hospital], I felt like I was ready to take it on myself. . . . I don't know if it was because it was like, I'm not a child anymore, I can't go to [paediatric hospital], so I have to take on those adult responsibilities. . . . I could have just been wrong and I wasn't able to take those things on, but it felt like I was. B4 "My mom expected it to continue like treatment at [paediatric hospital] where she was responsible and she was the one pushing me to do things"			61
	Theme 1: Family-related challenges as- sociated with transition	p.260	C1 When I left the program, I was 17. . . . I felt like I had to do it on my own.			62
	Theme 1: Family-related challenges as- sociated with transition	p.260	I16 As an adult, I feel I have a lot more autonomy and I don't have to do what she [my mother] says. I would always say, "as an adult, I don't have to listen to what you say. I can do it myself." I feel like she is not in charge anymore. . . .			63
	Theme 1: Family-related challenges as- sociated with transition	p.260	L4: "There's no sort of, like, in between. You go from being guided blindly to like, this is the truth, it's naked in front of you, and you have to figure out how to deal with it, and like manage it, and stuff"			64

	Theme 1: Family-related challenges associated with transition	p.260-261	A5: I think it was a lot harder to remain motivated [after discharge from paediatric care] because there was that unknown where I could just completely – [trails off]. I didn't have to go to [paediatric hospital].. anymore, I could stop the psychologist if I wanted to. I was an adult, I could make my own decisions. A5: :“Part of me wanted to get better and part of me didn't”			65
	Theme 1: Family-related challenges associated with transition	p.261	C4: When I left, I was happy because . . . I wasn't going to be told what to do or how to eat or clean my plate, things like that. I think I was more scared at the same time because I knew I was going to be on my own and . . . how quickly I could kind of relapse again.			66
	Theme 1: Family-related challenges associated with transition	p.261	E2-14: As much as I wanted to get out, it was like, “Oh God, what's going to happen?”		X	67
	Theme 1: Family-related challenges associated with transition	p.261	B17: Just give me some space, like, let me do some things myself. But at the same time, offer some support. Kinda like, let me do it, but be there when I need help and like, keep watching me...		X	68
	Theme 1: Family-related challenges associated with transition	p.261	F14: Giving more independence, but not making it completely up to you. And still say[ing] that you have to do things			69
	Theme 1: Family-related challenges associated with transition	p.261	G9: I feel like before she [my mother] was a bit overinvolved [because of] pressure from the program. . . . [Now] she's not really involved. She knows what's going on but she doesn't intervene or anything. . . . It's not really helpful, but it's not unhelpful.			70
	Theme 2: Conceptualizations of familial support during transition and ongoing recovery	p.262	K9: Being involved in my treatment means she's [my mother] part of doing it to me: whether that means supervising meals, making meals . . . monitoring me, all that stuff is being involved in the treatment. Being a support, I think, is just being there: I need to talk to you, I need to tell you, you need to offer me advice, and someone to listen and just remind me why I'm here, why I'm doing this. Stuff like that.			71
	Theme 2: Conceptualizations of familial support during transition and ongoing recovery	p.262	D5: “We were on a nutrition plan, and so basically, when I was in the transition phase, we just kind of kept up with that and my parents just tried to follow that a little bit more until I was comfortable doing things on my own. That took a while too, but definitely that helped because I wouldn't have known what to do on my own”			72
	Theme 2: Conceptualizations of familial support during transition and ongoing recovery	p.262	M7: “I think initially it was good to really give me a push to eat and to try to normalize it, but at the same time, it wasn't for myself. It was for other reasons and it wasn't enough to really sustain the foundations of wanting to heal for myself”			73

	Theme 2: Conceptualizations of familial support during transition and ongoing recovery	p.263	B14: My mom has always been a support. But I feel like sometimes she . . . takes too much upon herself and she makes me feel like I'm a child. When it's like, I'm 21..		X	74
	Theme 2: Conceptualizations of familial support during transition and ongoing recovery	p.263	H21: I tell them this is my recovery, you can't do it for me. Like, I want your support, but that's not the same as you doing it for me			75
	Theme 2: Conceptualizations of familial support during transition and ongoing recovery	p.263	M9: Especially at that age when you really want to start to gain independence, I felt like a child. . . . At some point, I felt like I really could be eating it on my own, and there was just no way that she would let me do that.			76
	Theme 2: Conceptualizations of familial support during transition and ongoing recovery	p.263	C5: I had my dad with me all the time, so I knew he understood my problem and he listened to my concerns if I had anything [sic] and he would give me advice..			77
	Theme 2: Conceptualizations of familial support during transition and ongoing recovery	p.263	D9: Now they're very supportive and my mom and dad always say to me, "if you ever want to talk about anything, we're here." And they'll check in once in a while and be like, "what's going on with you?" But it's never directly about the ED, it's just an open question. And I think they do that because they know now that it's not an issue, but they do let me know that they're there just in case			78
	Theme 2: Conceptualizations of familial support during transition and ongoing recovery	p.263	I16: She [my mother] could sympathize and listen to me when I am having trouble, and try to distract me. M12: Being able to have someone listen, I guess, and checking in. Maybe even just asking how your day is going, or if they're noticing habits, like talking to you about it.			79
	Theme 2: Conceptualizations of familial support during transition and ongoing recovery	p.264	C1: "During that time, it was really rough because I was basically on my own. I didn't really have any other support to look onto except my parents, but I felt like my parents didn't really understand what was going on"			80
	Theme 2: Conceptualizations of familial support during transition and ongoing recovery	p.264	H3 "They [my parents] don't know what it [ED] is, they think it's really weird. They don't know this type of thing existed, they thought I was just kind of going through a rebellious phase"			81

	Theme 2: Conceptualizations of familial support during transition and ongoing recovery	p.264	A16: The hardest part for my parents has been when I do experience a blip, they sort of go crazy.			82
	Theme 2: Conceptualizations of familial support during transition and ongoing recovery	p.264	M4: I'm glad she [my mother] was really on board and was worried at me, but at the same time, depending on the week – if I had lost or gained – then it definitely would affect how I was, you know, treated afterwards. And it was not, well, I didn't like that part of it.			83
	Theme 2: Conceptualizations of familial support during transition and ongoing recovery	p.264	P10: And my mom – our relationship is really, really good, and it's strengthened. But it's kind of also weakened because if something bad happens she totally flips out.			84
Authors	Findings	Illustrations (Page Number)	Evidence	Unequivocal	Unsupported	Revised Finding Number
Escoffie et al. (2022)	Seeing And Being Seen • Reduced sense of Isolation	p.5	"It has showed me that other people go through something that I thought was just me. If some people say 'when something happens to me I do this', I go 'oh my God! that happens to me also' and its reassuring" (adolescent)			85
	Seeing and being Seen • Learning from and with each other	p.5	"It was good listening to other people's ideas because that helped me think of my own things, of what would help me" (adolescent)			86
	Holistic Shift • Family Connection	p.5	My mum and dad [now] know how to help me, as opposed to just getting angry" (adolescent) "... I am definitely getting along with them [parents] better" (adolescent)			87
	Holistic Shift • New Insights and coping	p.5	"Like making a set plan of the eating, I thought that was helpful 'cause then like you are not hungry for you to binge or whatever and things like writing down your worries that was helpful" (adolescent) "I think it's benefited her as I said she has some insight into the reasons why she is doing it, so it's definitely had a positive impact on her" (parent/caregiver)	X		88
	Holistic Shift • Practical Help	p.5	"It's a lot of talking obviously, and then there's things like distractions and they do give you a lot of sheets [coping skills leaflets] so you can take stuff home with you so that it doesn't stay at the session cause it's easy to go home and kind of push it to the side but because they give you sheets and then you go through your bag and then you find it and you kind of remember and that's good" (adolescent)			89

	The Unspoken [no subtheme]	p.5	"[there] weren't exactly rules but ... you do start to think 'well is what I'm about to say, ok' and stuff like that, so you do kind of have to think twice before you say stuff which really isn't the point I don't think" (adolescent)			90
Authors	Findings	Illustrations (Page Number)	Evidence	Unequivocal	Unsupported	Revised Finding Number
Konstantellou et al. (2019)	Experiences of Uncertainty • Negative experiences of uncertainty	p.535-356	'...well uncertainty kind of scares me ...' (FG1, P4). 'I think I've found uncertainty quite hard and stuff...' (FG3, P12).		X	91
		p.535	'I think that also when it is more affecting you, like ... something that is going to happen ... in a football match...is much less anxiety provoking than when you are uncertain about what others think of you...' (FG2, P7).		X	92
	Experiences of Uncertainty • Positive experiences of uncertainty	p.535	'...well I really like uncertainty and I've just moved school and yeah I just... it's quite fun for me' (FG1, P1). 'I think that the good uncertainty... it can keep you with an open mind...' (FG3, P12).		X	93
		p.535	'...uncertainty can be good but it's primarily when you kind of instigates it yourself...it's like OK to not be certain about something when it is you who has kind of changed it because that way you still have a measure of control over it...' (FG1, P4). '...when it is good uncertainty it's like you know that something good is going to happen, and it is not going to result in something bad...' (FG3, P13).		X	94
	Experiences of Uncertainty • Uncertainty experienced by everyone		'I think everyone experiences it [uncertainty] and even from like young children to adults...' (FG3, P13).			95
	Experiences of Uncertainty • Cognitive bias and uncertainty	p.537	'...you are just so fixated on all of the bad possibilities that you kind of lose your mind to what could possibly be really helpful...' (FG1, P2). "I can't think of anything else, I just think about what could happen and how bad it could be..." (FG3, P12). With the bad uncertainty it is like you feel there is a worst case scenario that could happen and you are always focussing on that...' (FG3, P13).			96
	Responses to Uncertainty • Negative responses	p.537	'I get anxious and get really stressed can't concentrate or focus my mind on anything else' (FG3, P12).			97
	Responses to Uncertainty • Positive Responses	p.537	'I get the sort of like quite excited feeling in my stomach when something different happens...' (FG1, P1). 'I quite like it [uncertainty] at times it gives you an adrenaline boost...' (FG2, P7).			98

Responses to Uncertainty	• Before and after experiences of uncertainty	p.537	'...that's the thing after the uncertain thing happens, you...feel a whole lot better.....and I kind of feel better than I did before the uncertainty' (FG1, P3).			99
Anorexia and Uncertainty	• Function of AN	p.537	'... one of the things that I think sort of you get anorexia is from sort of not being in control of your life and you want something to be able to control, and food is one of those aspects' (FG1, P1). '... I felt more safe and secure like you said you can kind of you feel more in control and not eating made it easier coz I wasn't as anxious' (FG3, P12).	X		100
Anorexia and Uncertainty	• Uncertainty and presences of AN	p.537	'sometimes you have like a predisposition to get things like anorexia just because of your personality ...[AN] then increases it [uncertainty] to a whole new level, and just takes it to the kind of extreme so though you may already have had a difficulty with facing change... it just magnifies it...' (FG1, P2). 'I've always had uncertainty, like before I had the eating disorder...But I think you know the eating disorder has just really highlighted how much uncertainty was in my life ...' (FG3, P11).	X		101
Anorexia And Uncertainty	• Uncertainty and Recovery	p.537	'...the thing I'm most like uncertain about is when am I going to be in normal weight... I just don't know when it will happen I don't know ...how I will feel about it when it does...' (FG1, P3). '...The whole every day what's uncertain what is going to come next, is it going to be bad, if worst come to worst what is going to happen to me in after been in treatment, will I still be in treatment?' (FG3, P13).	X		102
Control	• Need for Control	p.538	'I like to kind of be in control of what I do' (FG1; P2). 'I have this compulsive urge to kind of ...know...kind of everything and if it doesn't work your way then it's quite distressing if you've gone to the trouble of like planning it' (FG1, P2).' Fear of not knowing...' (FG3, P11).	X		103
Control	• Change and Control	p.538	"...I tend to kind of get quite upset when situations present themselves to me that I had not expected... sometimes it is kind of worse when somebody tries to kind of make it how it was because it's already been changed and situations have already happened..." (FG1, P4). '... if something like did change, I'd prefer it if like if like on the spur of the moment it was me doing the change not like someone else telling me like this is the change you're going to do it.' (FG1, P3)	X		104
Control	• Total Control is unfeasible	p.538	'... the hard thing is trying to grasp the fact that not everything is in your hands and grasp the fact that you can't, you can't really plan everything because you don't actually know what is actually going to happen' (FG1, P3).		X	105
Coping	• Effective Coping	p.538	'... the hard thing is trying to grasp the fact that not everything is in your hands and grasp the fact that you can't, you can't really plan everything because you don't actually know what is actually going to happen' (FG1, P3).		X	106
Coping with Uncertainty	• Maladaptive Coping	p.538	'...coz I think you can end up having quite negative coping strategies that don't actually deal with it, they just steer it on to something else, like to deal with the uncertainty to try and get control in other areas or something' (FG1, P5). 'I don't think I cope very well, don't know how to or what ways...' (FG2, P8).			107

Authors	Findings	Illustrations (Page Number)	Evidence	Unequivocal	Unsupported	Revised Finding Number
Ma (2012)	Symptomatic Cycle • Between Patient & parents	p. 192	13yr Male w/ AN "Since my childhood, my mom kept forcing me to follow her way of doing things If I don't eat, she kept scolding me. I am overwhelmed by her excessive love. She is sick. She never thought that she could make any mistake. She forced us (the patient and his younger brother) to listen to her when she was crying; how painful she was in facing my father's infidelity; how my grandma and my aunties had ill-treated her in the past. I was frightened by her mood swings."	X		108
	Symptomatic Cycle • Between Patient & parents	p.193	15yr old w/ AN "My mom treats me as a prisoner at home. She keeps nagging me about eating and eating. Seemingly there's nothing else in my life except eating that deserves her care and concern. I know eating is important but it's sick to talk about it repeatedly."	X		109
	Roles in Healing	p.194	Patient L "All along I have a good relationship with my father. My relationship with my mom had improved a lot after treatment" (post-treatment interview). "He had never stayed at home for such a long time before my illness. I am happy, very happy. I like his company as he is knowledgeable. There are so many things that we can chat about."			110
	Roles in Healing	p.195	Patient L "He had never stayed at home for such a long time before my illness. I am happy, very happy. I like his company as he is knowledgeable. There are so many things that we can chat about."			111
	Roles in Healing	p.195	Patient L "In the past, my mom often said that my weight did not increase because I ate too little. She didn't know that the more she nagged me, the stronger my resistance; and the less effort I'll make to strive for recovery. She failed to appreciate my effort, however hard I have tried. Now we are happier. Each of us had slowed down the pace. . . . I was feeling better and better since they appreciated my effort"	X		112
	Roles in Healing	p.195	Patient L "He [father] was very encouraging. When I didn't eat much, I knew that he was quite anxious. Probably he had controlled himself. He didn't say anything bad about it. He just said: 'please don't force yourself to eat much this time if you don't like eating.' If I ate more, he was very pleased and praised me at once. I didn't want them to look miserable and depressed. I was happier when they were in better mood"			113
	Roles in Healing	p.197	Patient L "She [therapist] did not talk much about eating in treatment. She worked on the family relationships. Let's understand her work in this way. With the onset of the illness, the family must have problems and the family relationship must be damaged. . . . When our communication improved and our relationships were repaired, we became more harmonious and the child would listen to her parents" (post-treatment interview).			114
	Roles in Healing	p.197	Patient L "We quarrelled but she [therapist] tried to understand our conflict from different perspectives: my mom's, my dad's and my view. When my parents quarrelled with me, they had the upper hand. She [therapist] would side with me and let my parents see my views." Depending on the situation, she would not help me all the time. Sometime I was wrong. To my mom, she helped her to see things from my dad's and my perspective too" (the post-treatment interview).			115
Authors	Findings (Themes in Papers)	Illustrations (page number)	Evidence	Unequivocal	Unsupported	Revised Number
Medway, Rhodes et al. (2019)	Before FBT: developmental function and impact of AN	135	Emily: 'I still sat with them (friends) at lunch at school, but it was almost like there was no relationship there I was just a zombie'.			116

	Phase One of FBT: • Further Regression developmentally	136	Emily: 'I had to focus on getting better physically . . . I think it was a really important time, thirteen, fourteen, to start being your own person, and I didn't really get that opportunity'.			117
	Phase One of FBT: • Further Regression developmentally	136	Rebecca: 'thrown straight back to when I was 10 years old and reliant on my parents telling me what I can and can't do'.	X		118
	Beyond phase one: Three trajectories of adolescent development • Supporting return to adolescent pursuits	137	Grace: I had never kissed a boy. I'd never gone to a party . . . I'm quite lucky that it [AN] happened in that time of my life because you can't have a boyfriend if you don't eat . . . You're not going to get invited to parties . . . Whereas I think if I had gone through that now where I have all this freedom and have had those experiences, there'd be less motivation to seem normal and get normal.			119
	Beyond phase one: Three trajectories of adolescent development • Supporting return to adolescent pursuits	137	Tara: As I had more control, I felt like I was more free and more able to enjoy my social life or my schooling life or I was able to work . . . The more I got, the more beneficial it was for me because I was like, well this is great . . . How could I throw it away and go back to something like that?			120
	Beyond phase one: Three trajectories of adolescent development • Supporting return to adolescent pursuits	137	Sabrina: 'Once I was at a healthy weight and out of hospital, I just went nuts . . . I wanted to explore everything that I'd missed'.			121
	Beyond phase one: Three trajectories of adolescent development • Facilitating autonomy	137	Emily: Independence, things like boyfriends, going to parties, new relationships. I couldn't connect with that at all, it kind of scared me . . . If it was outside of family, I would get really nervous and scared'.			122
	Beyond phase one: Three trajectories of adolescent development • Facilitating autonomy	138	Emily: 'I was kind of attached to my parents because I had relied on them for so long . . . I think later on it [phase one] might have contributed to not being able to do things on my own'.			123

	Beyond phase one: Three trajectories of adolescent development • Providing freedom to develop post FBT	138	Sally: Therapy helped, but not in the way I thought it would . . . It helped me by annoying me until I wanted to avoid it . . . I just wanted to be living my life’.				124
Authors	Findings (Themes in Paper)	Illustrations (page number)	Evidence	Unequivocal	Credible	Unsupported	Revised Finding Number
(Mogorovich & Caltabiano, 2018)	Young person’s experience	1263	Example 1: [...] The unit was good but there was no specialist eating disorder program...I put on weight in hospital but remained sick”	X			125
	Young person’s experience	1263	Example 1a: “I needed someone to connect to...they need to understand what you’re going through, take into consideration what you say... it was scary, I didn’t even drink any water”		X		126
	Therapeutic alliance	1263	Example 2: “There were too many people in the room, they wanted to do the Maudsley, their method, wanted to do the family meal... they were professional but the service didn’t fit, didn’t meet our need”		X		127
	Therapeutic alliance	1263	Example 2a: “CYMHS suggested/pushed for Maudsley, wanted to slap the label even if it didn’t fit for us, it was like they were offended, my parents felt excluded, unsupported, stressful for everybody”	X			128
	Satisfaction with service	1263	Example 3: “The hospital didn’t make me feel better about food or eating...I was told my problems, my actions were being stubborn”		X		129
	Satisfaction with service	1263	Example 3a: “The lack of specialised care disrupted any chance of recovery, I was put in an acute ward with anorexia at 18 for 6 months...I just wanted to point out the massive gaps in the health system and the detrimental effects it has on people”.	X			130
Authors	Findings	Illustrations (Page Number)	Evidence	Unequivocal	Unsupported		Revised Finding Number
Nilsen et al (2019)	Subtheme It’s not always best to go by the book	p.4	P: ... individuality ... ehm ... yes ... be aware that they are different patients ... different disorders ... and different illness histories ... maybe not just do the same thing over and over again ... that it is not always ... it’s not always best to go by the book ... [P60].	X			131

	Subtheme 2: managing the balance between the symptoms and the person	p.5	P: I wish that, at least in certain phases of treatment ... that there could have been more focus on me, who I was, and not just how the ED influenced me. I was in pretty bad shape when I was admitted and it became easy, in a way, to not see me ... one only saw what was driving me. That was also a frustration I had back then, because I was really suffering and the ED became, in a way, my survival technique and that they in a way just took that from me, without giving me the chance to get better. That was very painful ... and ... that ... yes ... I did gain weight during that admission, but I didn't feel that I had really improved, thinking differently, when I was discharged ... [P56].	X		132
	Subtheme 2: managing the balance between the symptoms and the person	p.5	P: I often felt like a number, from week to week ... that in a way ... it was the number on the scale that decided how it went that week ... and that this didn't relate to how I felt ... and when you, or the staff, was most happy ... because I had gained ... that was the most difficult part for me ... [P10]	X		133
	Subtheme 3: managing the balance between flexibility and firmness	p.5	P: That I wasn't allowed to negotiate then ... That it was ... That I couldn't do. That was a good thing, because then I gave up on that, and ... even if it sounds a bit silly; that you should eat every last bit of that yoghurt ... it was ... making me safe ... [...] ... Ehm ... that it was ... ehm, that it was ... ehm ... strict ... that was at least making me secure ... [P34].	X		134
	Subtheme 3: managing the balance between flexibility and firmness	p.5	P: I think the rules should be more individually adjusted, so if you don't have a certain problem, you don't need to face the same rules as those who in fact struggle with it ... [P51].			135
	Subtheme 1: beware of stereotypes and prejudice: cultivating respect and curiosity	p.6	P: They were considerate, respected me for who I was. They were attentive, that was of importance too, and I felt in different ways that they understood me, and that I ... like, opened up and in ways observed, noticed their reactions. And then I felt even more secure ... and, that I could open up even more and more. That I remember as a good thing ... [P23]	X		136
	Subtheme 1: beware of stereotypes and prejudice: cultivating respect and curiosity	p.6	P: ... they said things that maybe ... as if they knew ... said things in ways that sounded like they in a way knew things better than me ... and that ... They couldn't know how I felt and how things were for me ... And some were maybe generalizing a bit, on how the ED was ... because that is individual, for everybody ... [P56].	X		137
	Subtheme 2: exploring and working with personal goals: strengthening the young person's own motivation for recovery	p.6	P: ... that [motivation] is the most crucial aspect, right? in the treatment of eating disorders ... so ... that is the most important ... when motivation emerges you have to do anything to maintain it ... because it is so crucial and rare ... that is what makes eating disorders so difficult to treat ... that it is the only disorder you don't want to get free from ... that's why motivation is so important when talking about treatment ... [P60].	X		138
	Subtheme 3: providing information and transferring knowledge in meaningful ways	p.6	P: It would have been useful with more information on the physical consequences by being underweight over time, and on how physical and mental states influence each other. Because that is really something I've had to discover myself. I don't think I really got any information ... [P10].	X		139

	Subtheme 3: providing information and transferring knowledge in meaningful ways	p.6	P: ... You have to make them think ... not just tell them to ... for example; "you have to eat so and so much" ... it wouldn't be of any help ... maybe there and then ... but in the end you have to work on the mental part ... make them to work on the psychological issues first ... that was at least what I did ... and after a while the other things will find its way ... it is important to find the drive ... to answer the questions of "why ... should I do this, why should I eat more ... why should I gain weight" ... and [help them] transcend the fear we all have, of getting fat ... and all that ... [P22].	X		140
	Subtheme 4: enabling a shift of focus by providing activities	p.7	P: Once we went to an amusement park ... and we got to live more as normal human beings ... [P33].		X	141
	Subtheme 4: enabling a shift of focus by providing activities	p.7	P: It was very quiet here. It was helpful when I could go out and go for a walk and things like that ... It easily becomes boring when you're admitted ... so I think ... It was a small activity room here ... but things were very little organized around that ... [...] so maybe a bit more drive from the staff too ... to ask whether we should do things ... [P31].			142
	Subtheme 5: addressing and working with covert ED behaviors at the ward: be attentive and preventive	p.7	P: If I hadn't had the shirt on, then I couldn't have put the weight belt on, and maybe they would have discovered that my bladder was completely full ... ehm ... I think at most I drank 4 l of water ... [P32].			143
	Subtheme 5: addressing and working with covert ED behaviors at the ward: be attentive and preventive	p.7	P: Look more after patients when they are at the loo ... mhm ... and don't allow too much solitary time in their room. I was running around continually, to burn calories. It was very exhausting, yet I felt I just had to ... [P63].			144
Authors	Findings	Illustrations (Page Number)	Evidence	Unequivocal	Unsupported	Revised Finding Number
Nilsen et al (2021).a	Enabling new ways of understanding and relating <ul style="list-style-type: none"> • Between the ward and home. Bridging contexts 	p.396	P: We became more strongly attached to each other, because I feel, you kind of slip apart from each other when you get an eating problem and like; "I was in my corner, and she was in hers", but when we were here together, and did all the things together, and both focusing on the same, then we shared a common ground ... and then, the relationship improved too ... [...] ... I look back and think it was very, very good, for the both of us ... [P13]			145
	Enhancing or maintaining negative power dynamics <ul style="list-style-type: none"> • Negative peer influence. Potentially nurturing the eating disorder 	p.397	P: I was surrounded by girls, who were ... everyone was ill, and we gave each other ideas, and I felt it was kind of a toxic environment, it was really, no, it was no good at all. And it eventually became a struggle between the patients; it was all about who could sneak away most food and it was all this talk about that one should water load as much as possible on the day of weighing, and we gave each other advice on how to attach weights to our clothes and stuff, there were no limits ... [P6]			146

	<p>Enhancing or maintaining negative power dynamics</p> <ul style="list-style-type: none"> • Family-based inpatient treatment should not be the only option 	p.397	<p>P: I think it would have been easier to fight ... with the food, without my parents present. Because when they were present I only wanted to oppose them, in addition to resisting treatment. I didn't want to eat what I was supposed to in the first place. And even less so when they were present and said I had to. If it were only you that stated that, I guess I would have been easier to persuade ... [P10]</p>			147
	<p>Vulnerable transitions</p> <ul style="list-style-type: none"> • Planned leaves can both aid the treatment and enhance the ED 	p.398	<p>P: It was a bit scary the first times, that it was, but ... ehm ... it was a very important part of treatment, because this [the ward] was not where I was supposed to get used to being ... [P24]</p> <p>P: It was a pleasant feeling ... but I didn't follow the meal plan and things like that ... as I was supposed to ... I always managed to sneak away things ... a lot of food ... [P63]</p>			148
	<p>Vulnerable transitions</p> <ul style="list-style-type: none"> • Providing safe transitions (moving in - moving out) 	p.398	<p>P: No ... in NO way ... I didn't want to go there, I was very much against it, really ... [...] I felt that here, I am supposed to be placed and they [staff] shall decide over me ... [...] They [my parents] had a wish to be admitted, they realized that it didn't work out at home ... [...] So they, I think, felt very much that we needed help ... they were exhausted and couldn't handle it any longer ... [P6]</p>			149
	<p>Sibling relationships and different ways of involvement</p> <ul style="list-style-type: none"> • Proving information and enabling taking part 	p.399	<p>P: I think that she had needed to have more conversations, yes. About the things she found difficult related to having a sick sister. Because Mom and Dad were very much involved in the treatment and talked a lot with the professionals, but she was very much left out on her own, at least she felt like that, then. I can only state what she said, and what she told me. That she had needed more individual conversations, to maybe hear more about how things went with me, and to be able to talk about what's on her mind, related to having a sick sister ... [P20]</p>			150
	<p>Sibling relationships and different ways of involvement</p> <ul style="list-style-type: none"> • Appropriate involvement of siblings 	p.299	<p>P: I don't think young children should be at the unit, I don't see it possible, that it can be of any good ... [...] It was a lot of turbulence, you know. It is sufficient that parents ... they have a responsibility for their child and that's why it is necessary for them to be present. But I don't think that the siblings need to be part of that, they should be protected against that ... [P60]</p>			152
Authors	Findings	Illustrations (Page Number)	Evidence	Unequivocal	Unsupported	Revised Finding Number
Nilsen et al. (2021).b	<p>Main theme 1: expectations and valuation of needs. Entering treatment from different vantage points</p> <ul style="list-style-type: none"> • Subtheme 2: from opposition to realizing that "something had to happen" 	p.6	<p>I was kind of... forced... I was really fed up with treatment and did not want to be there [Brenda, 20 years, 14 during the admission, an extract resonating with most YP-AN at the time of the admission, as they overall recalled low readiness for a new treatment effort]</p>			153

<p>Main theme 1: expectations and valuation of needs. Entering treatment from different vantage points</p> <ul style="list-style-type: none"> • Subtheme 2: from opposition to realizing that "something had to happen" 	p.6		<p>I guess I thought, "I'm not going to go there". That it was totally unacceptable. I guess I didn't imagine that I needed another admission, after [recently] being discharged at the medical ward... [...] It was necessary, I see that now. That I got help somewhere, so, if it was at [name of unit] or a different place, I don't know, but it was nevertheless essential that they stopped me from losing further weight... [Molly, 18 years, 15 during the admission, although her vantage point was characterized by initial opposition, the excerpt showed how her perspectives on being admitted had changed over time]</p>			154
<p>Main theme 2: interactions with peers during admission as highly beneficial or problematic</p> <ul style="list-style-type: none"> • Subtheme 2: peer interactions as problematic: heightened pressure and symptom contagion 	p.7		<p>For me, the surroundings were very negative... and I guess I was very susceptible too, and that I think everybody was [YP-AN, Jane, 21 years, 16 during the admission, on being admitted with peers with severe challenges in a vulnerable phase, a sensation resonating with the majority of the YP-AN when reflecting back on interactions with peers]</p>	X		155
<p>Main theme 4: influencing within-family relationships</p> <ul style="list-style-type: none"> • Subtheme 1: strengthening within-family relationships 	p.9		<p>When I think back, I do believe it is the worst thing I've ever experienced [reflecting back on the time of the admission] [still] I did observe, there, that my parents seemed a bit happier, calmer. At home, I felt it was like, police and thief, and our relationship was suffering when we were at home [prior to the admission], and I felt it was strengthened when we were there. They became more my supporters [...] I would say it was of benefit for my family... [Jane, 21 years, 16 during the admission, recalling that although the admission represented the worst of memories, it was beneficial for the family]</p>			156
<p>Main theme 5: being admitted is at best only half the job: reflections on leaving the EDU</p> <ul style="list-style-type: none"> • Subtheme 1: leaving the EDU while the ED is still on board 	p.10		<p>When I was admitted, at the time I didn't eat by myself [nasogastric tube] ... Nor did I start with serving myself, and [thus] did never practice that, so, that I think was something we could have worked on... [Diana, 20 years, 17 during the admission, on the potential benefit of having progressed further before being discharged]</p>			157

	Main theme 5: being admitted is at best only half the job: reflections on leaving the EDU • Subtheme 2: being transferred back to where it did not work out in the first place	p.10	I was sent back to the outpatient clinic where I had been prior to the admission and that did not work out at all. And the fact that I was sent back to that place, that was kind of... yes, it did not work out to say it bluntly. So, I'm having a hard time figuring out that one, why it was like that [...] And I met a person at the outpatient clinic that didn't know much, and that was very frustrating and contributed to the ED growing and gained more space again [Molly, 18 years, 15 during the admission, on finding it difficult to accept that she had to go back to where it did not work, while implying how crucial expertise can be to prevent things getting worse]			158
Authors	Findings (Themes in Paper)	Illustrations (Page Number)	Evidence	Unequivocal	Unsupported	Revised Finding Number
(Sibeoni et al., 2020)	Positive of therapeutic alliance	23	Human qualities • Q1 - A2: She was the first one I saw when I arrived, she seemed very gentle and she reassured me. • Q2 - A7: The nurses were so close to me that I had the impression that they'd replaced my family.			159
	Positive of therapeutic alliance	23	An active role in the treatment • Q6 - A14 - To the question 'What helped you?': The fact that I could count on my parents even though we might fight a lot.			160
	Positive of therapeutic alliance	23	Taking Time • Q11 - A6: off course, the more you know them, the easier it gets [...] It's like you need time to trust someone.			161
	Negatives of therapeutic relationships	24	Being too Close or to distant • Q19 - A6: I wasn't at all comfortable and I really had the impression of being interrogated. And I didn't like that at all.			162
	Negatives of therapeutic relationships	24	Focusing on Weight Gain • Q22 - A6: They saw us as all the same, because we were thin, underweight. And, in fact, it's not that, it happens mostly in the head. It's that there's something that's wrong, we each have a different story. • Q23 - A15: He put me in a general category... he said, 'yes anorexic people they do this, they don't do that' and I had the impression that he wasn't treating me as a patient but really as the disease.			163
	Negatives of therapeutic relationships	24	Control and constraints • Q27 - A6: Because they already imposed a lot on me. For me, it was really too much, they were imposing too many things all at once. It was going too fast. And I had an argument at the appointment with the child psychiatrist.			164

Authors	Findings	Illustrations (Page Number)	Evidence	Unsupported	Revised Finding Number
	Negatives of therapeutic relationships	24	<p style="text-align: center;">Psychiatrization</p> <ul style="list-style-type: none"> Q30 - A1: I think that third parties, they tend to take it personally, therefore 'this anorexic behaviour is directed against me'. And as a result often they tend to enter into a form of conflict or rejection. 		165
Voriadaki et al (2015)	The similarity in food-related experiences facilitated awareness of the illness	p.12	Claire: From Day 1, I started believing I have a problem ... just by what everyone else was saying here, because I could relate to it, and I thought 'That's what I feel' ... I could not see that before ... I was surprised because I thought there was nothing wrong with me. I just thought I had an obsession with dieting. (FG-A)		166
	Becoming aware of the adolescents' and parents' position and role in relation to the illness	p.13	The day reinforced my motives for recovery, having observed the other patients and realizing, as an outsider, the effects of the illness. (Diane's diary, Day 1)		167
	Becoming aware of the adolescents' and parents' position and role in relation to the illness	p.14	Betty: Day 2 was a shift for me. When we did the role play I felt kind of a 'cheat'.	X	168
	Becoming aware of the adolescents' and parents' position and role in relation to the illness	p.14	Diane: Yeah, and I do find feeling guilty can help so that my mother does not have to push, but it does not help improve my self-image. (FG-A)	X	169
	Becoming aware of the adolescents' and parents' position and role in relation to the illness	p.14	Lunch was a breakthrough for me as I was able to eat half a sandwich. I felt I had achieved something and expressed this with the other girls.... As a group, we all felt something had been achieved. (Betty's diary, Day 2)		170
	An intense day that revealed the current upsets and future possibilities	p.15	The timeline task made me and my mum feel happy and let me look into the future when I'm better. Everything seemed achievable. But the statues brought me back down again. It showed how there's hard times to come before we get anywhere. I left the clinic feeling worried. (Claire's diary, Day 3)		171
	Reflecting on progress achieved and the challenge of recovery	p.17	Claire: During the week, with the support of other people, I think I made a step forward, but then last week I took steps back, ... cause I had to go back to school and it was a stressful change. (FG-A)		172

	Reflecting on progress achieved and the challenge of recovery	p.18	Eva: I find it really hard how I have to eat so much and I am not allowed to do any exercise ... my mum is so strict now ... Diane: Mine too, she is pushing more. Anna: And my brother has become lots more involved ... it's like you have the whole family against you. Betty: But my dad says to me 'You know, you need to let me push you to help', so that does help me. Eva: Yeah, as much as we don't want [the team] to encourage our parents to push, they need to. That is the only way to recover, as I am not in a situation where I can do it myself. (FG-A)		173
Authors	Findings	Illustrations (Page Number)	Evidence	Unsupported	Revised Finding Number
Wallis et al (2017)	Conflict and disconnection	p.5	"...they (relationships) got really tense because like it was stressful for me and it was like vicious for my parents so I don't think they really knew so much what to do like before we started coming here" (A5).		174
	Isolation and reduced confidence	p.5	I just like I kind of made my own little corner I wouldn't let anyone in" (A14)		175
	Isolation and reduced confidence	p.5	"we weren't being like a family, a bit separated, like I was separated from everyone else in the family" (A10)		176
	Therapeutic processes	p.6	"Treatment gave me tools and framework and a structure and permission I suppose" (M12).		177
	Therapeutic processes	p.6	"the program gave like a structure for my parents and a structure for me so they knew that they weren't alone. So I think that was a massive positive thing" (A8).		178
	Therapeutic processes	p.6	I think it helped us like when we'd come here because I wouldn't be talking a lot at home so then it would be the time we'd actually like communicate" (A11).		179
	Trust and security	p.6	"...it slowly got better and we got closer and we worked together and then once we got better it was like we forgot about all the arguments and we were just close again" (A13). W		180
	Trust and security	p.6	"I felt the need to be in control but as soon as they took one of them away from me you know I sort of had to put my trust in to them that they were going to take care of me" (A3)		181
	Trust and security	p.6	"I hated seeing them upset because of me and my acts and stuff like I'd rather just everyone be happy" (A13).		182
	Trust and security	p.6	"I understand that if she says I love you really does mean it because like I use to think that she use to just say that but it's not like that at all" (A2)		183
	Trust and security	p.7	"...they tried to be as understanding as they could be (parents) ...they were kind of like 'if you need us we're here let's just talk about it and I think it helped because for the first time I didn't actually shun them, I went to them...it's so weird cause for the first time in my life I let myself depend on some one else" (A1)		184
	Trust and security	p.7	"I don't think mum would have been able to do it without N (therapist) but N kind of gave mum the tools to do it...mum just kept doing what N was doing and it seemed to work better when mum did it...N had the right ideas and everything but you just need the right person... I think it has a lot to do with relationships um you can't run a away from your mum..." (A2).		185
	Closeness and communication		I guess I've become more confident in um talking to my parents about little problems and things like that" (A4).		186
	Sense of self	p.7	My trust in my parents helped me trust other people and trust myself as well actually" (A3).		187
	Sense of self	p.7	"I guess I like having my parents as sort of like a safety net, I don't know I really like being able to talk to them about stuff, like I'm really stressed out or whatever it makes me feel a lot better being able to talk to them" (A5)		188

Table 3: Overview of synthesised findings.

Finding Numbers*	Category	Synthesised Findings
7, 8, 14, 15, 25, 26, 27, 47, 64, 81, 101, 116, 119, 132, 133, 137, 163, 165	Loss of Identity	<p>Psychological distress: Emerging across studies, is the common theme of identity displacement associated with a loss of voice. Adolescents reported that their identity was often assumed to be the voice of the illness thereby externalising their identities with the eating disorder. Adolescents reported that due to this disordering of their identities, they were assumed to be incapable of having a valid voice or perspective in their own lives. Externalisation was experienced as invalidating rather than having the intended effect of empowering the person to reclaim their identity from the eating disorder. Participants in each study often felt disempowered as a person and therefore, disengaged from treatment with a sense of themselves as outsiders to their own health and wellbeing. Adolescents reported that psychological distress was poorly managed, with anxiety, depression and anger becoming common theme in all studies.</p>
14, 15, 26, 27, 31, 36,73, 101, 133,163, 165, 166	Externalisation of the Disease	
12, 14, 20, 21, 25, 26, 27, 30, 44, 49, 50, 61, 66, 76, 80, 83, 96, 100, 105, 106, 118, 128, 132, 133, 134, 149, 154, 165, 166, 181	Disempowerment and loss of Control	
7, 10, 11, 12, 13, 18, 19, 20 27, 33, 34, 47, 49, 50, 64, 66, 67, 80, 81, 83, 91, 92, 96, 97, 100, 103, 104, 107, 108, 109, 126, 132, 153, 165, 169,172, 175	Psychological distress	
2,3, 4, 16, 21, 23, 24, 25, 26, 28, 29, 30, 34, 40, 61, 68, 70, 71,72,74, 75, 77, 78, 79, 81, 83, 84, 88, 108, 109, 110, 112, 113, 118, 123, 147, 156, 160, 169, 171, 173, 179, 184, 185, 186, 187,188	Impact of Parental Support	
1, 5, 40, 41, 42, 47, 150,152	Impact on Sibling Relationships	<p>Impact on Relationships: In all studies, adolescents reported that family support in the context of the treatment was instrumental in saving their lives and contributed to a sense that they were not alone and mattered as a person. However, adolescents reported distress and interpersonal strain on their family relationships in the context of parents taking responsibility for their nutritional restoration. In all studies, feelings of anger, resentment, and frustration was used to describe parental relationships through the course of treatment. A change in the sibling dynamic was highlighted in three studies including the eating disorder influencing communication capabilities between siblings. In several studies, the emergence of new friendships with other children with eating disorders was highlighted whilst receiving treatment. Social isolation was a primary concern for adolescents when describing social milestones including parties, friends, and boyfriends. Adolescents reported that as the eating disorder occurred during a critical stage of development, independence was inhibited, and parental dependence continued to occur long after treatment ceased.</p>
12, 13, 26, 33, 47, 48, 63, 74, 75, 80, 81, 82, 84, 87, 108, 112, 115, 116, 122, 147, 149, 150, 160, 165, 168, 173, 174, 175, 176, 182	Conflict with Family and Friends	
6, 29, 51, 55, 59, 60, 85, 86, 131, 145, 146, 167, 170	Development of new relationships with other patients	

16, 17, 36, 37, 46, 55, 59, 65, 68, 114, 115, 133, 136, 138, 142, 149, 159, 161, 164, 181, 185	Therapeutic Alliance	<p>Therapeutic Alliance and the Health care service: The common theme that emerges across studies by participants is that FBT/Maudsley method is effective in improving physical markers such as weight restoration, however, the system fails to address the underlying psychological distress. This method fails to treat the condition as a mental health condition and the treatment process becomes one dimensional rather than upholding a much-needed holistic approach. Some adolescents reported that frustration with treatment, drove them to get physically better as a method to disengage in further treatment. However, in several of the studies relating to a group model there was an increased feeling of camaraderie with other patients, a deeper level of understanding by parents and increased positive sibling relationships. In addition to this, it was highlighted adolescents in all studies highlighted the importance of positive therapeutic relationships in treatment engagement and improving outcomes. Adolescents reported that strong therapeutic relationships occur from authentic relationships with clinicians where they felt both seen and heard. Adolescents that disengaged from this model of care, did not re-engage with this method, and supported private treatment methods.</p>
11, 18, 26, 27, 30, 50, 123, 125, 127, 128, 129, 130, 132, 133, 135, 137, 139, 143, 144, 146, 148, 157, 158, 162	Health care system Failures	
7, 8, 9, 15, 16, 22, 45, 46, 48, 56, 57, 59, 71, 72, 75, 102, 117, 119, 120, 121, 167, 180, 187, 188	Finding Remission	
10, 11, 12, 13, 14, 18, 19, 20, 26, 30, 33, 49, 50, 65, 70, 73, 74, 80, 81, 84, 90, 108, 109, 122, 123, 124, 127, 128, 130, 132, 135, 137, 140, 144, 146, 147, 148, 152, 157, 162, 163, 164, 169	Negatives of model of care	
6, 21, 22, 24, 28, 29, 32, 34, 35, 36, 37, 38, 40, 41, 42, 44, 45, 46, 48, 51, 54, 56, 59, 60, 71, 72, 86, 87, 88, 89, 131, 134, 141, 145, 154, 156, 171, 177, 178, 179, 184, 185, 186, 187, 188	Benefits of a group vs individual family therapy	

Note: *The findings numbers of descriptions are detailed in Supplementary Table 1.

Psychological Distress

The first synthesized finding identified related to the adolescent’s identity crisis which was associated with family-based therapy treatment. Four categories were identified which were supported by 67 findings of qualitative evidence. Adolescents reported that their identity was often assumed to be the voice of the illness thereby externalising their identities with the eating disorder (Conti, et al. [17-18,24-26,29,31]). “He put me in a general category . . . he said, ‘yes anorexic people they do this, they don’t do that’ and I had the impression that he wasn’t treating me as a patient but really as the disease.” page 5, (Sibeoni, et al. [29]). Adolescents expressed that due to this disordering of their individual identities, they were assumed to be incapable of having a valid voice to share their own unique perspective on their own lives (Conti, et al. [18]; Nilsen, et al. [25,26,29]). Consequently, adolescents recounted that externalization was experienced as invalidating rather than having the intended effect of empowering the person to reclaim their identity from the eating disorder (Conti, et al. [18,26,29]). Participants reported that their control was stripped away from them and given to their parents, which compounded the feelings of identity loss and not a person but an eating disorder (Cont, et al. [18,19,21,31]). Adolescents stated that they yearned for a sense

of connection and to be listened to (Mogorovich, [20]). Young people also reported disempowerment as an individual where their thoughts and behaviours were not valued as important (Conti, et al. [18,20,30]).

“My mom treats me as a prisoner at home. She keeps nagging me about eating and eating. Seemingly there’s nothing else in my life except eating that deserves her care and concern. I know eating is important but it’s sick to talk about it repeatedly.” page 193, (Ma [30]). Adolescents described therapy as ‘annoying’ and used remission as a means of disengaging from further therapy (Medway, et al. [19]). Psychological distress was poorly managed within this model of care with articulation of increased anxiety, depression, and anger with no timely support or intervention provided to them (Conti, et al. [18,20,24]). “I never really got a chance to properly, like talk out, like my anger, like with people. Like I never got to just express how I was really feeling, which is probably why I was so angry, because it was all, like building up inside, because I never got to express how I was feeling.” page 7 (Conti, et al. [18]).

Impact on Relationships

The second synthesized finding was related to the impact of family-based therapy/ Maudsley on inter-personal relationships. Within

this finding, four categories were developed and supported by 82 qualitative findings. Adolescents reported that family support in the context of treatment was instrumental in saving their lives (Conti, et al. [17-18,31]). Adolescents narrated that parental support reinforced that they were not alone and were valued as a person (Conti, et al. [18,29]). Participants reported that their family was essential component of this model of care largely because of their age, and they would not have been able to complete therapy without them (Conti, et al. [10,17-18,21,31]). However, in contrast many other adolescents stated that their relationship experienced distress and strain in the context of their parents' taking responsibility and control for their nutritional restoration (Conti, et al. [17,29]). Adolescents commonly reported hostility and the development of unhealthy relationships with their parents (Conti, et al. [17,21,29,30]).

"I used to be crying on a daily-basis um and just felt like no one understood and felt like when mum and dad were doing this family-based therapy if I got anxious and started crying then they'd get mad at me for crying and then they'd say, like they'd call me, just, they'd call me mean things but I know they didn't mean it but everyone just got (pause) it wasn't a good dynamic." page 412 (Conti, et al. [17]). Participants reported feeling attached to their parents which inhibited fundamental development in pubescence and the development of independence (Dimitropoulos, et al. [19,31]). Additionally, participants reported that although treatment gave their parents a deeper understanding of the disease, they reported that treatment felt more for the parents than for the adolescent (Coopey, et al. [10,22]). Adolescents narrated that they experienced a limited relationship development with friends and peers, with negative consequences on academic progression as well (Medway et al., 2019). In contrast, adolescents also formed relationships with co-patients during their treatment, this was received with mixed reports. Participants reported that although this normalised some eating related concerns, it was also toxic environment and often resulted in further distress (Coopey, et al. [10,20,22]).

"I was surrounded by girls, who were ... everyone was ill, and we gave each other ideas, and I felt it was kind of a toxic environment, it was really, no, it was no good at all. And it eventually became a struggle between the patients; it was all about who could sneak away most food and it was all this talk about that one should water load as much as possible on the day of weighing, and we gave each other advice on how to attach weights to our clothes and stuff, there were no limits ..." page 6 (Nilsen Rø, [27]). The diagnosis of an eating disorder inhibited primarily social interactions with boyfriends, and the opportunity to attend social norms (Medway, et al. [19]). Participants felt that health professionals, friends, and family members took their eating disorder personally which often resulted in conflict or rejection (Sibeoni, et al. [29]). Adolescents did report that through remission they were able to re-establish their social life and remain future focused (Medway, et al. [19]). Consequently, participants highlighted the improvement of sibling relationships that occurred with remission (Baumas, et al.

[22,28]). "With my sister we laugh all the time, we have regained the complicity we had before, that is nice." page 5 (Baumas, et al. [28]).

Therapeutic Alliance and the Health Care Service

The therapeutic alliance and health care service was developed based upon five categories and a total of 111 findings. Participants reported the family model of care lacked individuality in meeting their own unique care needs for rehabilitation (Baumas, et al. [17-18,20,26,28]). Participants described that they felt excluded, unsupported, and stressed by family-based therapy, from both parents and healthcare professionals (Mogorovich & Caltabiano, et al. [20,26]). "CYMHS suggested/pushed for Maudsley, wanted to slap the label even if it didn't fit for us, it was like they were offended, my parents felt excluded, unsupported, stressful for everybody." page 1263 (Mogorovich & Caltabiano, [20]). Participants felt healthcare professionals took behaviour personally and they would often experience conflict or rejection in healthcare professional interactions (Conti, et al. [18,26,29]). Adolescents were told from healthcare professionals and parents that their behaviour was stubborn and had the impression that they were being interrogated (Mogorovich & Caltabiano, et al. [20,29]).

"I think that third parties, they tend to take it personally, therefore 'this anorexic behaviour is directed against me'. And as a result, often they tend to enter into a form of conflict or rejection." page 9 (Sibeoni, et al. [29]). Participants stated that family-based therapy/ the Maudsley method failed to focus on the internal thought process and feelings of concerns/distress because it only focused on weight restoration and food intake (Conti, et al. [17-18,26]). One adolescent reported suicidal ideation whilst receiving treatment, and highlighted the limited psychological support provided for these thoughts (Conti, et al. [18]). "I never got to the point where I could really end my life but there were feeling just wanting it to end because it's easier than the voices that are in your head." Page 8 (Conti, et al. [18]). Adolescents stated that they had a lack of specialist care provision to meet their individual care needs which had a detrimental effect on their recovery and rehabilitation (Mogorovich & Caltabiano, [20]). However, some participants reported positive therapeutic relationships, as 're-assuring' and meal plans as 'lifesaving' (Conti, et al. [18,23,29]). When participants perceived that they had a supportive therapeutic relationship it resulted in less arguments and conflict with the healthcare professional because there was trust (Conti et al., 2017; Sibeoni et al., 2020). Additionally, five studies (Baumas, et al. [10,22,23,25,28]) reported that group therapy resulted in increased feelings of camaraderie with other patients, a deeper level of understanding by parents and increased positive sibling relationships which was attained through open group counselling.

Discussion

This systematic review set out to address the research gap into understanding the experiences of adolescent eating disorders receiving family-based therapy/ Maudsley method. The research provides

valuable new insights into the challenges that adolescents face from their perspective and in their own words. The findings from this review has underscored that this is an important clinical and research focus, and to the best of our knowledge the most current and comprehensive qualitative systematic review conducted to date (Baudint, et al. [32-36]) Within the constraints of the data available in the evidence synthesis it was not possible to attain data regarding a variety of eating disorders as diagnosed by the DSM-5. Of note, there were very limited numbers of male participants, limited cultural considerations or no mention of socioeconomic background. It is noteworthy that all studies included in this review were from participants within the public sector, and so little is known about experiences among adolescents within the private setting. As per the Australian Institute of Health and Welfare (2022), the current economic burden of mental illness is approximately 220 billion dollars annually, with this expenditure expected to continue to rise. Due to the evident mental health crisis globally, access to public resources will continue to be strained and vulnerable families will be forced into privatisation. This will largely influence the methods of treatment for this demographic.

To diversify future research, researchers should focus on the lived experiences of adolescents across a range of clinical settings and with a variety of demographic backgrounds and eating disorders. From a clinical perspective, the leading first line approach in the treatment of adolescent eating disorders continues to be a specialised eating disorder-focused, family-based therapy (Hornberger, et al. [37]). Family-based therapy consists of three phases - weight restoration, weight recovery and finally psychosocial development. Although this model of care remains best practice in clinical guidelines, this review highlights elements that may potentially cause harm and the need to consider other ways for engaging adolescents and their families. In studies (Conti, et al. [17-18,26]) adolescents identified that due to externalisation, they were assumed to be incapable of having a valid voice to share their own opinions and advocate for their own needs. Externalisation is a method used to separate the adolescent from what is frequently termed 'the voice of anorexia'. Although this method can be beneficial in mitigating blame, it leads to the inevitable question of how to discern the voice of the eating disorder from the voice of the adolescent, and who makes this decision?

The efforts of parents are integral in family-based therapy. However, participants recounted distress and interpersonal strain on their family relationships in the context of parents taking responsibility for their nutritional restoration (Conti et al. [17,29-31]). Unintentionally, many parents focused solely on this responsibility and their focus shifted away from supporting their child's less visible emotional distress (Wufong [38]). This review highlighted, the importance of the role of the clinician and the development of the therapeutic alliance in the experiences of adolescents and parents (Conti, et al. [17]). A recent systematic review explored the clinicians experience of family-based therapy (Aradas [39]) and highlighted some of the methods, strategies, and challenges experienced by clinicians when establishing

these relationships. For example, (Aradas [39]) highlighted that there existed a parallel process between adolescents and the clinicians who treated them, where they were both told what to do through family-based therapy. From both perspectives, this that had the effect of impeding the development of their own sense of competence around treatment. Interestingly, within clinicians' narrative's similar themes including the 'us and them' debate paralleled with studies included in this review, with a lack of partnership.

Strengths and Limitations

This qualitative systematic review has many strengths. These include the clear and transparent methodology that followed a registered protocol, the independent reviewer's contributions throughout the entirety of the systematic review process, and the comprehensive literature search conducted by an expert Systematic Review Librarian of all current literature. However, this review only included studies published in the English language and therefore, valuable insights may have been missed in other cultural backgrounds. Furthermore, this review included all international literature but was largely representative of Western Medicine studies only.

Conclusion

This research addressed the knowledge gap into the lived experiences of adolescents affected by eating disorders who have received family-based therapy (Family-Based Therapy / Maudsley method). The findings identified that many young people experience psychological distress, relationship breakdown, and negative views of both the therapeutic alliance and the healthcare system despite participating in family-based therapy. The primary consensus of adolescents from this review, is that this model of care only addresses physical symptoms of the eating disorder including weight restoration and not the underlying psychological cause to support effective rehabilitation.

Relevance to Clinical Practice

Existing systematic reviews have focused largely on both parental (Wufong et al., 2019) and clinician experience (Aradas et al., 2019) of family-based therapy. This observation is surprising because the central focus should be on the individual 'young person' grappling with this condition. Future funding and efforts should target this gap in the literature to further understand how to address unmet social and psychological needs as identified in this model of care, to improve both patient experience and clinical outcomes. Policy makers, health care professionals and researchers are slowly making progress toward acknowledging the unique needs of adolescent eating disorders to improve their experience and clinical outcomes. Unfortunately, this model of care may continue to fail to treat holistic needs and psychological distress. As a practical short-term solution, health professionals should engage in training and reflect upon these findings to help meet the acute psychological distress that occurs in these settings.

Authors' Relationships and Activities

The authors declare that there are no relationships or activities that might bias, or be perceived to bias, their work.

Contribution Statement

SB and CP: Conceptualization, Methodology, Validation, Screening, Data Extraction, Formal analysis, Interpretation, Writing Original draft, Writing –Reviewing & Editing.

MT: Database Searches Methodology, Writing Original draft, Writing –Reviewing & Editing.

Conflicts of Interest

The authors report no conflict of interests.

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