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An Investigation of Clinicians' Experiences of delivering Family Based Therapy for
Adolescents with Anorexia Nervosa
And Clinical Research Portfolio

Sarah Byrne, MA (Hons) Psychology

Submitted in partial fulfilment of the requirements for the degree of
Doctorate in Clinical Psychology

Institute of Health and Wellbeing
College of Medical, Veterinary and Life Sciences
University of Glasgow

July 2019



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Chapter 1: Systematic Review

An Investigation of the Experiences of Clinicians providing Psychological Treatment to Children
and Adolescents with Eating Disorders: A Systematic Review

Word Count: 7494 (with quotes and references)

Prepared in accordance with authors' guidelines from International Journal of Eating Disorders (see
appendix 1.1)

Abstract

Objective: Eating disorders represent a group of serious psychiatric illnesses, and a number of treatments, most notably family based therapy, have been developed for the treatment of eating disorders in children and adolescents. This review sought to synthesise the existing qualitative evidence base for clinicians' experiences, beliefs and attitudes of providing psychological treatments to children and adolescents with an eating disorder diagnosis.

Method: A systematic search of eleven electronic databases and hand searching of reference lists was conducted, to identify relevant qualitative studies. Following this, 4757 records were screened for eligibility and 11 studies were identified as relevant (or partial elements relevant) for inclusion in this review. Thematic synthesis was employed to analyse the themes emerging from these qualitative studies.

Results: Five over-arching analytical themes were identified: 'eating disorder and the young person', 'the task for families', 'evaluating aspects of treatment,' 'the system around them' and 'barriers to the parental task'.

Discussion: The analytical themes suggest that clinicians are aware of the challenge of treating eating disorders in young people, and delineated a number of factors that can influence treatment outcomes. This review was limited due to the heterogeneity of the included studies, and their small sample sizes. Further research and replication of studies is necessary to address the paucity of research in this area, given the beneficial insights that clinicians are able to provide.

Keywords: *adolescent, child, feeding and eating disorders, attitude, anorexia, bulimia.*

1. Introduction

1.1. Clinician Experience of treating Eating Disorders in Children and Adolescents

Given the serious health risks of starvation and malnutrition in anorexia nervosa, it is often considered a particularly serious psychiatric illness, linked to elevated risks of mortality (Chesney, Goodwin and Fazel, 2014). This may be particularly relevant for children and adolescents, in view of evidence that prevalence of anorexia may be increasing in the female adolescent population (Smink, van Hoeken and Hoek 2012). The majority of research has focused on anorexia; however, there is also an elevated risk of mortality in bulimia, albeit less so than anorexia (Westmoreland, Krantz and Mehler, 2016). This review encompasses literature on clinicians working with young people with a diagnosis of any eating disorder; however, as noted above, the majority of the literature is focused on anorexia.

A number of therapies are utilised for anorexia nervosa or bulimia nervosa in the child and adolescent population, including family therapy, cognitive behavioural therapy - eating disorder focused, and adolescent-focused psychotherapy for anorexia (NICE guidelines, 2017). The common factors model (Wampold, 2001) outlines the therapeutic elements common through most, if not all, psychotherapies. Meta-analyses by Wampold (2015) of existing research evidence indicates the contributory nature of elements such as therapeutic alliance, therapist empathy and therapist adherence, to overall therapy outcomes, for example, relative large effect sizes (Cohen's $d=0.63$) were noted when correlating ratings of therapist expressed empathy with outcomes. These common factors are hypothesised to influence treatment success, regardless of modality used. This model would suggest, therefore, that it is apt to consider clinician experiences and beliefs around working with this population, given the potential effect of clinician related factors, irrespective of therapeutic model chosen.

Investigation of clinician experience, beliefs and attitudes is pertinent given the influence these factors may have upon psychological therapy outcomes in individuals with an eating disorder. Treasure, Crane, McKnight, Buchanan and Wolfe (2011) reported on the possibility of reinforcing the eating disorder through high expressed emotion, which is often evident in family members, but clinicians may also display high levels of emotion in session. Clinicians are highly trained in providing evidence-based interventions, but are open to subjective differences, pre-existing biases and opinions on treatment models. These differences may effect outcomes for the patient, for example, Kosmerly, Waller and LaFrance Robinson (2015) note that clinician anxiety was associated with deviation from the protocol for Family Based Therapy (FBT), which is a manualised approach where parents take an active role in re-feeding their child. This deviation from a manualised treatment may then affect therapeutic progress.

Furthermore, clinicians have a wealth of experience to reflect upon in terms of the individual and family factors (co-morbidities, parental motivation) that may affect treatment progress for the young person. For example, Coutrier, Kimber, Jack, Niccols, van Blyderveen and McVey (2013) reported that clinicians listed a number of these factors as influencing recovery. This systematic review therefore aims to investigate broadly the experiences, opinions and beliefs of clinicians providing psychological treatment to children and young people with an eating disorder. Previous reviews have examined some aspects of this e.g. therapeutic alliance in adults and adolescents with an eating disorder (Zaitsoff, Pullmer, Cyr, and Aime 2015), medical and psychological practitioner's reactions to working with individuals with an eating disorder (Thompson-Brenner, Satir, Franzo and Herzog, 2012).

The author of this review knows of no existing systematic review examining the qualitative evidence base on the experiences, opinions and beliefs of clinicians with psychological therapy training, delivering psychological treatment to children and adolescents with eating disorders. These experiences, opinions and beliefs were considered in the broadest sense, given the limited nature of the evidence base, and include, for example, clinicians' emotional reactions to working with these populations, perceived fidelity to their therapeutic models, clinicians' opinions on factors affecting therapeutic outcomes, and their perceived therapeutic alliance working with these populations. This is consistent with previous systematic reviews in this area (Thompson-Brenner et al, 2012) that adopt a broad search approach. It is prudent to consider these reactions and beliefs in the psychological therapist population only, without inclusion of medical practitioners, given that the provision of psychological therapy may be uniquely impacted by certain factors such as fidelity to therapeutic model, as noted in Wampold (2015).

1.2. Aim

The aim of this systematic review was to synthesise the existing qualitative literature on clinicians' experiences, beliefs and attitudes to providing psychological treatment to children and adolescents with an eating disorder diagnosis.

2. Methods

2.1. Search for pre-existing systematic reviews

A search was conducted by the author for pre-existing systematic reviews on this topic area. A search of PROSPERO was conducted using broad search terms of eating disorder (145 results), anorexia (184 results) and bulimia (89 results). There were no existing systematic reviews registered on PROSPERO investigating clinician experiences, beliefs and attitudes about providing psycholog-

ical treatment to children and adolescents with an eating disorder. A search of the main psychological and medical databases was then conducted (MEDLINE, Web of Science Core collection, BIOSIS, psycInfo, CINAHL, psycARTICLES, Psychology and Behavioural Sciences Collection, SocIndex, ERIC, Child Development and Adolescent Studies, Health Source, Journals@Ovid) and no existing systematic reviews on this area were found.

2.2. Inclusion and Exclusion Criteria

Criteria for Inclusion:

- 1) Study involves clinicians who have had training in at least one psychological therapy modality for treating eating disorders in children and adolescents
- 2) Clinicians' patients must be under 18 years of age and have a diagnosis of an eating disorder (as defined by DSM-V criteria)
- 3) Study must involve qualitative measurement of some aspect of clinicians' experiences, based on their provision of psychological treatment to children and adolescents with an eating disorder. For clarification, this will include any of the following: clinicians' beliefs or opinions on working with this population, their perceived fidelity to their therapeutic models, clinician opinions on available therapies for this population, clinicians' emotional reactions, therapeutic alliance with this population, and clinician's reflections on those factors that may influence treatment outcome. This may constitute part of an overall study; this component only will be extracted for this review.

Criteria for exclusion:

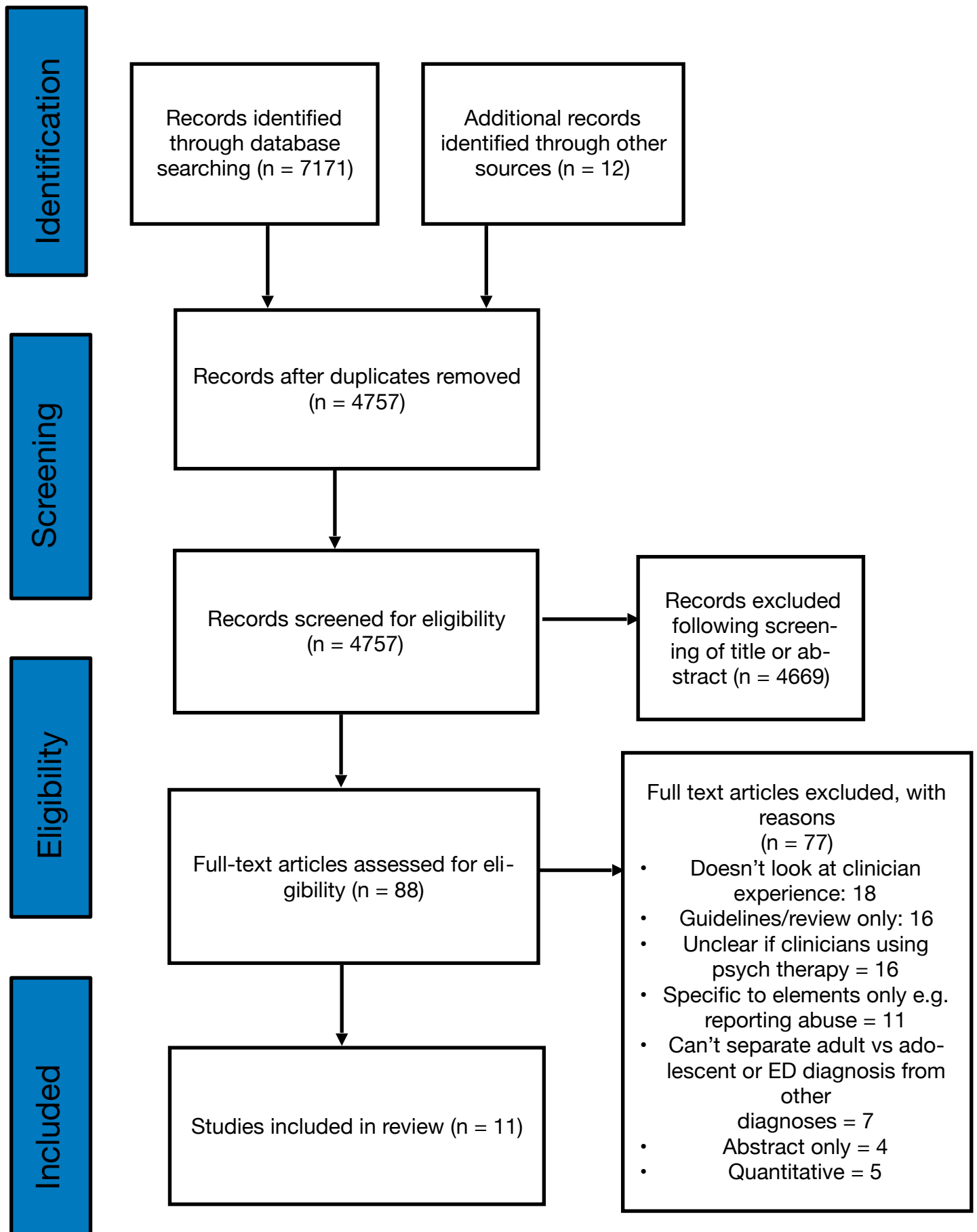
- 1) Journal articles that do not have an English translation

- 2) Clinicians' patients who are over 18 years of age (including studies that include patients both over and under 18 years of age, unless these populations can be clearly separated)
- 3) Clinicians who are providing treatment that is not psychological in nature e.g. medication.
- 4) Studies employing quantitative methods.

2.3. Search Strategy

Prior to conducting the search, the search strategy was discussed and agreed with the University of Glasgow librarian, as well as the author's academic supervisor. A systematic search was conducted including the following databases: MEDLINE (1966-present), psycINFO (1887-present), psycARTICLES (1894-present), CINAHL (1981-present), Psychology and Behavioural Sciences Collection (1930-present), Child Development and Adolescent Studies (1927-present), SocINDEX (1895-present), EMBASE (1947-present), Journals@Ovid (1996-present), ASSIA (1987-present) and Access University of Glasgow Full Text Journals. Search terms were adapted to map onto subject headings where relevant, for example, in the Medline databases. Search terms such as 'experiences' or 'beliefs' were not included as this may limit the results and thus potentially miss relevant papers. Full details of the search strategy are noted in appendix 1.2.

Figure 1: PRISMA diagram



2.4 Procedure

Those articles that were not relevant to the inclusion criteria, or duplications, were removed following initial screening of titles and abstracts. Full text versions of the remaining articles were then assessed for eligibility, and included if all of the criteria were met. A PRISMA four phase flow diagram was produced (Figure 1). Hand searching of reference lists was also conducted to screen for articles for inclusion.

2.5 Assessment of Study Quality

A data extraction sheet (see appendix 1.3) was constructed following appraisal of guidelines on data extraction e.g PRISMA guidelines (Moher, Liberati, Tetzlaff and Altman, 2009). The quality appraisal tool (Hawker, Payne, Kerr, Hardey and Powell, 2002) was chosen as it assesses for methodological rigour across different qualitative analysis methods. A copy of this tool is included in appendix 1.4. Three of the included articles were independently rated by a second, independent researcher (trainee clinical psychologist). Following this process, discrepancies were discussed and the quality rating for one article (Murray, Rand-Giovannetti, Griffiths and Nagata, 2018) was revised.

2.6. Data Synthesis

Thematic synthesis (Thomas and Harden, 2008) was chosen as an appropriate method for data synthesis, as it facilitates the analysis of data from qualitative studies utilising a variety of methodologies. Thematic synthesis involves three stages: coding of text line by line, whereby verbatim quotes or lines are taken from the articles and input into a database. Codes are then constructed from these quotations. These codes should be flexible and can be added to throughout the process. Similarities

and differences are then examined across the codes and grouped into hierarchical ‘trees’, resulting in a smaller number of descriptive themes. Finally, the descriptive themes generated are used to answer the review questions in the existing framework, which may require inference on the part of the reviewer. For example, a number of descriptive themes that have consistently emerged may be collapsed into an overarching analytic theme. These analytic themes then allow the author to create a deeper level of understanding and concepts than that derived from descriptive themes alone.

3. Results

3.1 Study Characteristics

Details of the sampling and methodology of the eleven included studies are outlined within table 1. Five of the studies reported on samples from Canada (Couturier et al, 2013; Couturier et al, 2017; Couturier, Kimber, Jack, Niccols, Van Blyderveen, and McVey, 2014; Dimitripoulos, Freeman, Lock and Le Grange, 2017; Dimitripoulos, Tran, Agarwal, Sheffield and Woodside, 2012), two of the samples were from the USA (Asp, 2016; Murray et al, 2018), two from the UK (Jarman, Smith and Walsh, 1997; Giombini, Turton, Turco, Nesbitt and Lask, 2017), and one from Australia (Plath, Williams and Wood, 2016). It was not clear in which country the remaining study was conducted (Kimber et al, 2018). Participants in the studies were clinicians working in CAMHS services, with a variety of different training backgrounds (e.g. psychology, social work), who were utilising a psychological approach with their patients, or working in private practice with young people with an eating disorder. Eight of the eleven studies included in this review involved clinicians utilising a Family Based Treatment (FBT) approach with children and adolescents with an eating disorder. All of the patients included in this review had a diagnosis of anorexia nervosa, although one study did examine typical vs atypical anorexia specifically (Kimber et al, 2018).

Partial elements were extracted from two papers (Giombini et al, 2017; Dimitropoulos et al, 2012; for inclusion in this review. These elements were therapists' reflections on providing cognitive remediation therapy to adolescents with anorexia (Giombini et al, 2017) and paediatric clinicians' perceptions of factors affecting adolescents with anorexia (Dimitropoulos et al, 2012).

3.2 Quality of the studies

Studies were evaluated using the appraisal tool (appendix 1.4) modified from Hawker et al (2002). The maximum score a study can achieve using this tool is 36. Studies scoring 30-36 were given the quality rating 'high', 24-29 quality rating 'medium', and below 24 quality rating 'low'. Hawker et al (2002) did not suggest quality cut offs; however, Lorenc et al (2014) proposed the above cut offs as a general rule of thumb. Six of the studies were rated 'high', four were rated 'medium', and one study was rated as 'low'. The quality of the papers was generally high, although studies often failed to detail their sample size calculations, and therefore were rated as 'Poor' on this element, which also limited their scores on 'transferability/generalisability.'

Table 1: Descriptions of included studies and quality ratings

Author & year, country	Aims of the study	Participants	Measures used	Research Methods	Quality Rating
Couturier et al (2013), Canada	<ul style="list-style-type: none"> - Therapist perspective on implementation of FBT - Factors influencing the use of FBT 	40 therapists providing intervention to young people (<18) with anorexia	Semi structured qualitative interview	Qualitative; conventional content analysis	High
Couturier et al (2017), Canada	<ul style="list-style-type: none"> - Themes arising in clinician consultation of therapists implementing FBT for adolescents 	Eight FBT therapists, who have treated at least one adolescent with FBT and who are receiving supervision	n/a - analysis of supervision discussions	Qualitative; conventional content analysis	High
Plath et al (2016), Australia	<ul style="list-style-type: none"> - Key positive aspects of FBT - Ways to engage parents in FBT - How and why therapists adapt FBT 	20 clinicians using FBT or family therapy approach with children and adolescents with anorexia	Survey (based on adapted clinician version of Outcome Effective Scale)	Qualitative; content analysis (survey), IPA (interviews)	Medium
Murray et al (2018); USA	<ul style="list-style-type: none"> - Clinician perspectives on the mechanisms of change in FBT - Factors that inhibit these mechanisms of change 	38 participants who were trained in FBT and co-authors of papers on anorexia in adolescents (excluded if answered 'not at all' knowledgeable on FBT)	Survey with four main questions (weight based change mechanisms, cognitive change mechanisms, factors in partial and unsuccessful outcomes)	Qualitative; content analyses/codebook	High
Dimitropoulos et al (2017); Canada	<ul style="list-style-type: none"> - How paediatric teams utilise the core principles of FBT - Clinicians' opinions on which principles are fundamental to success of FBT - Challenges that inhibit use of FBT principles 	30 clinicians using FBT in their clinical work with young people who have anorexia.	Six focus groups with a semi structured interview guide, plus self report	Qualitative; thematic analysis	High

Table 1: Descriptions of included studies and quality ratings

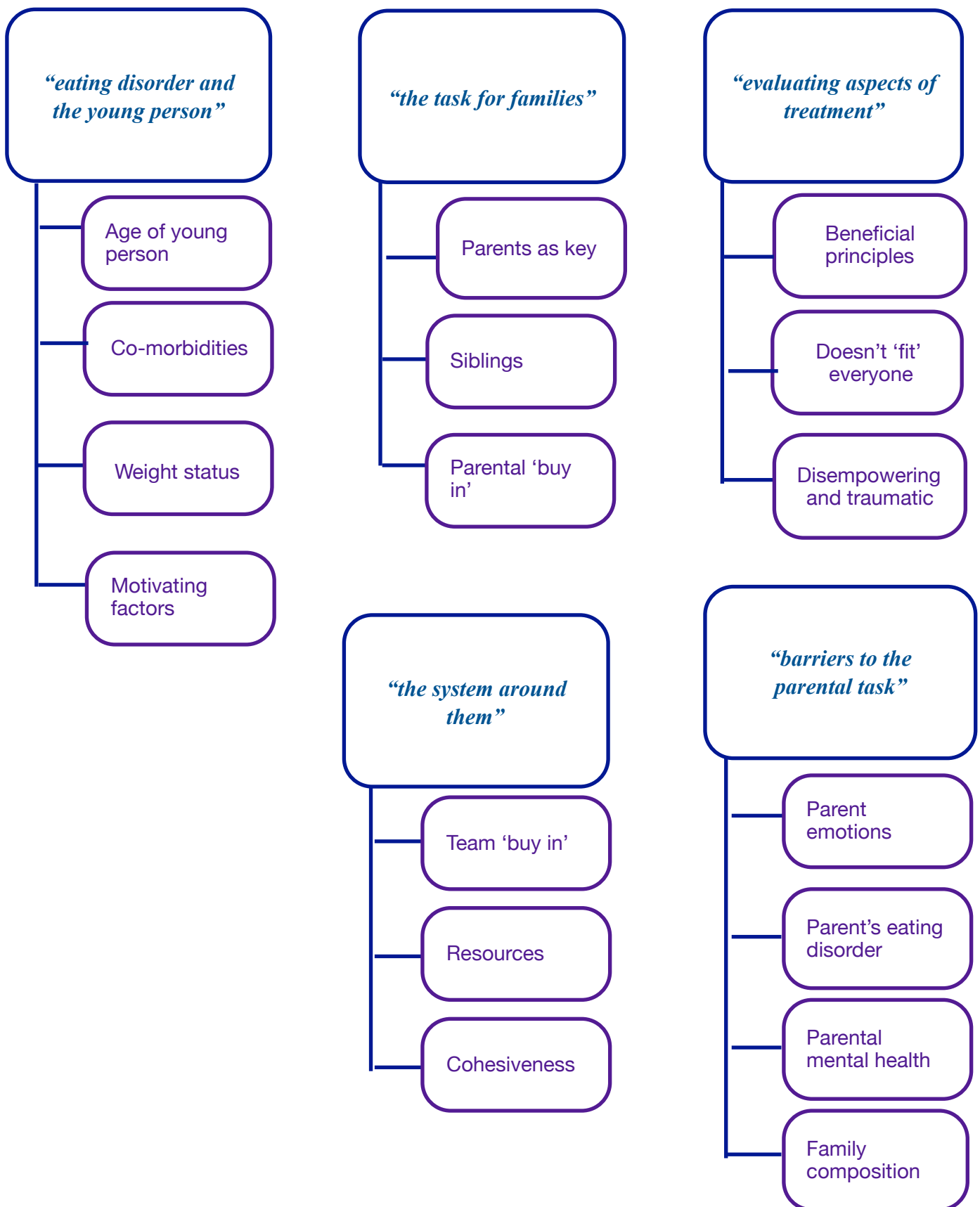
Author & year, country	Aims of the study	Participants	Measures used	Research Methods	Quality Rating
Asp (2016); USA	<ul style="list-style-type: none"> - The process of implementing FBT with adolescent clients living with anorexia nervosa - components of FBT that clinicians have found effective and challenging - new areas of growth and development are occurring within the practice of using FBT 	Four mental health clinicians utilising FBT for adolescents with anorexia	Semi structured interview	Qualitative - grounded theory	Medium
Jarman et al (1997); UK	<ul style="list-style-type: none"> - Clinicians' understandings and experiences working with anorexia in young people - Focus on clinicians' experiences of 'control' in anorexia 	Five CAMHS professionals with recent experience of young people with eating disorders	Semi structured interview	Qualitative; IPA	Medium
Couturier et al (2014); Canada	<ul style="list-style-type: none"> - Use of the knowledge transfer framework (Lavis et al, 2003) to identify factors that would facilitate use of FBT 	40 therapists who provide treatment to children and young people with anorexia	Semi structured interview	Qualitative; content analysis	High
Kimber et al (2018); unclear (noted most USA)	<ul style="list-style-type: none"> - how do clinicians differentiate atypical anorexia from typical anorexia - Identify challenges clinicians face working with atypical anorexia 	23 clinicians who had completed FBT training and were currently providing treatment to young people with typical and atypical anorexia	Semi-structured interview guide with open ended questions	Qualitative: inductive conventional content analysis	Medium

Author & year, country	Aims of the study	Participants	Measures used	Research Methods	Quality Rating
Giombini et al (2017); UK (Relevant part of study extracted)	- Investigation of therapists' perceptions of CRT as a therapy for adolescent AN population	Trained assistant psychologists - number not known	n/a - supervision reflections	Qualitative; unclear if any analysis done	Low
Dimitripoulous et al (2012); Canada (Relevant part of study extracted)	- To explore the factors that affect adolescents with anorexia transitioning from paediatric to adult services	8 paediatric clinicians who had worked with a young person transitioning in the last year	Semi structured interview used in focus groups and interviews	Qualitative; grounded theory	High

3.3 Qualitative Synthesis

Five themes were extracted from the results of the qualitative data synthesis (see figure 1). Although the inclusion criteria did not specifically delineate that FBT must be the therapy of note in the study, the nature of treating eating disorders in young people has led to a preponderance of FBT-related articles in this review.

Figure 1: Five overarching analytical themes derived from data synthesis, with descriptive themes noted below



‘eating disorder and the young person’

Seven of the eleven studies endorsed descriptive themes that formed an analytic theme *‘eating disorder and the young person’*, which covers the relationship between outcomes and illness/patient factors. Elements of the presentation of anorexia may impact upon different treatment targets; Murray et al (2018) noted that residual cognitive symptoms may be linked to chronicity of anorexia, especially core beliefs, as one participant stated:

“often in these instances, cognitions have been longstanding, entrenched core beliefs, that unless addressed in individual therapy, remain stuck”

However, this research also indicated that co-morbidities may preclude both weight restoration and resolution of cognitive symptoms in FBT, suggesting that associated co-morbidities of this illness may be more influential than other elements in the disruption of treatment progress.

Five of the included studies found that co-morbidities were detrimental to treatment outcomes; co-morbidities mentioned included perfectionistic traits (Giombini et al, 2017), depression and anxiety (Murray et al, 2018) and substance abuse or dysregulation (Dimitropoulos et al, 2017). The presence of co-morbidities complicates the presentation for the clinician and may lead to deviations from the treatment model, where the clinician feels this is necessary to attend to the co-morbidities too (Couturier et al, 2013).

Weight status is often considered when working with eating disorders generally, with the acknowledgement that there are adverse effects on cognition as a result of starvation and low body weight

(Dimitripoulous et al, 2012). However, Kimber et al (2018) compared atypical and typical anorexia presentations and found that the higher starting weight seen in atypical anorexia may disrupt the high anxiety levels clinicians orchestrate to increase parental motivation for therapy engagement. This would suggest that, despite the initial obvious conclusion that a higher starting weight would be beneficial, in atypical anorexia less dramatic weight loss may in fact hinder treatment progress.

Clinicians participating in Dimitripoulous et al's (2017) research described the age of the patient as important, where older children who are engaging in FBT tended to have poorer outcomes, in part because adolescents have started to develop their own identity and autonomy. One participant explained:

“...the older the child gets, the harder it is to keep it (focus on eating meals) up”

Issues of motivation and motivating factors were noted by Murray et al (2018), for example; participants in this study felt that young people needed to have social relationships, education, or hobbies to motivate them to recover from anorexia. Where these factors are missing, the young person may create a life and identity through the anorexia, and therefore find it more difficult to relinquish anorexia's control over them.

“the child has no life outside of AN, and cannot see a future without it”

'the task for families'

A number of studies also noted the family influence on engagement in therapy and prognosis, particularly parental influence, associated with the analytical theme 'the task for families'. A number of

studies noted the challenging nature of involvement in the treatment for parents (e.g. Plath et al, 2016), especially given that parents are instrumental in the re-feeding process for their child. All of the clinicians in Asp (2016), for example, endorsed the belief that the family is critical to recovery:

“the family system is the recovery, and I mean that is the key”

The parent being empowered and committed to the recovery of their child was suggested in one study as the most influential factor in FBT (Dimitropoulos et al, 2017). For example, one clinician in this study noted

“if parents are willing to supervise and monitor...it’s not as important to get the kid on board”

Clinicians may, for example, suspend treatment if parents are not participating, so critical are they to outcomes (Asp, 2016). Parental involvement was perceived by the clinicians as significant for weight gains even after the young person has reached adulthood (Dimitropoulos et al, 2012). Furthermore, Jarman, Smith and Walsh (1997) note the possibility of re-feeding the young person in the community, by utilising the parental resource, thus avoiding inpatient admission.

Siblings may also play a role in FBT treatment, although there may be some disagreement between young people, parents and clinicians as to whether siblings should be involved (Couturier et al, 2017). This theme suggests that in children and adolescents, clinicians feel that weight restoration is largely achieved through the mechanism of the family’s involvement, where the commitment of the young person with anorexia may be neither possible nor required for a good prognosis.

“barriers to the parental task”

A number of the studies acknowledged potential barriers to the fulfilment of the parental task, perhaps unsurprising considering the significance of the parents’ role in FBT, the main treatment modality included in this review. The mental health of the parents was described as influencing their child’s ability to engage in the challenging re-feeding task. This may be particularly salient if the parents’ mental health problem is linked to eating (Dimitripoulous et al, 2017):

“I think it’s harder when you have, let’s say, a parent who restricts. I think they get is more, that the parent is restricting, they’re less likely, if the parent doesn’t change their eating behaviours, to have good outcomes.”

There is a sense that the young person may be modelling eating patterns from a restricting parent; without change in the parental eating pattern, the young person is less likely to be motivated to adapt their own behaviours. This may need to be addressed directly to facilitate the young person’s recovery (Kimber et al, 2018). Apart from eating disordered behaviours, Murray et al (2018) noted that generally, parental mental illness impacts upon the successful application of the FBT model. One participant explained:

“co-morbid child or parent psychopathology blocks FBT”

This can include a number of different mental health concerns, for example, anxiety or depression.

Four studies went beyond mental illness diagnoses in parents, and reported the effects of negative parental emotions more generally. The high levels of commitment required from parents in FBT also

lead to feelings of burnout (Dimitripoulous et al, 2017). One study (Plath et al, 2016) in particular focused upon parental involvement and detailed a number of emotional reactions that clinicians have noted in parents. Clinicians felt, for example, that empathising and identifying with parental distress was an important first step in FBT sessions. Feeling hopeless and ashamed were two emotions that clinicians noticed in parents:

“well it is, isn’t it, shame on display. You walk around with a skeletal child and it’s like, it’s out there”

There is a complexity around the emotions experienced by parents of young people with anorexia, including lack of hope, shame, burnout, anxiety, sense of failure and loss. Couturier et al (2017) noted feelings of anger and guilt in mothers of adolescents with anorexia. This multitude of emotional reactions may reduce parents’ ability to engage, if they are overwhelmed by emotions (Asp, 2016). Across the articles included in the review there is an awareness of the need to attend to parents’ emotions, to facilitate their commitment to their hugely significant role in treatment.

Four of the studies also acknowledged the influence of family composition and unity on treatment progression, particularly pertinent given that the front line treatment for eating disorders in young people is a family based treatment. Murray et al (2018) and Dimitripoulous et al (2017) note perceptions of the importance of family unity and good functioning in the family system, for parental empowerment and successful outcomes in FBT. A participant in Asp (2016) described the benefits of parental unity on the child’s trust in their parents and ultimately on their recovery:

“I think the kid could, if the parents were to be able to be on the same page and have trust in the process, I think no matter what kid it was it would eventually work out”

“evaluating aspects of treatment”

The majority of studies highlighted the importance of discussion around treatment, and described beneficial aspects of the treatment modalities utilized, with the majority focusing on FBT (with one exception of Giombini et al, 2017, who discussed cognitive remediation therapy). A number of benefits described were linked to the principles of FBT, for example, the structure of the therapy (Couturier et al, 2013; Plath et al, 2016), empowerment of parents (Asp, 2016, Murray et al, 2018) and the use of an agnostic, externalising stance when considering anorexia (Couturier et al, 2013; Dimitripoulous et al, 2017). These principles were reported as benefitting families and facilitating engagement, for example, here’s one clinician’s thoughts on the use of externalisation reported by Dimitripoulous et al (2017):

“I think (externalisation) can be helpful for all family members because ...it’s just a good strategy for any mental illness because it’s so frustrating for people to deal with and try to avoid that anger going towards the child and instead having it projected towards the eating disorder”

Clinicians were particularly positive around the ability of FBT to restore weight in the young people, and this may be of significance when considering the intense concern clinicians and families feel for young people malnourished by eating disorders.

Clinicians also noted some potentially detrimental aspects of the models used with young people with eating disorders. Participants in Jarman et al (1997) were concerned with their role in disem-

powering the child as part of the treatment, as it can be necessary to remove control from the young person for the purposes of re-feeding.

‘I have to justify it to myself at time, that this is the right way. I don’t always feel that it’s the right way...’

Plath et al (2016) reported that, at times, clinicians are unable to continue with the FBT model at all, as the parental task is too demanding for the parents. Additionally, for some families, such as Aboriginal families’ clinicians, FBT may exacerbate existing power imbalances or cultures of oppression, where the power rests with the clinician (Boyd, 1996). There may also be an element of conflict arising within family systems as a result of FBT treatment (Asp, 2016). Taken together, these insights indicate that both parents and clinicians may feel that FBT represents a dis-enabling model, and that the demands placed upon them are prohibitive or do not ‘fit’ within their cultural perspective.

“the system around them”

A number of studies endorsed some aspect of the team or organisational setting in which they practice, as influencing their role as a clinician or having an effect on outcomes, or both. Couturier et al (2013) noted that ‘buy in’ for FBT as a therapy for eating disorders has implications for financial/training resources, as well as support for the clinician, via team discussions. Clinicians felt, for example, that additional resources were necessary to enable families to participate effectively in the treatment (Asp, 2016). The unity of the team was considered as crucial in addressing the challenges of treating anorexia (Plath et al, 2016).

Couturier et al (2014) focused on the elements of knowledge transfer of the FBT evidence base into clinical practice, and the facilitating factors for this transfer. This paper further echoed Couturier et al's (2013) finding of the importance of clinical administrator and team 'buy in', but also indicated the importance of training for clinicians. This included using a number of different approaches, such as online training, local experts, DVD vignettes and internal experts. A mix of these approaches may provide clinicians with the most holistic understanding of FBT, for example:

"I think a combination would be good, of researchers, cause they look at the data, they see the effectiveness, they've written the books. But also the hands-on local experts who are putting it into practice and using it every day"

It was also reported by nearly half of the participants in Couturier et al (2014) that wider awareness of eating disorders and the associated therapies is required for greater recognition by other professionals e.g. physicians. This lack of awareness blocks referrals to the clinicians, and therefore blocks treatment for these young people. This, therefore, again links to the importance of cohesiveness amongst professionals working together to treat children and adolescents with anorexia.

Discussion

This systematic review sought to synthesise the qualitative evidence base on clinicians' beliefs, experiences and attitudes towards providing psychological therapy to young people with eating disorders. Five themes emerged representing the benefits and concerns about available treatments, the impact of services on clinicians' practices, complicating illness factors, and the challenge of the tasks for parents, especially where there are complicating factors such as parental mental health. With respect to the young person, clinicians felt there was an impact of age on treatment outcomes,

where older adolescents found relinquishing control to their parents particularly difficult, in line with other research (Le Grange, Lock, Agras, Moye, Bryson, Jo and Kraemer, 2012). Clinicians also felt that where the young person has social interests and hobbies in their life, they may be more motivated to engage in treatment and recover. Whilst age is outside the control of the clinician, the research suggests that it may be prudent to enhance motivational factors in children and adolescents with an eating disorder, where possible. This is consistent with recommendations in Sibeoni et al's (2017) review indicating the importance of attending to psychosocial functioning, for example, the importance of adolescents socialising with their peers.

The presence of co-morbidities may be particularly pertinent, for example, where it precludes both weight gain and recovery from cognitive symptoms (Murray et al, 2018) and has also been noted as a significant issue in previous research (Lock, Couturier, Bryson and Agras, 2006). The weight status of the individual was also perceived as influential, where higher initial body weight, as seen in atypical anorexia, may negatively impact treatment outcomes, as family anxiety for the young person is lower (Kimber et al, 2018). This, then, may offer an important avenue for clinical practice, where the clinician is aware of the potential for lower parental anxiety in atypical anorexia, and that this may hinder the young person's recovery. It may also suggest, however, that clinicians' perceptions are predetermined when working with a young person with a co-morbidity or a higher body weight, and that they themselves may introduce these perceptions to the sessions, for example, by projecting less anxiety about the young person who has a higher starting weight. This could then impact upon clinical outcomes, and indicates a need to objectively measure, wherever possible, clinicians' perceptions.

As the majority of clinicians in the studies used FBT or family based approaches with young people, they endorsed the view that parents have a particularly challenging task in re-feeding their child, but

that their role was critical in the young person's recovery. They also argued that parents need to believe in the FBT model and that this may actually be of more importance than the young person's buy in (Dimitripoulous et al, 2017). This, however, could be influenced by clinicians' systemic training, for example, with a focus on family systems potentially overriding a focus on the young person's perspectives. Given the focus on the family in the majority of the studies, it was unsurprising that perceived barriers to involvement in the parental task were outlined in a number of studies. In particular, it may be prudent for clinicians to remain vigilant for eating disordered patterns of behaviour in the parents, and the potential for the modelling of this behaviour to the child. This is particularly pertinent given the two fold incidence of eating disorder diagnoses in children of parents with an eating disorder (Bould, Sovio, Koupil, Dalman, Micali, Lewis and Magnusson, 2015), and clinician's existing awareness of this may be beneficial for supporting families where this is the case. Generally, parental mental health conditions, and high levels of distress in parents, were perceived as reducing parental efficacy for involvement in the FBT tasks, as may be expected given the significant challenge for any parent of re-feeding a child with anorexia.

A number of studies reported clinicians' evaluative opinions of therapies for young people with eating disorders. The principles and techniques of FBT were especially endorsed by clinicians in one study, where externalising the anorexia as separate from the young person may have been associated with a reduction in the influence of negative parental emotions (Dimitripoulous et al, 2017). FBT may also offer the comfort to clinicians of good weight restoration in young people, which is especially important given the significant malnourishment characteristic of eating disorders, and the concern this elicits. The clinician's beliefs are in line with previous research, indicating that weight gain in FBT is as significant, if not higher, than in other therapeutic options (Watson and Bulik, 2013) and the evidence of FBT's efficacy has led to endorsement of FBT as first line treatment (NICE, 2017). However, clinicians have noted some concerns with available therapies for adolescents with

eating disorders. In one study, participants felt that the return of control to parents may disempower the young person (Jarman et al, 1997) and this may feel uncomfortable to clinicians traditionally working collaboratively. Additionally, while FBT has a solid evidence base, clinicians reported uncertainty regarding the application of this approach to some families, particularly where there may be cultural differences (Plath et al, 2016), or where it may increase family conflict (Asp, 2016). This is consistent with evidence that a substantial proportion of young people do not recover with FBT, for example, in Lock, Le Grange, Agras, Moye, Bryson and Jo (2010), 51% of adolescents who had received FBT were no longer in full remission at 12 month follow up, although partial remission rates were high (89%).

Finally, clinicians described the potential influence of the system around them on their role as a clinician, their ability to implement therapies, and on treatment outcomes. Resources are an area of concern, and a lack of financial and training resources may act as a barrier to implementation of FBT (Asp, 2016). Participants in Couturier et al (2014) felt the necessity of training and expert knowledge not only for their own implementation of FBT, but for the awareness of other professionals who may encounter young people with eating disorders. The reflections on the need for cohesiveness among professionals is of interest particularly within this population, as individuals with eating disorders often work with a number of professionals, such as dietitians and in-patient staff, and therefore the need for cohesiveness may be even greater than for individuals with other mental health diagnoses.

Implications for clinical services and research

There are a number of implications of this review that may be of benefit to clinicians working with this population. Clinicians may wish to pay special attention to particular sub-groups of their adoles-

cent clients; adolescents whose parents have an eating disorder, parents who experience difficult emotional reactions, older clients, and adolescents who are limited in their interests outwith the eating disorder. By identifying these subgroups, earlier acknowledgement and intervention with these issues may lead to more successful outcomes, or may facilitate the clinician in their already challenging role.

It may also be helpful to clinicians to reflect upon their own biases and beliefs that they may bring to therapy sessions, and whether these are influencing decisions they make in treatment. Clinicians may also wish to consider traumatic aspects of treatment for anorexia in adolescents, and minimise these where possible, for example, via patient feedback and reflective practice in supervision. At a service level, this review would indicate that clinicians need the support of the team around them, with access to training and resources. Given the potential impact of inter-professional relationships on treatment outcomes, clinicians may wish to consider ways to facilitate good team functioning and understanding of eating disorders. This could be achieved, for example, by formulating as a team and a focus on excellent communication between professionals. It may also be, however, that these reflections are open to subjectivity, for example, if there are particular tensions existing between professionals and systems.

Further research is prudent given the lack of replication in this area, and it may be beneficial to research the potential interventions that clinicians could implement to further assist the sub-groups at higher risk of unsuccessful outcomes, for example, additional sessions to support those parents with high levels of distress or mental health diagnoses. The evidence base may also benefit from further research on factors affecting treatment outcomes, with objective measures of clinician factors, including both qualitative and quantitative designs, for example, associations between clinician train-

ing background and clinician beliefs around factors affecting treatment outcomes for adolescent anorexia.

Limitations

The findings of this review are affected by the subjective nature of clinicians' perspectives, which are open to a number of influencing factors, for example, number of years of experience, therapeutic background, age or gender, thus potentially skewing their responses. Furthermore, clinicians are open to participant bias, in that they may give the researcher a response which they feel is 'right' or socially acceptable, as opposed to an accurate reflection of their experiences. Both researchers and participants in the included studies may also be affected by confirmation bias, for example, where they have a particular allegiance to a therapeutic model such as family based therapy.

The ecological validity of the results in the included studies may vary by country, as different countries utilise distinct health care systems, and these distinctions may influence clinician's perspectives, for example, perspectives on organisational factors may differ between state-funded health care and private health care systems. The limited nature of the research is such that only a few studies examined specific factors e.g. parental empowerment, or only partial elements of the paper were relevant to this review, thus narrowing the confidence of the conclusions. Finally, although the author consulted with the university librarian when devising a search strategy, it is possible that relevant search terms may have been overlooked that may lead to missed studies of relevance.

Conclusions

Clinicians providing psychological treatment to adolescents with eating disorders face a particularly challenging task in supporting recovery. A number of themes emerged in this review, indicating beliefs, evaluations and concerns clinicians have around psychological therapies for this population.

Findings were consistent with previous research which may suggest clinicians are acutely aware of the issues surrounding treating this population. This may also indicate that clinicians are an important source of insight into working with adolescents with eating disorders and their families. However, it is pertinent to consider that these reflections are subjective in nature, and it therefore may be more beneficial to utilise this review to highlight the need for awareness of clinician subjectivity.

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Chapter 2: Major Research Project

Barriers to and Facilitators of Treatment Outcome in Family Based Therapy for Children and Adolescents with Anorexia: A Clinician's Perspective

Word Count: 8323

Prepared in accordance with authors guidelines from International Journal of Eating Disorders (see Appendix 1.1)

Plain English Summary

Title: Barriers to and Facilitators of Treatment Outcome in Family Based Therapy for Children and Adolescents with Anorexia: A Clinician's Perspective

Background: Anorexia is a serious psychiatric condition with a significant mortality rate of 4% (Swanson, Crow & Merikangas, 2011). Family Based Therapy (“FBT”) was developed to treat adolescents with anorexia as an alternative to traditional inpatient hospital treatment. Research suggests that weight gain and reduction in severity of the eating disorder are maintained one year after treatment has ended (Lock et al, 2010). Five health boards in Scotland have now trained 39 clinicians in FBT for use with adolescents with anorexia, and implemented FBT in real world settings in Scotland. It is therefore useful to examine clinician experiences of providing this treatment within a real-world setting, and use these reflections to improve the delivery of the therapy.

Aim: To investigate clinicians' experiences of delivering FBT within a clinical setting, specifically focusing on those factors which may act as either a facilitator or a barrier to successful treatment outcomes.

Methods: This research used a qualitative design that allowed participants to express their experiences, beliefs and attitudes around using FBT with adolescents with anorexia. Those clinicians trained in, and using, FBT in their work were invited by email to take part in the interviews. Eight FBT clinicians were recruited for the interviews from the health boards. The researcher used a semi-structured interview with the participants. Interviews lasted from 60-90 minutes to allow for appropriate avenues to be explored, and they were audio recorded. Details of clinicians were anonymised and interview recordings destroyed afterwards. The interviews were transcribed and coded, and the researcher identified themes occurring across the eight interviews.

Results: The themes emerging from the analysis can be considered within a framework of clinicians' perspectives, dividing into factors that facilitate implementation of FBT, factors that may act

as barriers to implementing FBT, and factors that can act as either facilitator or barrier, depending on the context. Eight perceived facilitators, seven perceived barriers and four factors that could act as either a facilitator or barrier were identified.

Conclusions: This research adds to limited research into FBT for adolescents with anorexia applied in a real world setting, from the perspective of the clinician. It provides reflections on the factors that may be improve treatment outcome, or may be detrimental to treatment outcome, which can benefit clinicians implementing FBT. More research is required to investigate clinicians' perspectives, and consider how best to enhance facilitators and decrease barriers for FBT.

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Word Count: 495 (with references)

Abstract

Title: Barriers to and Facilitators of Treatment Outcome in Family Based Therapy for Children and Adolescents with Anorexia: A Clinician's Perspective

Objective: Family based therapy (FBT) has been identified as the first line treatment for adolescents with anorexia nervosa, and has been implemented in five health boards in the West of Scotland. This research seeks to examine the experiences and beliefs of clinicians delivering FBT to young people with anorexia, with a particular focus on their beliefs around facilitating and detrimental factors to treatment outcomes.

Method: Clinicians working in each of the five health boards were invited to take part in the study. Eight clinicians providing FBT to adolescents with anorexia nervosa were recruited. Semi-structured interviews were conducted and data were analysed using thematic analysis. This was then synthesised into sub-themes, mapping onto the framework of barriers and facilitators to implementation of FBT.

Results: Analysis identified eight facilitating factors and seven potential barriers, from the clinicians' perspective. Of note, four factors were identified that may act as either a facilitator or a barrier, depending on other contextual factors.

Discussion: The present findings provide insights into the perspective of clinicians providing FBT for anorexia in real world CAMHS services. These insights may suggest potential avenues for additional attention from clinicians, such as areas of potential bias, and where potential barriers can be shaped into facilitators. Future research into clinicians' experiences and strategies that may enhance facilitators and decrease barriers would be beneficial.

Keywords: *adolescent, child, anorexia nervosa, family therapy, Scotland, qualitative research*

Introduction

Anorexia nervosa is a serious psychiatric disorder, defined in ICD-11 criteria as significantly lowered body weight, with a BMI-for-age under fifth percentile in children, which is not explained by a physical health problem. This is accompanied by restrictive or purging behaviours to prevent weight gain and disturbed perception of body image (WHO, 2018). Anorexia has a lifetime prevalence rate of 0.3% in adolescents aged 13-18, and a significant mortality rate of 4% (Swanson, Crow, Le Grange, Swensden & Merikangas, 2011). A recent meta-analysis reported that anorexia has the highest mortality rate for any psychiatric disorder (Arcelus, Mitchell, Wales & Nielsen, 2011). A number of therapies have been developed and utilised to treat anorexia, for example, adolescent-focused individual therapy (Fitzpatrick, Moye, Hoste, Lock & Le Grange, 2010) or enhanced cognitive behavioural therapy (Dalle Grave, Calugi, Doll & Fairburn, 2013). However, 20% of people affected by anorexia do not recover (Steinhausen, 2002), with poor outcomes in terms of co-morbidities, quality of life and mortality risk. It is therefore important that timely and effective treatments are available to adolescents with anorexia, to reduce the likelihood of poor prognosis.

Family based therapy (FBT) for anorexia nervosa in adolescents has been developed as an alternative to inpatient and day hospital treatment for this population (Lock & Le Grange, 2012). The use of a family based treatment reduces disruption to the social and educational life of the adolescent, and encourages recovery beyond the initial goal of weight restoration. The inclusion of the family in treatment may reduce the risk of relapse, improve family relations, and encourage growth of personal autonomy for the adolescent within appropriate parental boundaries (Lock & Le Grange, 2012).

FBT involves three phases of treatment which young people move through, and where deemed necessary by lack of progress, young people can move back to the previous phase. The initial phase of treatment seeks to increase the adolescent's weight, thus reducing the physical health effects associated with an eating disorder, for example, disrupted menses or cardiac dysfunction. The FBT practi-

tioner in this phase assesses the family's typical interaction patterns while assisting the parents to re-feed their child. The focus here is on an empathic response to the adolescent's difficulties, while the family remain persistent in their attempts to encourage normal eating patterns. The second phase aims to return control over eating to the adolescent, once appropriate weight gain has been achieved. Issues surrounding the family relationships or the difficulties of adolescence can be addressed within this phase. In the final phase, a normal weight is maintained and the focus is on establishing a healthy adolescent identity, balancing independence and autonomy with necessary parental restrictions. FBT is currently the first line treatment for anorexia in children and adolescents (NES Matrix, 2015). Research indicates that the improvements on weight gain and EDE-Q scores (a measure of eating disorder severity) achieved in individual and FBT treatment are more likely to be maintained following FBT treatment than individual treatment (Lock et al, 2010).

The West of Scotland Child and Adolescent Mental Health Services (CAMHS) Network Family Based Treatment Implementation Steering Group developed a strategic plan in 2015 to support the implementation of FBT across the West of Scotland. 39 therapists were trained in FBT in the five health boards of the steering group (Lanarkshire, Ayrshire and Arran, Greater Glasgow and Clyde, Forth Valley, Dumfries and Galloway). It is of interest to the clinicians involved that there is an evaluation of the implementation of FBT in West of Scotland. One possible area of interest is the experiences and beliefs of the clinicians delivering the therapy in these areas.

There is a paucity of research on clinician experience of delivering FBT for adolescents with anorexia. Previous research (Couturier et al, 2013) has examined some elements of clinician experience delivering this intervention. Couturier et al (2013) interviewed forty professionals working with adolescents with anorexia in services using FBT as one of their intervention models, and asked about their opinions and experiences of using FBT. Thematic analysis indicated that clinicians felt a number of factors influenced treatment outcome, either positively or negatively, including family

factors such as parental motivation for FBT, intervention factors such as use of a manualised format, and illness factors such as presence/absence of co-morbidities. Factors such as fidelity to the FBT model may also be pertinent to consider, as previous research has indicated that deviation from manualised treatments may result in poorer therapeutic outcomes (Waller & Turner, 2016).

Qualitative research with clinicians may therefore provide us with important information regarding their perception of factors influencing outcome. However, this information is likely open to human bias as clinicians are likely to use heuristics (Tversky & Kahneman, 1974) to inform their decisions, for example, through availability bias in recalling more recent cases. Examples based on the availability heuristic may skew a clinicians' perception of a particular characteristic, as well as the potential enhancing effect of negative emotion on memory (Kensinger, 2007). This can mean that a clinician may more readily recall instances where a factor such as a co-morbidity resulted in poorer therapeutic outcomes. These biases are also pertinent to note as they may be present in the therapy session, potentially effecting the therapeutic relationship, for example, where the client feels misunderstood by the therapist.

This exploratory study provides an opportunity to qualitatively examine clinicians' experiences in implementing FBT within Scottish CAMHS settings, and those factors that were perceived to have facilitated or blocked treatment success. These reflections can thereafter be utilised in these services to maximise facilitating factors and minimise barriers, whilst also providing some considerations for other services who may wish to introduce FBT. However, therapists' perceptions regarding factors influencing outcome may be subject to bias, and an exploration of the clinician's experience may illuminate issues clinicians themselves may bring when introducing FBT to a service. An awareness of clinicians' perceptions may also highlight areas where they may approach a case with a pre-conceived notion, for example, that an individual's characteristics may render them less likely to succeed in therapy. This awareness of clinicians' perceptions can then be used for reflective purposes.

In sum, the aim of this exploratory research was to delineate potential factors that may act as either facilitators or barriers to successful FBT treatment, based on the perceptions of clinicians trained in, and utilising, this modality with young people with anorexia.

Methods

Design

A qualitative design was employed to explore the clinicians' experiences and opinions, allowing participants to report their perceptions of implementing FBT without the constraints often linked to quantitative studies, such as use of structured questionnaires. Additional quantitative analyses were planned but were not possible.¹ Thematic analysis was chosen for two main reasons; it enables the researcher to generate codes and themes through a bottom up, data-driven analysis, without imposing a particular theoretical position (Braun & Clarke, 2006). It also represents an accessible approach for a researcher without expertise in qualitative methods (Braun & Clarke, 2012).

Participants

Participants were eight clinicians who worked across three of the five health boards included in the West of Scotland CAMHS Steering Group. No clinicians were recruited from NHS Forth Valley or NHS Ayrshire and Arran. Although 39 therapists have had FBT training, only those 14 therapists who utilise FBT with this population were approached for recruitment. A purposive sampling approach was required for this research as participants were selected based on the characteristics of their training and experience. The inclusion criteria was clinicians with relevant FBT training and experience of treating adolescents with anorexia using the FBT treatment protocol, working within a

¹ *The initial proposal for this research included a quantitative element to investigate changes in adolescents' weight measurements and number of hospital admissions during and after receipt of FBT. However, the data to complete this were not available for analysis and thus this component was abandoned.*

CAMHS service in one of the health boards. Given the small target population, it was not possible to place further stipulations about a minimum number of FBT cases completed by clinicians.

Sample Size and Data Saturation

Sample size was determined using guidelines from Braun and Clarke (2013) and by availability of participants matching the inclusion criteria. The total sample represents over half of the available pool of clinicians, who represent a fairly homogenous group. It is expected, therefore, that themes from these eight interviews will represent the clinician pool as a whole, as the majority of codes are likely to be identified within the first six transcripts in a homogenous sample (Guest, Bunce and Johnson, 2006).

Ethics

As this is a multi-centre project, ethics was submitted for approval via IRAS, for co-ordination by the NRSPCC. This research was exempt from NHS Ethics as participants are NHS staff and are recruited by virtue of their profession. NHS Lanarkshire R&D (principal investigator's employer) acted as sponsor for this project. Non-REC approval was sought and granted by R&D departments in each of the five health boards (see appendix 2.1). All FBT clinicians were initially contacted via email by a lead FBT clinician involved in this project, prior to the study commencing. This allowed clinicians to opt out of receiving an email invitation to take part (see appendix 2.2). No clinicians opted out of the study at this stage. Following R&D approvals, clinicians were invited to take part via email (see appendix 2.3), with a copy of the participant information sheet (see appendix 2.4) and consent form (see appendix 2.5) included. Potential participants then contacted the principal investigator (SB) via email and arranged a suitable time to conduct the interview. Interviews took place at the clinician's place of work, with permissions for this granted by the head of department in each health board.

Interviews were recorded on a portable recording device, with permission from participants. Audio files were uploaded to a secure server and thereafter deleted from the device. Consent forms were stored within a locked filing cabinet separate from other study materials. Each participant was assigned a unique code, and later assigned a pseudonym for the purposes of this report. Transcriptions were created using only the unique identifier code and all identifiable information (e.g. health boards) was removed from the transcriptions.

Procedure

The principal investigator (SB) conducted interviews at participants' place of work. The participant information sheet was again supplied for the participants' review and any questions answered. Written consent was then obtained. The interview schedule (see appendix 2.6) was created in consultation with another researcher (DS), who is herself an FBT trained clinician. A FBT fidelity rating form (Fitzpatrick et al, 2015) was utilised to inform the fidelity element of the interview schedule(see appendix 2.7).

Semi-structured questions were utilised in the interview to focus and prompt participants on the themes of interest, whilst still encouraging exploration of their subjective opinions and experiences. Interviews lasted between 40-70 minutes and were transcribed verbatim by the principal investigator from the recordings.

Data Analysis

Data were analysed using thematic analysis according to Braun and Clarke (2006)'s six phase model (see appendix 2.8). Thematic analysis is the process of identifying codes and themes within a qualitative data set. This method is relevant for the present research as it is concerned with the subjective

experiences of clinicians, and allows for a data-driven approach to analysis. It is best suited to research questions that examine a specific group's conceptualisation of a topic (Joffe, 2011). The analysis could not be entirely inductive in nature given the pre-determined nature of the topics in the interview. However, the framework that emerged was inductive in nature and not based upon the topics included in the interview schedule.

Stage one of the thematic analysis involved reading and re-reading the transcripts, making notes regarding any codes or themes that initially emerged. A coding table was then generated, identifying code(s) within the data set. Analysis of the codes began to delineate themes and sub themes in the data set (see appendix 2.9 for coding example). These themes and sub themes were reviewed and refined a number of times, for example, by combining or separating sub themes. Themes were then clearly defined and named in a relevant manner.

Reflexivity

The principal investigator's background in clinical psychology training facilitated the analysis of the transcripts, given her experience of interpreting and analysing complex language to understand patients' beliefs and opinions in session. However, identification of codes and themes may be open to researcher bias, and therefore two of the eight transcripts were coded by another investigator (DS), blind to the principal investigator's analyses. Discussion took place following this regarding coding to ensure inter-rater agreement. Furthermore, throughout the coding process, the principal investigator kept detailed notes of decisions made and thought processes, with the aim of continually refining the thematic process. This process enabled the researcher to amend codes and themes until they were an accurate representation of the data set as a whole.

Results

Eight clinicians indicated their wish to take part in the study and completed the semi-structured interview with the principal investigator (SB). Relevant professional characteristics of the eight participants are outlined below in Table 1; names are pseudonyms. All participants are female, which is in line with the over-representation of females in CAMHS.

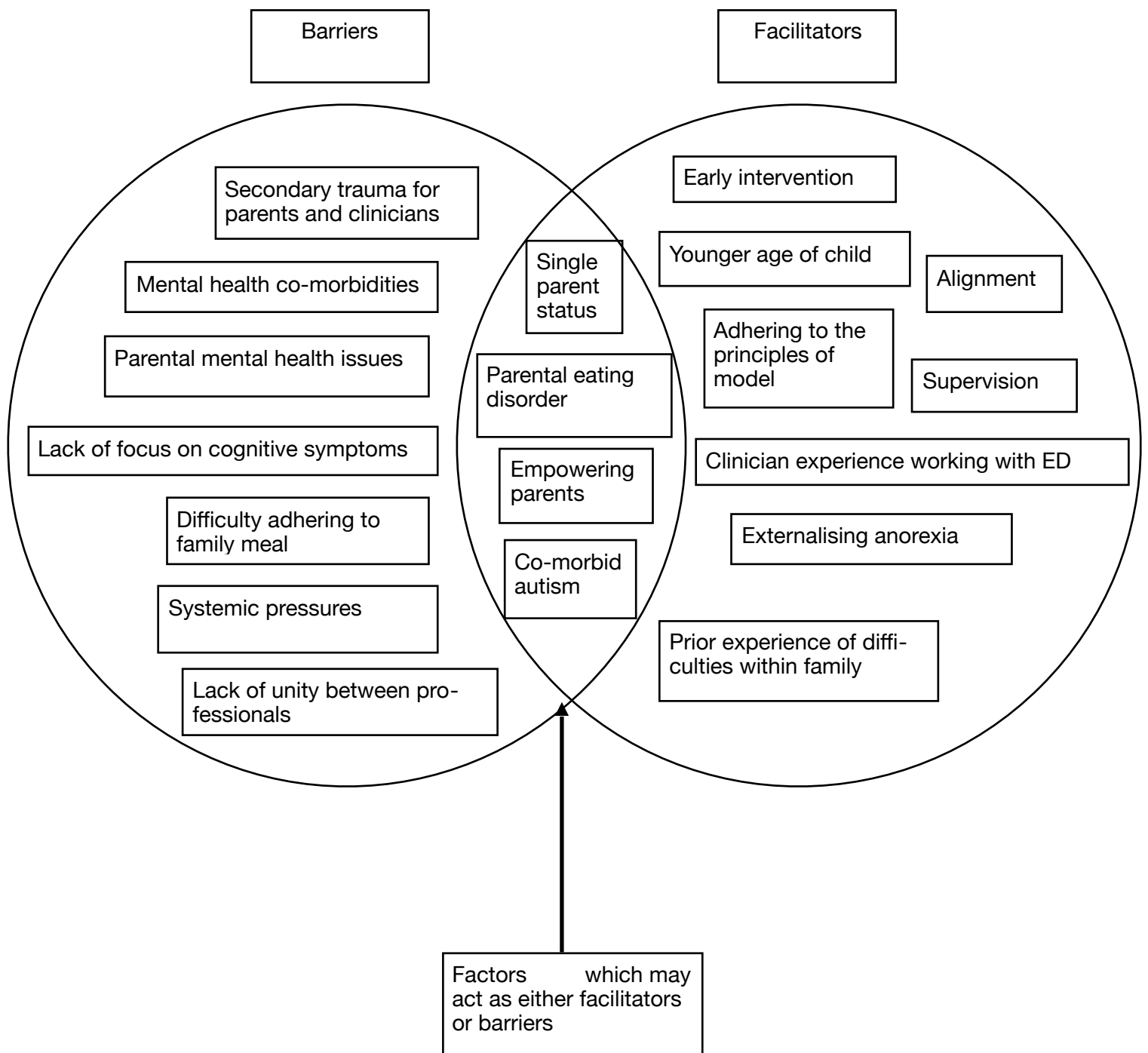
Participant	Background	Generic or specialist service	Level of FBT training	Approximate Number of Cases Using FBT model
Jennifer	Psychologist	Generic	Two day training & supervision	10
Susan	CAMHS clinician	Specialist	Accredited	25-30
Rachel	Family therapist	Specialist	Accredited	25+
Cara	Occupational Therapist	Generic	Accredited	20-30
Amy	Psychologist	Generic	Two day training & supervision	6
Rebecca	Occupational Therapist	Specialist	Accredited Supervisor	50+
Sinead	Mental Health nurse	Specialist	Accredited	50+
Helen	Psychologist	Generic	Two day training & supervision	2

Table 1: Relevant professional characteristics of study participants

An inductive analysis of the transcripts was conducted to yield themes. Super-ordinate themes of ‘barriers to treatment outcome’ and ‘facilitators of treatment outcome’ were identified through analysis of the data. A third super-ordinate theme emerged, which incorporated factors which may act as either barriers or facilitators, dependent on context and other influences e.g. clinicians’ strategies. Eight facilitators, seven barriers, and four factors that may be either facilitator or barrier emerged as sub-ordinate themes. These factors are presented as an overarching framework in figure 1 below.

Additional quotations that contributed to the derivation of codes and themes are noted in appendix 2.10.

Figure 1: Factors which clinicians perceived as either barriers, facilitators, or factors which could be either a facilitator or a barrier, when implementing FBT



Factors perceived as facilitators by clinicians

Eight factors emerged that clinicians believed could facilitate successful FBT treatment in children and adolescents with an eating disorder; early intervention, younger age of child, alignment, adhering to the model, supervision, clinician experience working with ED, externalising anorexia and prior experience of family difficulties. These factors occurred at individual, family, clinician and system levels. At an individual level, the timing of the intervention, both in terms of the length of illness and the age of the young person, can influence engagement in therapy. Where the patient is younger, clinicians tend to find that FBT progresses more easily than with an older adolescent, perhaps linked to the developmental stage of the young person and the acceptability of parental authority.

“...as I say, a 12 year old is much more inclined to do what a parent says than a 17 year old” [Cara]

Early identification and treatment of anorexia was acknowledged by clinicians as particularly important for a prompt recovery. Where anorexia has been present for a longer period of time, clinicians' experience was that the symptoms have become entrenched and resistant to treatment.

“we definitely find that early intervention is key to a good outcome and a shorter treatment time” [Cara]

It may therefore be prudent for families and professionals to focus on early identification and intervention for anorexia, for speedier recovery and reduced use of services.

At a family level, clinicians felt that a family with prior experience of dealing with a difficult issue were more likely to have developed coping skills that can be used in FBT.

“a lived experience of having dealt with something hard within the family, with the family, I think that can help” [Jennifer]

Participants also reflected that without this lived experience, families may be somewhat de-skilled and this can add to the overwhelming feelings parents experience around the responsibility of re-feeding. Additionally, families who are aligned in their goal of engaging in FBT and ‘defeating’ anorexia were perceived by clinicians as more likely to be successful in treatment. This could be expected given the focus on family in this therapy, and the concept of parental alignment was highlighted as important by seven participants.

“if we very quickly see that parents are working together, communicating really well..and tackling the disorder... we can be fairly confident that they’re, they’re going to make a pretty good recovery” [Rebecca]

Furthermore, clinicians felt that families who are able to externalise the anorexia as a separate entity from their young person are more likely to be successful. Participants explained that this approach reduces the blame placed upon the young person, by the adolescent and their family, and thus facilitates parental support of their child.

“families where anorexia exists ...do get into a stage of blaming them for what’s going on, and so it is really helpful to externalise the anorexia and talk about it as something out-with them, something they can beat” [Susan]

At a clinician level, clinicians reported the benefit of extensive experience working with eating disorders, and with the FBT model. Clinicians who are less familiar with the nuances of treatment success may find it difficult to know when to suspend treatment, which could create feelings of failure in families who are pursuing a treatment without progress.

“I think it’s knowing when to stop and I think that comes with experience, think you have to know, you have to know the model incredibly well, emm, and have seen enough families where it has worked, to know very quickly when it has not worked” [Rebecca]

Experience of eating disorders and FBT may facilitate the clinicians’ decision making, in continuing to utilise FBT and reflecting upon whether this remains the most useful treatment for a particular family.

Clinicians also perceived their adherence to the principles of FBT as pertinent to the likelihood of treatment success.

“You are probably more likely to get better outcomes if you adhere to it I guess? ...the research tells you that the more you adhere to it, the better the outcome” [Jennifer]

Participants described the ease with which they adhere to the core principles of FBT, incorporating them into their therapeutic practice. The core principles may be easier to adhere to than more minor details of the treatment.

“I think the principles are just part of me now erm, and so, so yeah, they would be followed through it all” [Rebecca]

Finally, the majority of clinicians reflected upon the importance of supervision for treatment outcomes, in that discussion and reflections with a supervisor facilitates best practice and fidelity to the model.

“supervision helps bring you back as to why those key messages are really really important” [Jennifer]

“I think, if you don’t have supervision your fidelity to model can sometimes slip a little bit” [Cara]

The provision of supervision is considered of such importance to treatment outcomes by clinicians, that FBT was not provided by one trained clinician who did not have access to supervision. This suggests that the systems around clinicians may need to provide certain resources to facilitate the provision of this therapy, albeit supervision is a key element of psychological intervention delivery generally.

“it’s only been the last year that I’ve been prac...practising FBT, because of the lack of supervision...” [Helen]

Factors perceived as barriers by clinicians

Seven potential barriers were identified by clinicians in this study; mental health co-morbidities, parental mental health issues, secondary trauma for parents and clinicians, lack of focus on cognitive

symptoms, difficulty adhering to family meal, systemic pressures and lack of unity between professionals. These factors spanned individual, family, treatment, clinician and system levels.

At an individual level, clinicians reflected upon the presence of mental health co-morbidities in the young people they work with, and that these add an additional layer of complexity to treatment. FBT does not directly tackle these co-morbidities and therefore these young people may present with particularly high levels of distress, which clinicians felt can disrupt the progress of treatment.

“Their levels of distress, there’s usually something underlying, either an underlying anxiety...” [Rebecca]

Parental mental health issues may also inhibit treatment progress, as parents are key to provision of FBT. Clinicians felt this could also block treatment success, as parents generally struggle to manage the extremely demanding tasks of FBT, but the addition of their own mental health issues creates further stress and demands on their resilience.

“parental mental health, as well, is a big one...and weighing up obviously ‘we need you to be well in order to do this but its hugely stressful for you” [Amy]

Clinicians also felt that regardless of whether parents had their own mental health issues, the risks and precariousness of physical health that anorexia brings to the young person can act as a type of vicarious trauma for parents. Some clinicians also perceived this secondary trauma as impacting upon themselves too.

“the sorts of things families tell us of the trauma of it all, em, and eh, having to say to parents often “i think you should be seeking out some support for yourself in your own right” [Rebecca]

“I think there is secondary trauma from working with eating disorders” [Rachel]

The potential traumatising effects of parenting a child with anorexia, or working with a child with anorexia, may act as a distracting factor from working through the challenges of FBT.

At a treatment level, clinicians perceived the lack of attention on cognitive symptoms in FBT as potentially detrimental to outcomes.

“body image still a huge issue, cognitively I think there are still very much rules around ‘well now I’m 100% that’s it’ and we’ve just shifted his rule around weight” [Amy]

Some clinicians did note that this may result in residual symptoms around eating rules and body image, and that young people may then need an additional treatment, such as CBT-E, to shift these cognitive symptoms. This may indicate that lack of attention to these symptoms can act as a barrier to successful treatment outcomes in FBT.

Some of the clinicians reported a particular difficulty with delivery of the family meal, one of the key sessions in the first phase of FBT.

“I think the bit that I still struggle with is the family meal...and setting up a family meal in a clinic setting” [Helen]

The practicalities of this session, requiring a kitchen, within a CAMHS setting meant that some clinicians reported adapting or removing entirely this session. However, given that FBT as manualised supports the importance of the family meal session, these changes could potentially influence treatment outcomes.

At a systemic level, clinicians acknowledged the need for time and resources to adequately implement FBT for children and adolescents. Size of caseloads or lack of practical resources, as noted in the family meal example, may act as a barrier to clinicians' provision of FBT as manualised, and as such this deviation could be detrimental to treatment outcomes for young people.

“if they're..actually able to implement the model the way the model is designed to be, due to not having time pressures or not feeling you have to get through your patients..” [Jennifer]

Furthermore, some of the clinicians felt that knowledge of the key principles of FBT, and knowledge of eating disorders generally, may vary across professionals. This variability in messages that professionals may then give families involved in FBT, for example, when the young person is an inpatient, can confuse families and detract from the manualised treatment as provided by the clinician.

“they've been giving messages that aren't quite in accordance with the FBT messages to families” [Susan]

“... more service level, how we implement FBT...I don't think we kind of have the links with paediatrics that we would possibly need...in order to do it effectively” [Amy]

A lack of unity across professionals can therefore dilute the key messages of FBT, thus deviating from the treatment as manualised, with the consequence of impacting outcomes.

Factors that may act as either a barrier or a facilitator

Of interest, a third category emerged of factors that can act as either barrier or facilitator, depending on other influential factors, such as clinicians' knowledge and strategies, or parental attitudes. These four factors were single parent status, parental eating disorder, empowering parents and co-morbid autism.

Within the young person, an additional diagnosis of autism spectrum disorder (ASD), or a suspected diagnosis of ASD, was considered as influential on outcomes by all of the clinicians interviewed.

Clinicians tended to view ASD as acting as a barrier, where lack of flexibility of thought in the young person is detrimental to changing eating disordered behaviours.

“ When you throw autism in the mix, you get a bit tricky... I think naturally they're going to be a bit more rigid” [Amy]

However, two clinicians interviewed suggested that ASD could in fact act as a facilitator of treatment outcome, and that inflexibility of thought could benefit recovery from anorexia, in that the young persons' rules changed towards weight gain.

“once parents have re-established rules, eh young people with ASD go with the rules...it can sort of work in our favour a little bit” [Rebecca]

It is possible that these clinicians, contrary to the expected bias that ASD will further complicate treatment, have used the symptoms of ASD as a facilitator of successful FBT treatment.

Parental eating disorder was again considered by the majority of clinicians as acting as a barrier to treatment success. In particular, clinicians felt mothers may have their own mental health issues with eating and food and therefore their attitudes to eating may reinforce the young person's anorexia and thus thwart treatment success.

“ Mum had half a bagel for her lunch, and I just thought ‘who has half a bagel?’ ...there was something about mum's attitude, and I think early on with that girl she had been a little overweight, and her mum had given her lots of positive regard for losing weight” [Cara]

However, again some clinicians felt there could be exceptions to the rule, and that the attitude of the parent themselves to their experience of an eating disorder may be influential.

“...the mum herself had a diagnosis of anorexia in childhood, and that would be one of the things that you would be told to be aware of, but actually it didn't impact her at all, in fact it enabled her because what it did was...she knew okay...this was not good...I can't allow my daughter to go down the same road, so she was much more able actually to do it.” [Jennifer]

This may suggest that where a parent is able to reflect upon the impact of their own experiences of anorexia, this can facilitate their motivation to succeed in FBT.

Empowering parents to take charge of re-feeding their child is considered one of the key principles in FBT. Generally, clinicians agreed with this principle and noted many parents find a relief in being given permission to take on this role and remove control from their child.

“that model where you empower parents to look after their own children and, and nobody can feed their child better than their own parent can” [Cara]

However, some clinicians perceived that this message could potentially be detrimental, and ties in to previous barriers mentioned in parental mental health and secondary trauma. These clinicians noted that parents can be overwhelmed by the responsibility of this task, and that this can inhibit treatment success, where parental distress levels are too high.

“you’re very much putting the ball in their court, and getting them to take responsibility for weight restoration ... I think that can be overwhelming for families” [Susan]

Finally, a number of clinicians considered that single parents had a more difficult task implementing FBT alone, and that a lack of a supporting partner increased the sense of responsibility and the levels of stress that the parent feels.

“one of the things that...can be tricky, for that, is the single parents... it can be really challenging, it can be really challenging, because, because parents are effectively doing it on their own” [Rebecca]

Again, though, some clinicians considered that there were nuances to this, in that a single parent does not need to achieve alignment with a partner, and that this could in fact facilitate their progress through FBT.

“I mean there could be the obvious of if you have two people, you could say well that’s obviously going to be easier and better. That’s only if you’re on the same page. So sometimes you would have a single parent, actually all of my single parents have been really successful” [Rachel]

Discussion

The aim of this research was to qualitatively examine the experiences and views of clinicians practising FBT with young people who have anorexia. The focus of this study specifically was to consider the clinicians’ perspectives on potential facilitators of, and barriers to, treatment success. A third category emerged from the data, suggesting that there are factors which have the potential to act as facilitator or barrier, dependent on the influence of extraneous factors such as a clinician’s individual strategies and parental attitudes. This category may be particularly relevant as it may suggest areas where these reflections can be used by clinicians to improve practice. An overarching framework was constructed (figure 1) which clearly delineated these factors.

Facilitators of FBT treatment success

Clinicians considered a number of individual factors that increase their hopefulness for the young person’s recovery, for example, early intervention and younger age of the child. This was consistent with previous research, for example, suggesting chronicity of illness is associated with unfavourable outcomes (Steinhausen, 2002). All professionals working with young people with eating disorders

may therefore wish to be alert to the onset of the eating disorder, and consequently increase the likelihood of early intervention and good therapeutic outcomes.

Clinicians themselves reflected upon the need for experience when working with young people with eating disorders, including knowledge of eating disorders and of the FBT model. The perceived benefit of experience is unsurprising but may be particularly pertinent when working with this population, given the severity of anorexia. Adherence to the model was considered as paramount by the clinicians, who appear to be aware of the link between adherence and therapeutic outcomes, as noted in previous research (Waller and Turner, 2016). Supervision was perceived by clinicians as beneficial to fidelity and therefore potentially of benefit to therapy outcomes. Supervision is considered so crucial for FBT, as with other psychological therapies, that lack of supervision precluded use of FBT. It is therefore suggestive that services should prioritise provision of resources such as supervision, as an inability to provide this may block access to the gold standard treatment for anorexia in young people.

Within families, prior experience of dealing with a difficult situation, and the resultant coping mechanisms that may arise from this experience, can thereafter facilitate parents through the challenges of FBT tasks. Clinicians may wish to note those families who are relatively new to challenging situations, and provide additional suggestions or strategies to those families. Parents that can separate the anorexia from the young person were perceived by clinicians as more able to engage in the therapeutic process, and direct feelings of anger and blame towards the anorexia rather than their child. Clinicians may be able to pay attention to this externalisation process in sessions and further scaffold this for families who are finding this more challenging. Finally, clinicians reported parental alignment as a facilitating factor for treatment outcomes. Again, this may be a process which clinicians can reflect upon with parents in session, to further enhance alignment.

Barriers to FBT treatment success

Co-morbidities were a particularly salient feature within the transcripts, with mental health comorbidities considered potentially detrimental, consistent with previous research by Couturier et al (2013). Co-morbidities were felt to add an additional level of complexity to the case, where FBT would not directly treat these co-morbidities, but nevertheless they may increase levels of distress in the young person. Parental mental health issues were also perceived as detrimental to treatment outcomes, where parents' own ill health may preclude full engagement in the challenging tasks of FBT. Clinicians may therefore wish to reflect upon the presence of mental health problems in both the young person and their parents, and signpost to additional services who can advise and treat these difficulties. Given the high mortality rates and physical health risks seen in anorexia, parenting a child with anorexia and working as a professional with children with anorexia is considered as potentially traumatising for parents and clinicians. The risk of death or serious physical health concerns can be experienced by parents and clinicians as secondary trauma, which may require time and resources to support individuals through, for example, via therapy for parents and supervision for clinicians.

Some of the clinicians in this study reported aspects of the treatment as potentially detrimental to treatment outcomes. There was the perception that FBT does not attend to cognitive symptoms, and that this may leave young people with residual symptoms, which may need to be remedied by further therapy such as CBT-E. Conversely, research suggests weight gain following FBT is superior and longer lasting than individual treatment (Lock et al, 2010); these reflections by clinicians may therefore represent their own preferences for cognitive models or strategies. There were also reflections upon the practicalities of adhering to the family meal session in FBT, due to factors such as

access to kitchen space. These practical issues may need to be thought through by the systems that support clinicians; although some of the clinicians interviewed expressed a strict adherence to the family meal with every individual.

Consistent with this, clinicians felt that the systems they work in may not accurately account for the time and resources necessary to fully implement FBT. They expressed a belief that large clinician caseloads and lack of resources acted as barriers to implementation of FBT as manualised. Additionally, they reflected upon the need for unity across professionals, where all professionals working with the young person should be familiar with FBT principles and only utilise this approach, to avoid confusion in families. These systemic factors could be reflected upon by service managers and providers; however, similar issues may be equally applicable for clinicians practising other forms of psychological therapy, and may not indicate a pressing need regarding FBT specifically.

Factors which may act as either a facilitator or a barrier to treatment success

Four factors emerged which could not be clearly categorised into either a facilitator or a barrier, as clinicians reflected that they may act as either, depending on the individual circumstances of the family and clinician involved. Co-morbid autism was a particularly salient feature in the transcripts, discussed by all participants. The majority of participants felt that the rigid, rule bound thinking seen in autism was detrimental to treatment outcome; however, two participants felt that this rigid thinking style could be harnessed for the benefit of treatment progress. Of interest, those two participants were among the most experienced of clinicians included in the study, which could further lend credence to the suggestion that clinician experience is a facilitator. Reflections upon this finding may benefit therapeutic practice, where clinicians could set aside their initial belief that autism is a barrier

er to progress, and instead utilise insights from other clinicians to harness this thinking style for the benefit of the young person.

A young person supported by a single parent only was reported as a disadvantage by the majority of clinicians in the study, who felt that this increased the levels of stress and responsibility on that parent. Again, though, some clinicians felt that a more important factor was alignment, and that a single parent with high levels of focus and motivation was better for outcomes than two parents who may not necessarily be aligned in their attitudes towards FBT. As before, there is the potential for a clinician to make a judgement that a single parent only family will find FBT more difficult, potentially missing the nuances of the factors that may actually benefit families.

Similarly, a number of participants considered that parental eating disorder would act as a barrier to treatment success. However, some clinicians reflected upon their experiences of working with families, and in particular mothers, with eating disorders, who were actually more motivated to prevent their child experiencing an eating disorder, as a result of having their own experience of this. This could indicate that clinician could in fact utilise parent's knowledge and experiences to enhance treatment outcomes, where the parent felt able and willing to do so. There may be subtleties to this decision not covered by this research, for example, whether the parent has recovered from the eating disorder or not.

Finally, empowering parents to take charge of the re-feeding of their child is a key principle within FBT. Some participants felt that this was particularly valuable, in permitting parents to take control of their child's diet, where this control may have been previously relinquished. However, this perceived facilitator can also act as a barrier, with parents who feel overwhelmed by the challenging nature of this task, and would prefer more guidance and support from others. This may link to

parental mental health and secondary trauma factors highlighted previously. Clinicians may reflect again upon the nuances of which families to push towards empowerment and control of re-feeding, and which families may be better suited to a different therapeutic approach.

Overall, whilst recommendations can be drawn from the analysis of clinicians' perspectives in this study, it is also beneficial to reflect upon the biases and beliefs that clinicians may bring to therapy sessions. As with all humans, clinicians are susceptible to the use of heuristics (Tversky and Kahneman, 1974) when making decisions, and may jump to particular conclusions based on cognitive 'shortcuts', such as recent examples or emotionally laden memories. This can be seen in the research findings around factors that can be either barriers or facilitators, where clinicians can, for example, assume that co-morbid autism will be detrimental, as this can be consistent with prior difficult experiences the clinician has had working with co-morbid anorexia and autism. These biases may therefore limit the clinicians' own flexibility, reducing the likelihood that they will harness this factor as a facilitator. Reflections upon these findings may therefore help clinicians remain aware of, and open to changing, their own biases in practice.

Limitations

There are a number of limitations identified in this research study. The subjective nature of the clinicians' responses introduces bias into the analysis, for example, where participants wish to give the 'correct' answer to a question, or the answer that they feel the researcher is looking for. As in any qualitative research, participants could also find it difficult to reflect upon their own weaknesses or lack of fidelity with another person. The researcher herself is also open to potential biases, for example, pre-conceived notions around FBT which could be introduced to the interview process at an unconscious level.

It would have been preferable to have completed the quantitative analyses initially proposed, as a complement to the qualitative component, for example, by comparing treatment outcomes in those with and without co-morbidities. Furthermore, Guest et al (2006) reported that data saturation is evident following 12 interviews, and this research has been limited to eight interviews. The participants, however, do represent over half of the FBT clinicians currently working within the West of Scotland. Additionally, the FBT experience of the clinicians in this study varied significantly, which may limit generalisability. The use of thematic analysis, whilst accessible for a novice qualitative researcher, may not represent the best available qualitative analysis method.

Implications for Clinical Practice

The findings from this study have implications for clinical practice that may be of use to FBT clinicians. Recommendations can be drawn from the perspective of clinicians, for example, at a service level, for example, it may be beneficial to create stronger links with other professionals and services, disseminating knowledge and advice on FBT to ensure this treatment is applied consistently. Improved understanding of eating disorders in professionals can facilitate earlier identification of an eating disorder; early identification may enable the young person to achieve swifter recovery. It may also be helpful for clinicians and service managers to consider ways to enhance their adherence to aspects of the model, such as the family meal, for example, by tackling the practicalities interfering with this session.

There may also be populations for whom additional attention could be given, with a view to improving outcomes, for example, parents with mental health problems, parents who are not aligned or who are lacking in coping mechanisms from experience. More support may be necessary for certain

families, for example, by provision of additional sessions. Reflections upon the biases that clinicians bring to therapy, and utilising peer supervision, would also be a pertinent implication from this research, as they may be able to use these reflections to improve outcomes. An example of this would be clinicians sharing knowledge with their peers on how to harness rigid thinking styles seen in autism, to act as a facilitating factor.

Implications for Future Research

There is a paucity of research on clinician perspectives on working with this population generally. Further research, particularly replicative research, could be beneficial as the clinicians who provide psychological treatment do play a significant role in recovery. Future research could more clearly outline the subtleties of the factors considered in this study, for example, whether greater clinician experience correlates with their ability to harness ambiguous factors as facilitators, instead of barriers. Comparisons of qualitative data with quantitative data would provide more confidence in some of the conclusions in this study, for example, correlations between factors outlined in this paper and changes on outcome measures for anorexia. Finally, additional research into biases, and strategies to minimise the impact of biases, would be of use to FBT clinicians, as well as to psychological therapists generally

Conclusions

The barriers and facilitators outlined in this research offer clinicians some useful reflections on factors to be aware of in therapy sessions. There were a number of factors that could be either facilitators or barriers, providing an opportunity for clinicians to work towards using these factors as facilitators, thereby increasing the likelihood of treatment success. As this research is qualitative and thus

subjective, it is prudent that clinicians utilising this analysis remain aware of their own biases and are alert to these in the therapeutic space.

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Appendix 1.1: Guidelines for submission to the International journal of Eating Disorders

Title Page

On the title page, authors should list the **title**, the short running title, the full names of all **authors**, and their affiliations. Authors should also state the **number of words** contained in the abstract and the number of words of the manuscript (excluding tables and references).

Title

The title should be short and informative, containing major keywords related to the content. The title should not contain abbreviations (see [Wiley's best practice SEO tips](#)).

Authorship

For details on eligibility for author listing, please refer to the journal's [Authorship policy](#) outlined in Section 5 of these Author Guidelines.

Acknowledgments

Contributions from individuals who do not meet the criteria for authorship should be listed, with permission from the contributor, in an Acknowledgments section. Financial and material support should also be mentioned. Thanks to anonymous reviewers are not appropriate.

Conflict of Interest Statement

Authors will be asked to provide a conflict of interest statement during the submission process. See the journal's policy on [Conflict of Interest](#) outlined in Section 5 of these Author Guidelines. Authors should ensure they liaise with all co-authors to confirm agreement with the final statement.

Abstract

The word maximum and abstract format varies by contribution type (see above). When an abstract is required, the abstract should be typed as a single paragraph. The journal requires **structured abstracts** with three exceptions: the journal will continue to use unstructured abstracts for Clinical Case Reports, Commentaries and "An Idea Worth Researching".

Structured abstracts should be organized as follows: **Objective**: briefly indicate the primary purpose of the article, or major question addressed in the study. **Method**: indicate the sources of data, give brief overview of methodology, or, if review article, how the literature was searched and articles selected for discussion. For research based articles, this section should briefly note study design, how participants were selected, and major study measures. **Results**: summarize the key findings. **Discussion**: indicate main clinical, theoretical, or research applications/implications.

Keywords

Please provide five to seven keywords. Keywords should be taken from those recommended by the US National Library of Medicine's Medical Subject Headings (MeSH) browser list at www.nlm.nih.gov/mesh.

Main Text

- Authors should refrain from using terms that are stigmatizing or terms that are ambiguous. For further explanation and examples, see the 2016 IJED article by Weissman et al. entitled "*Speaking of that: Terms to avoid or reconsider in the eating disorders field*" (DOI: 10.1002/eat.22528.)

- The text should be divided as outlined in Section 3 “Manuscript Categories and Requirements”.
- Manuscripts reporting original research should follow the **IMRaD guidelines** (*I*ntroduction, *M*ethods, *R*esults, and *D*iscussion), which are recommended by the International Committee of Medical Journal Editors (ICMJE) (*J. Pharmacol. Pharmacother.* 2010, 1, 42–58).
- To facilitate evaluation by the Editors and Reviewers, each manuscript page should be numbered; the text should be double-spaced; and line numbers should be applied (restarting from 1 on each page). Instructions on how to implement this feature in Microsoft Word are given here.
- The journal uses US spelling. Authors may submit using any form of English as the spelling of accepted papers is converted to US English during the production process.
- Footnotes to the text are not allowed and any such material should be incorporated into the text as parenthetical matter.
- It is the primary responsibility of the authors to proofread thoroughly and ensure correct spelling and punctuation, completeness and accuracy of references, clarity of expression, thoughtful construction of sentences, and legible appearance prior to the manuscript's submission.
- Authors for whom English is not their first language are encouraged to seek assistance from a native or fluent English speaker to proof read the manuscript prior to submission. Wiley offers a paid service that provides expert help in English language editing—further details are given below.
- Articles reporting data taken from or deposited elsewhere should refer to the journal policy on Data Storage and Documentation in Section 5 (below).

References

References in all manuscripts should follow the style of the American Psychological Association (6th edition), except in regards to spelling. The APA website includes [a range of resources for authors learning to write in APA style](#), including [An overview of the Publication Manual of the American Psychological Association, Sixth Edition](#); includes [free tutorials on APA Style basics](#) and an [APA Style Blog](#). Please note APA referencing style requires that a Digital Object Identifier (DOI) be provided for all references where available.

Tables

Each table must be numbered in order of appearance in the text with Arabic numerals and be cited at an appropriate point in the text. Tables should be self-contained and complement, not duplicate, information contained in the text. They should be editable (i.e., created in Microsoft Word or similar), not pasted as images. Legends should be concise but comprehensive—the table, legend, and footnotes must be understandable without reference to the text. All abbreviations must be defined in footnotes. Footnote symbols: †, ‡, §, ¶, should be used (in that order) and *, **, *** should be reserved for P-values. Statistical measures such as standard deviation (SD) or standard error of the mean (SEM) should be identified in the headings. The journal’s [Editorial Policy on Sample Size and Statistics](#) is given in Section 5.

Figure Legends/Captions

Each figure caption should have a brief title that describes the entire figure without citing specific panels, followed by a description of each panel. Captions should be concise but comprehensive—the figure and its caption must be understandable without reference to the text. Be sure to explain abbreviations in figures even if they have already been explained in-text. Axes for figures must be la-

beled with appropriate units of measurement and description. Include definitions of any symbols used and units of measurement.

2. Figures

Although authors are encouraged to send the highest quality figures possible, for peer-review purposes, a wide variety of formats, sizes, and resolutions are accepted. [Click here](#) for the basic figure requirements for figures submitted with manuscripts for initial peer review, as well as the more detailed post-acceptance figure requirements.

Helvetica typeface is preferred for lettering within figures. All letters, numbers and symbols must be at least 2 mm in height. Courier typeface should be used for sequence figures. Figures should be numbered consecutively with Arabic numerals, and they should be numbered in the order in which they appear in the text.

Figures should be submitted as electronic images to fit either one (55 mm, 2 3/16", 13 picas), two (115 mm, 4 1/2", 27 picas), or three (175 mm, 6 7/8", 41 picas) columns. The length of an illustration cannot exceed 227 mm (9"). Journal quality reproduction requires grey scale and color files at resolutions of 300 dpi. Bitmapped line art should be submitted at resolutions of 600–1200 dpi.

Figures submitted in color will be reproduced in color online free of charge. Authors wishing to have figures printed in color in hard copies of the journal will be charged a fee by the Publisher; further details are given [elsewhere](#) in these Author Guidelines. Authors should note however, that it is preferable that line figures (e.g., graphs) are supplied in black and white so that they are legible if printed by a reader in black and white.

Appendix 1.2: Search Strategy

Database	Search Terms
<p>EMBASE, Journals@Ovid, Access University of Glasgow</p>	<p>1.(clinician* or psychologist* or professional* or therapist* or counselor* or counsellors* or practitioner*).ab. or (clinician* or psychologist* or professional* or therapist* or counselor* or counsellors* or practitioner*).ti.</p> <p>2. ("adolescents" or "adolescent" or "teenager" or "teenagers" or "teen" or "teens" or "youth" or "youths" or "minor" or "minors" or "child" or "children").sh. or (adolescents or adolescent or teenager or teenagers or teen or teens or youth or youths or minor or minors or child or children).ti. or (adolescents or adolescent or teenager or teenagers or teen or teens or youth or youths or minor or minors or child or children).ab.</p> <p>3. ("eating disorders" or "eating disorder" or "disordered eating" or "EDNOS" or "anorexia" or "bulimia" or "anorexia nervosa" or "bulimia nervosa" or "binge-eating" or "appetite disorders" or "feeding disorders").sh. or (anorexia or bulimia or eating disorder* or disordered eating or EDNOS or binge-eat*).ti. or (anorexia or bulimia or eating disorder* or disordered eating or EDNOS or binge-eat*).ab.</p> <p>4. 1 AND 2 AND 3</p>

Database	Search Terms
Assia	<p>1. mainsubject("adolescents" OR "adolescent" OR "teenager" OR "teenagers" OR "teen" OR "teens" OR "youth" OR "youths" OR "minor" OR "minors" OR "child" OR "children") OR ti(adolescents OR adolescent OR teenager OR teenagers OR teen OR teens OR youth OR youths OR minor OR minors OR child OR children) OR ab(adolescents OR adolescent OR teenager OR teenagers OR teen OR teens OR youth OR youths OR minor OR minors OR child OR children)</p> <p>2. mainsubject("eating disorders" OR "eating disorder" OR "disordered eating" OR "EDNOS" OR "anorexia" OR "bulimia" OR "anorexia nervosa" OR "bulimia nervosa" OR "binge-eating" OR "appetite disorders" OR "feeding disorders") OR ti(anorexia OR bulimia OR eating disorder* OR disordered eating OR EDNOS OR binge-eat) OR ab(anorexia OR bulimia OR eating disorder* OR disordered eating OR EDNOS OR binge-eat)</p> <p>3. mainsubject(clinician* OR psychologist* OR professional* OR therapist* OR counselor* OR counsellor* OR practitioner*) OR ti(clinician* OR psychologist* OR professional* OR therapist* OR counselor* OR counsellor* OR practitioner*) OR ab(clinician* OR psychologist* OR professional* OR therapist* OR counselor* OR counsellor* OR practitioner*)</p> <p>4. 1 AND 2 AND 3</p>

Database	Search Terms
MEDLINE	<p>1. TI (anorexia or bulimia or "eating disorder" or "appetite disorder" or "feeding disorder" or "disordered eating" or "eating disorder not otherwise specified") OR AB (anorexia or bulimia or "eating disorder" or "appetite disorder" or "feeding disorder" or "disordered eating" or "eating disorder not otherwise specified")</p> <p>2. TI (adolescent or adolescents or child or children or teenager or teenagers or teen or teens or youth or youths or minor or minors) OR AB (adolescent or adolescents or child or children or teenager or teenagers or teen or teens or youth or youths or minor or minors)</p> <p>3. TI (clinician or clinicians or practitioner or practitioners or professional or professionals or psychologist or psychologists or therapist or therapists or counsellor or counsellors or counselor or counselors) OR AB (clinician or clinicians or practitioner or practitioners or professional or professionals or psychologist or psychologists or therapist or therapists or counsellor or counsellors or counselor or counselors)</p> <p>4.MH "eating disorder" or "anorexia" or "bulimia" or "anorexia nervosa" or "bulimia nervosa" or "EDNOS" or appetite disorders”</p> <p>5. MH "adolescents" or "teens" or "teenagers" or "youth" or "minors"</p> <p>6. (s1 or s4) AND (s2 or s5) AND S3</p>

Database	Search Terms
<p>PsycInfo, PsycArticles, CINAHL, SocIndex, Child Development and Adolescent Studies, Psychology and Behavioural Sciences Collection.</p>	<p>1.SU ("eating disorders" or "eating disorder" or "disordered eating" or "EDNOS" or "anorexia" or "bulimia" or "anorexia nervosa" or "bulimia nervosa" or "binge-eating" or "appetite disorders" or "feeding disorders") OR TI (anorexia or bulimia or eating disorder* or disordered eating or ED-NOS or binge-eat*) OR AB (anorexia or bulimia or eating disorder* or disordered eating or ED-NOS or binge-eat*)</p> <p>2. SU ("adolescents" or "adolescent" or "teenager" or "teenagers" or "teen" or "teens" or "youth" or "youths" or "minor" or "minors" or "child" or "children") OR TI (adolescents or adolescent or teenager or teenagers or teen or teens or youth or youths or minor or minors or child or children) OR AB (adolescents or adolescent or teenager or teenagers or teen or teens or youth or youths or minor or minors or child or children)</p> <p>3. TI (clinician* or psychologist* or professional* or therapist* or counselor* or counsellors* or practitioner*) OR AB (clinician* or psychologist* or professional* or therapist* or counselor* or counsellors* or practitioner*)</p> <p>4. 1 AND 2 AND 3</p>

Appendix 1.3: Data Extraction Form

Title:

Authors:

Journal:

Keywords:

Research Question:

Study Design:

Sample:

Inclusion/exclusion criteria:

Measures used (if any):

Approaches to data analysis:

What does this paper tell us about working as a psychologist with adolescents with an ED?:

Strengths:

Limitations:

Appendix 1.4 Quality Appraisal tool (Hawker et al, 2002)

Question	Good Rating (4 points)	Fair Rating (3 points)	Poor Rating (2 points)	Very Poor Rating (1 point)
Abstract and title: Did they provide a clear description of the study?	Structured abstract with full information and clear title	abstract with most of the information	inadequate abstract	no abstract
Introduction and aims: Was there a good background and clear statement of the aims of the research?	Full but concise background to discussion/ study containing up to date literature review and highlighting gaps in knowledge	Some background and literature review. research questions outlined	some background but no aim/ objectives/ questions OR aims/ objectives but inadequate background	no mention of aims/ objectives. No background or literature review
Method and data: Is the method appropriate and clearly explained?	Method is appropriate and described clearly (e.g. questionnaires included). Clear details of the data collection and recording	Method appropriate, description could be better. data described.	Questionable whether method is appropriate. Method described inadequately. Little description of data.	No mention of method AND/ OR method inappropriate AND/OR no details of data.

Question	Good Rating (4 points)	Fair Rating (3 points)	Poor Rating (2 points)	Very Poor Rating (1 point)
Sampling: was the sampling strategy appropriate to address the aims?	Details (age / gender /race / context) of who was studied and how they were recruited. Hy this group was targeted. The sample size was justified for the study. Response rates shown and explained.	Sample size justified. Most information given, but some missing.	Sampling mentioned but few descriptive details.	No details of sample.
Data analysis: Was the description of the data analysis sufficiently rigorous?	Clear description of how analysis was done. Qualitative: description of how themes derived/ respondent validation or triangulation. Quantitative: Reasons for tests selected hypothesis driven/ numbers add up/ statistical significance discussed	Qualitative: descriptive discussion of analysis. Quantitative: as before, some missing information	Minimal details about analysis	no discussion of analysis

Question	Good Rating (4 points)	Fair Rating (3 points)	Poor Rating (2 points)	Very Poor Rating (1 point)
Ethics and bias: Have ethical issues been addressed, and necessary ethical approval gained? Has the relationship between researchers and participants been adequately considered?	where necessary, issues of confidentiality, sensitivity and consent were addressed. Bias: researcher was reflexive and/or aware of own bias.	Lip service was paid to it (i.e. these issues were acknowledged)	brief mention of issues	no mention of issues
Results: is there a clear statement of the findings?	findings explicit, easy to understand, and in logical progression. Tables, if present, are explained in text. Results relate directly to aims. Sufficient data are presented to support findings.	Findings mentioned but more explanation could be given. Data presented relate directly to results.	Findings hpresented haphazardly, not explained, and do not progress logically from results.	Findings not mentioned or do not relate to aims.

Question	Good Rating (4 points)	Fair Rating (3 points)	Poor Rating (2 points)	Very Poor Rating (1 point)
Transferability or generalisability: are the findings of this study transferable (generalisable) to a wider population?	context and setting of the study is described sufficiently to allow comparison with other contexts and settings, plus high score in Question 4 (sampling)	some context and setting described, but more needed to replicate or compare the study with others, plus fair score or higher in question 4	minimal description of context/setting	no description of context/setting
Implications and usefulness: how important are these findings to policy and practice?	contributes something new and/or different in terms of understanding /insight or perspective. Suggests ideas for further research. Suggests implications for policy and/or practice.	two of the above (state what is missing in comments)	only one of the above	none of the above

NHS Forth Valley

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Fax:



Date 14 November 2018
Your Ref
Our Ref
Enquiries to Direct line: 01324 214690
Email: FV-UHB.RandD-depart@nhs.net
R&D ref FV1126

Mrs Sarah Byrne
University of Glasgow, 1st Floor, Administration Building
Gartnavel Royal Hospital 1055 Great Western Road
Glasgow G12 0XH

Dear Mrs Byrne

Study title: An Investigation of Family Based Therapy in a Clinical Setting for Adolescents with Anorexia Nervosa
NRES number: N/A

I am pleased to confirm that I formally gave Management Approval to the study above on 14 November 2018. This approval is subject to the following conditions:

- A signed letter of access for yourself

Please note this approval covers the qualitative research element only.

This approval is granted subject to your compliance with the following:

1. Any amendments to the protocol or research team must have Ethics Committee and R&D approval (as well as approval from any other relevant regulatory organisation) before they can be implemented. Please ensure that the R&D Office and (where appropriate) NRS are informed of any amendments as soon as you become aware of them.

2. You and any local Principal Investigator are responsible for ensuring that all members of the research team have the appropriate experience and training, including GCP training if required.

3. If someone working within NHS Forth Valley is recruiting participants, those figures **MUST** be recorded on the EDGE research management system. If you have not used EDGE before, you should already have been offered training on the system. If recruitment is all being handled outside Forth Valley, you will be contacted monthly for the latest recruitment figures.

3. All those involved in the project will be required to work within accepted guidelines of health and safety and data protection principles, any other relevant statutory legislation, UK Policy Framework for Health and Social Care Research and IHC-GCP guidelines. A copy of the Framework can be accessed at: <http://www.nhsresearchscotland.org.uk/uploads/tinyMCE/uk-policy-framework-health-social-care-research%20v1.1.pdf> and ICH-GCP guidelines may be found at <http://www.ich.org/LOB/media/MEDIA482.pdf>

Chairman: Alex Linkston CBE
Chief Executive: Cathie Cowan

Forth Valley NHS Board is the common name for Forth Valley Health Board
Registered Office: Carseview House, Castle Business Park, Stirling, FK9 4SW
www.nhsforthvalley.com Facebook.com/nhsforthvalley @nhsforthvalley

4. As custodian of the information collected during this project you are responsible for ensuring the security of all personal information collected in line with NHS Scotland IT security policies, until the destruction of this data.

5. You or the local Principal Investigator will be required to provide the following reports and information during the course of your study:

- A progress report **annually**
- Report on SAEs and SUSARs if your study is a Clinical Trial of an Investigational Medicinal Product
- Any information required for the purpose of internal or external audit and monitoring
- Copies of any external monitoring reports
- Notification of the end of recruitment and the end of the study
- A copy of the final report, when available.
- Copies of or full citations for any publications or abstracts

The appropriate forms will be provided to you by the Research and Development office when they are needed. Other information may be required from time to time.

Yours sincerely

pp
MR. ANDREW MURRAY
Medical Director

CC:
Rory.connor@glasgow.ac.uk

Research and Development Support Unit
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Sarah Byrne
NHS Lanarkshire
Motherwell CAMHS Team
Airbles Road Centre
59 Airbles Road
Motherwell

Date: 22ND November 2018

Our ref: JC/TC/18/DGY/030

Study title: FBT for anorexia in adolescents

Protocol version approved: v4 **Dated:** 23/04/2018

Dear Sarah

Thank you for sending me details of your study with a request for management approval. I can confirm that the study review team has reviewed the documentation and on this basis I am pleased to inform you that your study has management approval for commencement within NHS Dumfries and Galloway.

It is a condition of this approval that everyone involved in this study abides by the guidelines/protocols laid down by this Health Board in respect of confidentiality and Research Governance. It is your responsibility to ensure you are familiar with these; please do not hesitate to seek advice if you are unsure. Copies of Research Governance Framework documents are available via the website www.sehd.scot.nhs.uk/cso and then use the publications link.

We also note that it is the sponsor's responsibility to ensure that appropriate training is in place for all local investigators. It is important that all research must be carried out in compliance with the Research Governance Framework for Health and Community Care and the new EU Clinical Trials Directive (for clinical trials involving investigational medicinal products).

As part of the Health Board's responsibilities under Research Governance a sample of studies will be monitored, and it is therefore important that all records in connection with the study are kept up to date and available for review. We are also required to inform you that details of your study will be entered onto our R&D database. As custodian of the information collated during this research project, you are responsible for ensuring the security of all personal information collected, in line with NHS Scotland IT Security Policies, until the destruction of this data.

**Research and Development Support Unit
Ground Floor
Dumfries and Galloway Royal Infirmary
Bankend Road
Dumfries
DG1 4AP**



If your study is adopted by UKCRN into a portfolio then please advise this department of recruitment figures by adding accrual data to that database on a monthly basis.

Please notify the R&D office immediately you become aware of any serious adverse events associated with this research.

You must contact the R&D Department if/when the project is subject to any minor or substantial amendments so that these can be appropriately assessed, and approved, where necessary. I understand that performance of this study will not infringe on NHS Dumfries and Galloway's ability to deliver our usual level of service.

May I take this opportunity to wish you every success with your project. Please do not hesitate to seek help and advice from the R&D Support Unit (ext 33165/33815) if there is anything you feel you require assistance with. I look forward to hearing about your work and would appreciate a short annual report and a final report when the study is complete.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Janie Candlish'.

Mrs Janie Candlish
Clinical Trials/Research Project Manager

cc: SREDA Database
cc: Professor Rory O'Connor University of Glasgow
cc: Danielle Skene East Kilbride CAMHS Service
cc: Raymond Hamill R&D Manager Lanarkshire



Mrs Sarah Byrne
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 1st Floor, Administration Building
 Gartnavel Royal Hospital
 1055 Great Western Road
 Glasgow G12 0XH

R&D Department
 Corporate Services Building
 Monklands Hospital
 Monkscourt Avenue
 AIRDRIE
 ML6 0JS

Date 5th November 2018
 Enquiries to Elizabeth McGonigal,
 R&D Facilitator
 Direct Line 01236 712459
 Email elizabeth.mcgonigal@lanarkshire.scot.nhs.uk

Dear Mrs Byrne

Project title: An Investigation of Family Based Therapy in a Clinical Setting for Adolescents with Anorexia Nervosa

R&D ID:

NRS ID NUMBER:

I am writing to you as Chief Investigator of the above study to advise that R&D Management approval has been granted for the conduct of your study within NHS Lanarkshire as detailed below:

NAME	TITLE	ROLE	NHSL SITE TO WHICH APPROVAL APPLIES
Mrs Sarah Byrne	Trainee Clinical Psychologist	Principal Investigator	NHS Lanarkshire

As you are aware, NHS Lanarkshire has agreed to be the Sponsor for your study. On its behalf, the R&D Department has a number of responsibilities; these include ensuring that you understand your own role as Chief Investigator of this study. To help with this we have outlined the responsibilities of the Chief Investigator in the attached document for you information.

All research projects within NHS Lanarkshire will be subject to annual audit via a questionnaire that we will ask you to complete. In addition, we are required to carry out formal monitoring of a proportion of projects, in particular those projects that are sponsored by NHS Lanarkshire. In either case, you will find it helpful to maintain a well organised Site File. You may find it helpful to use the folder that we have included for that purpose.

For the study to be carried out you are subject to the following conditions:



Conditions

- This approval letter only covers the qualitative research element of your proposal. The Service Evaluation element will need to be approved by the Psychology Department.
- You are required to comply with Good Clinical Practice, Ethics Guidelines, Health & Safety Act 1999 and relevant UK and EU Data Protection legislation.
- The research is carried out in accordance with the Scottish Executive's Research Governance Framework for Health and Community Care (copy available via the Chief Scientist Office website: <http://www.cso.scot.nhs.uk/> or the Research & Development Intranet site: <http://firstport2/staff-support/research-and-development/default.aspx>)
- You must ensure that all confidential information is maintained in secure storage. You are further obligated under this agreement to report to the NHS Lanarkshire Data Protection Office and the Research & Development Office infringements, either by accident or otherwise, which constitutes a breach of confidentiality.
- Clinical trial agreements (if applicable), or any other agreements in relation to the study, have been signed off by all relevant signatories.
- You must contact the Lead Nation Coordinating Centre if/when the project is subject to any minor or substantial amendments so that these can be appropriately assessed, and approved, where necessary.
- You notify the R&D Department if any additional researchers become involved in the project within NHS Lanarkshire
- You notify the R&D Department when you have completed your research, or if you decide to terminate it prematurely.
- You must send brief annual reports followed by a final report and summary to the R&D office in hard copy and electronic formats as well as any publications.
- If the research involves any investigators who are not employed by NHS Lanarkshire, but who will be dealing with NHS Lanarkshire patients, there may be a requirement for an SCRO check and occupational health assessment. If this is the case then please contact the R&D Department to make arrangements for this to be undertaken and an honorary contract issued.

I trust these conditions are acceptable to you.

Yours sincerely,

**Raymond Hamill – Senior R&D Manager**

c.c.

NAME	TITLE	CONTACT ADDRESS	ROLE
Raymond Hamill	Senior R&D Manager	Raymond.Hamill@lanarkshire.scot.nhs.uk	Sponsor Contact
Dr Danielle Skene	Specialist Clinical Psychologist	Danielle.skene@lanarkshire.scot.nhs.uk	Field Supervisor

Enc 1 x Site File

1 x Responsibilities as Sponsor Notes



Responsibilities as Sponsor

Site File

As an aid to the conduct of your study we have provided a Site File that you may wish to use. As Sponsor of the study we are required to carry out audit of all project, and to conduct detailed monitoring visits for a proportion (approximately 10%) - The study Site File should help you ensure that you have the relevant documentation to assist in this process. If your project is selected for monitoring, we will contact you well in advance to arrange a suitable time.

Our responsibilities as Sponsor are defined within the Research Governance Framework for Health and Community Care. A summary of these, along with those of the Chief Investigator, is provided in the following table for your information.

RESPONSIBILITIES OF CHIEF INVESTIGATOR	NHSL RESPONSIBILITIES AS SPONSOR
Obtain relevant / appropriate Research Ethics opinion.	Assess adequateness of the independent, expert review.
Obtain NHSL Research Management Approval.	Ensure that the Chief/Principle Investigator has the necessary expertise, experience and education to conduct the study.
Ensure that the members of the research team have the necessary expertise, experience and education to perform their roles.	Provide a formal written agreement of sponsorship conditions, and notification of confirmation of the sponsorship role.
Ensure the necessary resources are available for the study.	Provide NHS indemnity to the Chief Investigator and research team.
Act in accordance with regulations set out by your professional body(s) and the conditions of your employment contract.	Provide mechanisms and processes to exploit any potential Intellectual Property.
Identify archiving arrangements at the study outset.	Project monitoring commensurate with risk.
Record and review significant developments that may affect the study, particularly those which put the safety of the individuals at risk or affect the scientific direction and report to the sponsor as appropriate.	Make available local, national and international guidelines, regulations and legislation governing research in the UK.
Record, report and review all untoward medical occurrence (adverse events or reactions) including classification of causality, seriousness and expectedness.	Provide ongoing advice and guidance to promote quality study management and conduct.
Notify R&D and appropriate REC of significant news, changes, amendments and modifications to the study.	Determine the acceptability of the archive arrangements proposed by the Chief Investigator and, if the archive facility becomes unsuitable, provide alternative arrangements.
Maintain a record of all incidents, providing an annual report to the sponsor.	Determine length of archive/retention period for essential study documents and subsequent destruction date
Inform REC and R&D of the study end.	
Maintain a log of archived documents and their location.	
Inform R&D of any publications arising from the study or dissemination of findings.	
Inform R&D of any potential Intellectual Property.	

Senior Research Administrator: Kayleigh McKenna
Telephone Number: 0141 232 1826
E-Mail: kayleigh.mckenna@ggc.scot.nhs.uk
Website: www.nhsggc.org.uk/r&d

Clinical Research & Development
West Glasgow ACH
Dalnair Street
Glasgow G3 8SJ
Scotland, UK

26/11/2018

Dr Sarah Byrne
NHS Lanarkshire
Motherwell CAMHS Team
Airbles Road Centre
59 Airbles Road
Motherwell
ML1 2TP

NHS GG&C Board Approval

Dear Dr Byrne

Study Title:	An Investigation of Family Based Therapy in a Clinical Setting for Adolescents with Anorexia Nervosa
Principal Investigator:	Dr Sarah Byrne
GG&C HB site	CAMHS
Sponsor	NHS Lanarkshire
R&D reference:	
REC reference:	
Protocol no: (including version and date)	Version 03 dated 06.09.18

I am pleased to confirm that Greater Glasgow & Clyde Health Board is now able to grant **Approval** for the above study.

Conditions of Approval

1. **For Clinical Trials** as defined by the Medicines for Human Use Clinical Trial Regulations, 2004
 - a. During the life span of the study GGHB requires the following information relating to this site
 - i. Notification of any potential serious breaches.
 - ii. Notification of any regulatory inspections.

It is your responsibility to ensure that all staff involved in the study at this site have the appropriate GCP training according to the GGHB GCP policy (www.nhsggc.org.uk/content/default.asp?page=s1411), evidence of such training to be filed in the site file.

2. **For all studies** the following information is required during their lifespan.
 - a. Recruitment Numbers on a quarterly basis
 - b. Any change of staff named on the original SSI form
 - c. Any amendments – Substantial or Non Substantial

- d. Notification of Trial/study end including final recruitment figures
- e. Final Report & Copies of Publications/Abstracts

Please add this approval to your study file as this letter may be subject to audit and monitoring.

Your personal information will be held on a secure national web-based NHS database.

I wish you every success with this research study

Yours sincerely,

Pp Mrs Elaine O'Neill

Mrs Kayleigh McKenna
Senior Research Administrator

CC: Raymond Hamill (NHS Lanarkshire)

Research & Development
 56a Lister Street
 University Hospital Crosshouse
 Kilmarnock
 KA2 0BB

Mrs Sarah Byrne
 Trainee Clinical Psychologist
 NHS Lanarkshire
 Motherwell CAMHS Team
 Airbles Road Centre
 59 Airbles Road
 Motherwell
 ML1 2TP

Date 14 November 2018
 Your Ref
 Our Ref CM/KLB/NM R&D 2018AA048
 Enquiries to Karen Bell
 Extension 25850
 Direct line 01563 825850
 Fax 01563 825806
 Email Karen.Bell2@aapct.scot.nhs.uk

Dear Mrs Byrne

An Investigation of Family Based Therapy in a Clinical Setting for Adolescents with Anorexia Nervosa

I confirm that NHS Ayrshire and Arran have reviewed the undernoted documents and grant R&D Management approval for the above study.

Documents received:

Document	Version	Date
SSI form	Version 5.9.1	14/11/18
Protocol	Version 4.0	23/04/18
R&D Form	Version 5.9.1	19/09/18
R&D Form – Part C	Version 5.9.1	27/10/18
Interview Protocol	Version 3.0	06/09/18
Invitation Email	Version 1.0	06/09/18
Consent Form	Version 2.0	06/09/18
PIS	Version 2.0	06/09/18

The terms of approval state that the investigator authorised to undertake this study is: -

- Mrs Sarah Byrne, Trainee Clinical Psychologist, NHS Lanarkshire

PLEASE NOTE: We await your signed NHS to NHS confirmation of pre-engagement check before we can issue your Letter of Access. Access to NHS Ayrshire and Arran is not permitted until the Letter of Access has been issued.

With no additional investigators.

The sponsors for this study are NHS Lanarkshire.

This approval letter is valid until 14 January 2020.

Regular reports of the study require to be submitted. Your first report should be submitted to Dr K Bell, Research & Development Manager in 12 months time and subsequently at yearly intervals until the work is completed.

Please note that as a requirement of this type of study your name, designation, work address, work telephone number, work e-mail address, work related qualifications and whole time equivalent will be held on the Scottish National Research Database so that NHS R&D staff in Scotland can access this information for purposes related to project management and report monitoring.

In addition approval is granted subject to the following conditions: -

- All research activity must comply with the standards detailed in the UK Policy Framework for Health and Social Care Research <http://beta.hra.nhs.uk/planning-and-improving-research/policies-standards-legislation/uk-policy-framework-health-social-care-research> and appropriate statutory legislation. It is your responsibility to ensure that you are familiar with these, however please do not hesitate to seek further advice if you are unsure.
- Recruitment figures must be submitted to R&D on a monthly basis. If recruitment figures are not received timeously you will be contacted by a member of the R&D team to provide this data.
- You are required to comply with Good Clinical Practice (ICH-GCP guidelines may be found at www.ich.org/LOB/media/MEDIA482.pdf), Ethics Guidelines, Health & Safety Act 1999, General Data Protection Regulation (GDPR) and Data Protection Act 2018.
- If any amendments are to be made to the study protocol and or the Research Team the Researcher must seek Ethical and Management Approval for the changes before they can be implemented.
- The Researcher and NHS Ayrshire and Arran must permit and assist with any monitoring, auditing or inspection of the project by the relevant authorities.
- The NHS Ayrshire and Arran Complaints Department should be informed if any complaints arise regarding the project and the R&D Department must be copied into this correspondence.
- The outcome and lessons learnt from complaints must be communicated to funders, sponsors and other partners associated with the project.

- As custodian of the information collated during this research project you are responsible at all times for ensuring the security of all personal information collated in line with NHS Scotland policies on information assurance and security, until the secure destruction of these data. The retention time periods for such data should comply with the requirements of the Scottish Government Records Management: NHS Code Of Practice. Under no circumstances should personal data be stored on any unencrypted removable media e.g. laptop, USB or mobile device (for further information and guidance please contact the Information Governance Team based at University Hospital Crosshouse 01563 825831 or 826813).

If I can be of any further assistance please do not hesitate to contact me. On behalf of the department, I wish you every success with the project.

Yours sincerely

Dr Crawford McGuffie
Joint Medical Director

c.c.

Professor Rory O'Connor, Chair of Health Psychology, University of Glasgow (Academic Supervisor)

Dr John Taylor, Associate Medical Director – Mental Health Services, NHS Ayrshire and Arran

Dr Danielle Skene, Specialist Clinical Psychologist, NHS Lanarkshire (Academic Supervisor)

Raymond Hamill, NHS Lanarkshire (sponsor contact)

Information Governance, NHS Ayrshire & Arran

Lesley Douglas, Finance, Ailsa Hospital

Appendix 2.2: Opt-out email

“Hi all. My name is Sarah Byrne and I’m a final year trainee clinical psychologist at University of Glasgow/NHS Lanarkshire. My thesis is on FBT therapist’s experiences, beliefs and attitudes around providing FBT to adolescents with an eating disorder. It will involve a semi structured interview of around 60-90 minutes. This is a preliminary email and not an invitation to take part; it is part of the requirements for ethical approval.

If you would like to be removed from the email list that will be used for invitation purposes, please could you let Danielle Skene (clinical supervisor) or Maria Dale know. Your details will then be removed from the list prior to my accessing the list for study purposes.”

Appendix 2.3: Invitation email to clinicians

Dear X,

Invitation to take part in a research study: An Investigation of Family Based Therapy (FBT) in a Clinical Setting for Adolescents with Anorexia

I am writing to you to invite you to take part in a research study investigating family based therapy for adolescents with anorexia in the West Coast of Scotland. You have been invited to take part by virtue of your training in FBT for use with this population.

This study will interview clinicians and investigates clinician's experiences and beliefs with utilising FBT for this population, their perceived treatment fidelity, and those factors which, in their experience, can affect treatment outcome. It is hoped that this information, once analysed, will provide insight into the benefits and challenges of using this treatment modality, and may enhance practitioner and service reflection upon the implementation of this approach. This research is conducted as part of the requirements for the Doctorate in Clinical Psychology. The chief investigator for this research is myself, Sarah Byrne (Trainee Clinical Psychologist, NHS Lanarkshire), supervised by Professor Rory O'Connor (Academic Supervisor, University of Glasgow) and by Dr Danielle Skene (Field Supervisor, NHS Lanarkshire).

If you would like to take part in the study, please find attached information sheet for more information on participating in this research. If you have any questions regarding the study, please do not hesitate to contact me on s.eschle.1@research.gla.ac.uk. If you do not wish to take part in the study, this will not affect your rights as an NHS employee.

If you have decided that you would like to arrange a date to take part in the study, please email me on the above details.

Many thanks for taking the time to read this invitation.

Best wishes,
Sarah



University of Glasgow | College of Medical,
Veterinary & Life Sciences

An Investigation of Family Based Therapy in a Clinical Setting for Adolescents with Anorexia

Participant Information Sheet

Version Number: 2

Date: 6th September 2018

You have been given this information sheet as you are eligible to take part in this study. Before you decide, it is important for you to understand the purpose of the research and what it will involve. This sheet outlines the information you may require to inform whether you may wish to participate in this study. Please take your time to read the information carefully and ask the researcher if anything is unclear or you have any further questions. If you decide to take part in the study, you will be given a copy of this information sheet and a signed consent form.

What is the purpose of the study?

The purpose of this study is to gather qualitative experiences and opinions from clinicians who have been trained in family based therapy and are utilising this approach with adolescents who have been diagnosed with anorexia. Clinicians from five health boards including NHS Lanarkshire, NHS Greater Glasgow and Clyde, NHS Forth Valley, NHS Ayrshire and Arran and NHS Dumfries and Galloway, were trained in this approach. The goal of this study is to understand clinician's experience about the efficacy of this model, the factors that may influence the efficacy and their perceived fidelity to the model. This data gathered can thereafter inform current and future implementation of FBT in a 'real life' CAMHs service.

Why have I been invited to participate?

You have been invited to take part in this study as you have been trained in Family Based Therapy and you are working clinically using this modality with adolescents who have a diagnosis of anorexia nervosa.

Do I have to take part?

No, it is up to you to decide whether you would like to take part. If you do decide to take part, you

will be asked to sign a consent form. You may withdraw from the study at any time and without giving a reason.

What will happen to me if I take part in the study?

The study will involve a semi-structured interview exploring clinician's perceptions and experiences of the effectiveness of FBT for anorexia, the clinician's perceived fidelity to the FBT model, and those individual, family and clinician factors which in their experience can effect treatment outcome. The interview will take approximately 60-90 minutes to complete and will be audio-recorded. The interviews will take place in the participant's workplace.

Are there any benefits to taking part?

Taking part in this study will not directly benefit the participant. However, it is hoped that the study can inform clinical practise by utilising the detailed information gathered in the study to reflect upon the current implementation of FBT and advise future application of this model in other CAMHs services.

Are there any potential risks to taking part?

The researcher does not anticipate that there will be undue distress as a result of taking part in this study. However, should the participant feel distressed and wish to withdraw at any time, you will be able to do so. Additionally, participants may decline to answer a particular question, but wish to continue with the rest of the study.

What if I don't want to take part or I change my mind about participation during the study?

You are under no obligation to take part in this research. If you consent to take part but change your mind during the study, you can withdraw from the study at any time, without providing a reason. If you choose not to take part or to withdraw your consent, this will not affect your rights as an NHS employee.

Will my taking part in this study be kept confidential?

The information collected in this study will remain strictly confidential. You will be given a unique participant number to identify you and your data (contact details, consent forms) will be stored on a restricted access server within the University of Glasgow. Audio tapes of the interviews will thereafter be transcribed by the researcher, and the transcriptions will be stored separately on a password protected server at the University of Glasgow. The transcriptions will not contain any identifiable information, and will be linked to your identifiable information only by the unique participant number. Your audio tapes will be destroyed at the end of the study, and anonymised interview transcripts will be stored for a period of 10 years, in line with policy. Information you provide may be included in published reports or articles as direct quotations, but these will be anonymised.

What will happen to my data?

The University of Glasgow is responsible for storing your information for a period of ten years. Your information will not be passed on to a third party without your express permission. Researchers from the University of Glasgow collect, store and process all personal information in accordance with the General Data Protection Regulation (2018). The data will be stored in archiving facilities in line with the University of Glasgow retention policy of up to 10 years. After this period, further retention may be agreed or your data will be destroyed in line with the relevant standard procedures. Your identifiable information might be shared with people who ensure the study is done correctly, and if you agree, in anonymised form with other universities or organisations for scientific research purposes. Your anonymised data will form part of the study result published as part of this thesis, but your name will not appear in any publications relating to this research project.

What will happen to the results of the research study?

The results will be submitted in a report to the University of Glasgow as part of the qualification of Doctorate in Clinical Psychology. It is also hoped that this research will be published in a relevant journal.

Who is carrying out the study?

Sarah Byrne, Trainee Clinical Psychologist (NHS Lanarkshire) is carrying out this research as part of her Doctorate of Clinical Psychology at the University of Glasgow. The study is supervised by Professor Rory O'Connor (University of Glasgow) and Dr Danielle Skene (Clinical Psychologist, NHS Lanarkshire).

Who has reviewed the study?

The project has been reviewed by the Research and Development departments for each health board included.

What should I do if I have questions about the study?

Please contact the researcher on the details below who would be happy to answer any questions you may have.

What should I do if I want to take part in the study?

If you would like to take part in the study please inform the researcher who will go through an informed consent sheet with you.

Contact Information:

Sarah Byrne, Trainee Clinical Psychologist

Email:

Address: University of Glasgow, 1st Floor, Administration Building, 1055 Great Western Road, Glasgow G12 0XH.

Professor Rory O'Connor, Supervisor, Chair in Health Psychology (Mental Health and Wellbeing), Institute of Health and Wellbeing, University of Glasgow, Administration Building, 1055 Great Western Road, Glasgow, G12 0XH.

Email: rory.oconnor@glasgow.ac.uk

If you have any complaints about the study, and wish to speak to a researcher not involved in this project please contact:

Dr Katie Robb, Senior Lecturer (Mental Health and Wellbeing), Institute of Health and Wellbeing, University of Glasgow, 1st Floor, Administration Building, 1055 Great Western Road, Glasgow, G12 0XH.

Email: Katie.Robb@glasgow.ac.uk

Thank you for taking the time to read this Participant Information Sheet.

Appendix 2.5 Participant consent form



University of Glasgow | College of Medical,
Veterinary & Life Sciences

Centre number: XX

Project Number: XX

Participant Identification Number:

Title: An Investigation of Family based Therapy in a Clinical Setting for Adolescents with Anorexia Nervosa

Researcher: Sarah Byrne, Trainee Clinical Psychologist

Version Number: 2

Date: 6th September 2018

By signing this form you agree that:

Please Initial

I confirm that I have read and understood the participant information sheet version 2 dated 6th September 2018

I have had the opportunity to think about the information and ask any questions, and understood the answers given.

I understand that my participation is voluntary and that I may withdraw from the study at any time or refuse to answer any of the questions in the study, without giving any reason. This will not affect my legal rights or my NHS employment.

I agree to my interview being audio-recorded

I confirm that I agree to the way my data will be collected and processed and that data will be stored for up to ten years in University Archiving facilities in accordance with relevant Data Protection policies and regulations.

I understand that all data and information I provide will be kept confidential and will be seen only by study researchers and regulators whose job it is to check the work of researchers.

I agree that my name, contact details and data described in the information sheet will be kept for the purposes of this research project.

I understand that if I withdraw from the study, my data collected up to that point will be retained and used for the remainder of the study.

I understand that my information and things that I say in an interview may be quoted in reports or articles that are published, but my name and anything else that could tell people who I am will not be included.

I understand that the recorded interview will be transcribed word by word and the transcription stored for up to ten years in University archiving facilities in accordance with Data Protection policies and regulations.

I understand that my data may be used in future research. If my data is included in another project, it will remain anonymised.

I agree to participate in this study.

Name of participant

Date

Signature

Researcher

Date

Signature

Appendix 2.6: Interview Schedule

An Investigation of Family Based Therapy in a Clinical Setting for Adolescents with Anorexia

Interview protocol

Version Number: 3

Date: 6th September 2018

Part A General Questions

- 1) **Can you describe the extent of your experience working with FBT in anorexia, for example, roughly the number of patients you have seen since training?**
- 2) **What level of training in FBT have you obtained?**
- 3) **Do you have access to supervision for your FBT practice, either within or outwith your service?**
- 4) **Do you work in a generic CAMHs service or an eating disorder specific service?**
- 5) **Do you utilise any other modalities when treating adolescents with anorexia?**
- 6) **Generally what are your thoughts and feelings about treating anorexia in adolescents, given the seriousness of the condition and the evidence suggesting the difficulty in achieving recovery?**

Part B Effectiveness of FBT for Anorexia

- 1) **What are your views on the effectiveness of FBT for anorexia?**
- 2) **In your experience, what are the advantages of this modality?**
- 3) **In your experience, what are the disadvantages to this modality?**
- 4) **How do you feel FBT compares to other treatment modalities you may use/may have used for anorexia in adolescents?**
- 5) **From your experience, are there any changes you would make to FBT for anorexia?**
- 6) **Anything else you feel is relevant?**

Part C Perceived Fidelity to the FBT Protocol

- 1) **In your experience, generally how easy or difficult has it been to adhere to the FBT treatment protocol?**

Do you feel that there are advantages to adherence to the protocol? Are there any disadvantages?

- 2) **What has been your experience of adhering to the initial re-feeding phase of FBT?**
>>Are there elements of this phase that are particularly difficult e.g. demonstrating the usefulness of this particular model to the family, charging the parents with the responsibility of re-feeding, family meal, involving patients' siblings, maintaining parental focus on re-feeding?
- 3) **What has been your experience of adhering to the second phase of FBT - negotiating a new pattern of relationships?** >>Are there elements of this phase that are particularly difficult e.g. returning control of eating to the adolescent, examining the relationship between the issues of the adolescent and anorexia, modifying parental/sibling criticism?
- 4) **What has been your experience of adhering to the final phase of FBT - adolescent issues and termination?** >>Are there elements of this phase that are particularly difficult e.g. problem solving for adolescent issues, checking in with parents on their current role, planning for future issues, managing the end of therapy?
- 5) **How do you judge the timing of movement between the three phases?** Are there any challenges regarding this? Have you found a need to repeat or revisit phases?

Part D: Individual, Family and Clinician factors which may influence treatment outcome

- 1) **In your experience, what are the factors at an individual level that may positively influence treatment outcome? Any factors that may be detrimental to treatment outcome?**
- 2) **In your experience, what are the factors at a family level that may positively influence treatment outcome? Any factors that may be detrimental to treatment outcome?**
- 3) **In your experience, what are the factors at a clinician level that may positively influence treatment outcome? Any factors that may be detrimental to treatment outcome?**
- 4) **Are there elements of FBT that are generally perceived positively by patients and families? Are there elements that are generally perceived negatively by patients and families?**

**Research Interventions in Anorexia Nervosa (RIAN)
FAMILY THERAPY FIDELITY CHECK**

FBT Fidelity Rating Forms

Phase I Re-Feeding: Initial evaluation and Setting up Treatment

In the blanks provide rate all items on a scale of 1-7, as follows:

1	2	3	4	5	6	7
not at all		some		considerably		very much

Session 1 – The first Face-to-Face Meeting

Three main goals:

- Engage the family in the therapy
- Obtain a history about how the AN is effecting the family
- Obtain preliminary information about how the family functions, i.e., coalitions, authority structure, conflicts

To what degree did the therapist effectively:

- 1) ___ **Greet the family in a sincere but grave manner?**
- 2) ___ **Take a history that engages each family member in the process?**
- 3) ___ **Separate the illness from the patient?**
- 4) ___ **Orchestrate an intense scene around the seriousness of the illness and difficulty in recovery?**
- 5) ___ **Charge the parents with the task of re-feeding?**

Session 2 – The Family Meal

Three main goals:

- Continue the assessment of the family structure and its likely impact on the ability of the parents to successfully re-feed their daughter.
- Provide an opportunity for the parents to experience that they can succeed in re-feeding their daughter.
- Assess the family process specifically around eating.

To what degree did the therapist effectively:

- 1) ___ **Take a history and observe the family patterns around food preparation, food serving, and family discussions about eating especially as it relates to the patient?**
- 2) ___ **Help the parents convince their daughter to eat at least one mouthful more than she is prepared to, OR help set the parents on their way to work out among themselves how best they can go about in refeeding their daughter?**
- 3) ___ **To align the patient with her siblings for support?**

The Remainder of Phase I

Three goals for this part of treatment:

- Keep the family focused on the eating disorder
- Help the parents take charge of their daughter's eating
- Mobilize siblings to support the patient

To what degree did the therapist effectively:

- 1) ___ **Direct, re-direct, and focus therapeutic discussion on food and eating behaviors and their management until food, eating, and weight behaviors and concerns are relieved?**
- 2) ___ **Discuss, support, and help parental dyad's efforts at re-feeding?**
- 3) ___ **Discuss, support and help family to evaluate efforts of siblings to help their affected sibling?**
- 4) ___ **Continue to modify parental and sibling criticisms (if present)?**
- 5) ___ **Continue to distinguish adolescent patient and her interests from those of AN?**

**Research Interventions in Anorexia Nervosa (RIAN)
FAMILY THERAPY FIDELITY CHECK**

FBT Fidelity Rating Forms

Phase II – Negotiating for a new pattern of relationships

In the blanks provide rate all items on a scale of 1-7, as follows:

1	2	3	4	5	6	7
not at all		some		considerably		very much

Three major goals of the Second Phase of treatment are:

- Maintain parental management of eating disorder symptoms until adolescent until patient shows evidence that she is able to eat well and gain weight independently
- Return of food and weight control to adolescent
- Explore relationship between adolescent developmental issues and AN

To what degree did the therapist effectively:

- 1) ____ **Continue to support and assist parents in management of eating disorder symptoms until adolescent is able to eat well on her own?**
- 2) ____ **Assist parents and adolescent in negotiating the return of control of eating disorder symptoms to the adolescent?**
- 3) ____ **Encourage family to examine relationships between adolescent issues and the development of AN in their adolescent?**
- 4) ____ **Continue to modify parental and sibling criticism of patient, especially in relation to the task of returning control of eating to patient (if present)?**
- 5) ____ **Continue to assist siblings in supporting their ill sibling?**
- 6) ____ **Continue to highlight difference between adolescent's own ideas and needs and those of AN?**

**Research Interventions in Anorexia Nervosa (RIAN)
FAMILY THERAPY FIDELITY CHECK**

FBT Fidelity Rating Forms

Phase III – Adolescent Issues and termination

In the blanks provide rate all items on a scale of 1-7, as follows:

1	2	3	4	5	6	7
not at all		some		considerably		very much

There are three major goals for the Third Phase of treatment:

- Establish that the adolescent-parent relationship no longer requires the symptoms as idiom of communication.
- Review adolescent issues with family and to model problem solving of these type of issues
- Terminate treatment.

To what degree did the therapist effectively:

- 1) ___ **Review adolescent issues with family and to model problem solving of these types of issues?**
- 2) ___ **Involve family in “review” of issues?**
- 3) ___ **Check with parents how much they are doing as a couple?**
- 4) ___ **Delineation and exploration of Adolescent Themes for Exploration?**
- 5) ___ **Plan for future issues?**
- 6) ___ **Manage termination?**

**Research Interventions in Anorexia Nervosa (RIAN)
FAMILY THERAPY FIDELITY CHECK**

SFT Fidelity Rating Forms

Initial Sessions

In the blanks provided rate all items on a scale of 1-7, as follows:

1	2	3	4	5	6	7
not at all		some		considerably		very much

Therapist's General Approach

1. ___ Did the therapist keep a systems focus?
2. ___ Did the therapist remain circular?
3. ___ Did the therapist remain open to a range of views and ideas?
4. ___ Did the therapist consider the cultural context of the family with which they were working?
5. ___ Did the therapist take a non-pathologising stance in relation to the family?
6. ___ Was the therapist taking a self-reflexive stance?
7. ___ Did the therapist use the language and narratives presented by the family?
8. ___ Did the therapist work co-operatively with the family?

General Features of Therapy

1. ___ Did the therapist work to amplify change during the session?
2. ___ Did the therapist work to enhance mastery during the session?
3. ___ Did the therapist work to challenge existing patterns and assumptions?
4. ___ Did the therapist work to reframe the issues with which the family was struggling?
5. ___ Did the therapist work to develop new stories and explanations during the session?
6. ___ Did the therapist work to elicit solutions?
7. ___ Did the therapist work to introduce therapist ideas?
8. ___ Did the therapist gather relevant information?
9. ___ Did the therapist use an appropriate style of questioning?
10. ___ Did the therapist use child-centered interventions during the session?

Initial Sessions

1. ___ Did the therapist set the boundaries of therapy with the family?
2. ___ Did the therapist actively work to engage and involve all family members?
3. ___ Did the therapist work with the family to identify and define goals for the therapy?

Specific Therapy Technique

1. ___ Did the therapist use linear questions in talking with the family?
2. ___ Did the therapist use circular questions in talking with the family?
3. ___ Did the therapist use statements in talking with the family?

Proscribed Practice Adherence Items

1. ___ Did the therapist give advice?
2. ___ Did the therapist use psychodynamic interpretations?
3. ___ Was the therapist's practice un-transparent or closed?
4. ___ Did the therapist speak in monologues?
5. ___ Was the therapist consistently siding with one person?
6. ___ Was the therapist working in the transference?
7. ___ Was the therapist inattentive to the language used by the family?
8. ___ Did the therapist consistently use simple reflections of what the family said?
9. ___ Did the therapist take a polarized position to that of family members?
10. ___ Did the therapist stick within one time frame?
11. ___ Did the therapist agree with all the ideas from the family?
12. ___ Did the therapist ignore information presented by the family?
13. ___ Did the therapist show inappropriate affect?
14. ___ Did the therapist ignore the family's affect?
15. ___ Did the therapist ignore differences?
16. ___ Did the therapist attempt or support externalization regarding anorexia nervosa?
17. ___ Did the therapist attempt to raising parental anxiety about the effects of anorexia nervosa?

**Research Interventions in Anorexia Nervosa (RIAN)
FAMILY THERAPY FIDELITY CHECK**

SFT Fidelity Rating Forms

Middle Sessions

In the blanks provided rate all items on a scale of 1-7, as follows:

1	2	3	4	5	6	7
not at all		some		considerably		very much

Therapist's General Approach

1. ___ Did the therapist keep a systems focus?
2. ___ Did the therapist remain circular?
3. ___ Did the therapist remain open to a range of views and ideas?
4. ___ Did the therapist consider the cultural context of the family with which they were working?
5. ___ Did the therapist take a non-pathologising stance in relation to the family?
6. ___ Was the therapist taking a self-reflexive stance?
7. ___ Did the therapist use the language and narratives presented by the family?
8. ___ Did the therapist work co-operatively with the family?

General Features of Therapy

1. ___ Did the therapist work to amplify change during the session?
2. ___ Did the therapist work to enhance mastery during the session?
3. ___ Did the therapist work to challenge existing patterns and assumptions?
4. ___ Did the therapist work to reframe the issues with which the family was struggling?
5. ___ Did the therapist work to develop new stories and explanations during the session?
6. ___ Did the therapist work to elicit solutions?
7. ___ Did the therapist work to introduce therapist ideas?
8. ___ Did the therapist gather relevant information?
9. ___ Did the therapist use an appropriate style of questioning?
10. ___ Did the therapist use child-centered interventions during the session?

Middle Sessions

1. ___ Did the therapist monitor how well the family was engaged in the therapy and actively address any engagement issues?
2. ___ Is the therapist beginning to develop a picture of the family's thoughts, beliefs, myths or attitudes, which may be contributing to the family's dilemmas or difficulties?
3. ___ Did the therapist work towards change at the level of behaviors or beliefs?
4. ___ Did the therapist review the goals of therapy with the family

Specific Therapy Technique

1. ___ Did the therapist use linear questions in talking with the family?
2. ___ Did the therapist use circular questions in talking with the family?

Proscribed Practice Adherence Items

1. ___ Did the therapist give advice?
2. ___ Did the therapist use psychodynamic interpretations?
3. ___ Was the therapist's practice un-transparent or closed?
4. ___ Did the therapist speak in monologues?
5. ___ Was the therapist consistently siding with one person?
6. ___ Was the therapist working in the transference?
7. ___ Was the therapist inattentive to the language used by the family?
8. ___ Did the therapist consistently use simple reflections of what the family said?
9. ___ Did the therapist take a polarized position to that of family members?
10. ___ Did the therapist stick within one time frame?
11. ___ Did the therapist agree with all the ideas from the family?
12. ___ Did the therapist ignore information presented by the family?
13. ___ Did the therapist show inappropriate affect?
14. ___ Did the therapist ignore the family's affect?
15. ___ Did the therapist ignore differences?
16. ___ Did the therapist attempt or support externalization regarding anorexia nervosa?
17. ___ Did the therapist attempt to raising parental anxiety about the effects of anorexia nervosa?

**Research Interventions in Anorexia Nervosa (RIAN)
FAMILY THERAPY FIDELITY CHECK**

SFT Fidelity Rating Forms

End Sessions

In the blanks provided rate all items on a scale of 1-7, as follows:

1	2	3	4	5	6	7
not at all		some		considerably		very much

Therapist's General Approach

1. ___ Did the therapist keep a systems focus?
2. ___ Did the therapist remain circular?
3. ___ Did the therapist remain open to a range of views and ideas?
4. ___ Did the therapist consider the cultural context of the family with which they were working?
5. ___ Did the therapist take a non-pathologising stance in relation to the family?
6. ___ Was the therapist taking a self-reflexive stance?
7. ___ Did the therapist use the language and narratives presented by the family?
8. ___ Did the therapist work co-operatively with the family?

General Features of Therapy

1. ___ Did the therapist work to amplify change during the session?
2. ___ Did the therapist work to enhance mastery during the session?
3. ___ Did the therapist work to challenge existing patterns and assumptions?
4. ___ Did the therapist work to reframe the issues with which the family was struggling?
5. ___ Did the therapist work to develop new stories and explanations during the session?
6. ___ Did the therapist work to elicit solutions?
7. ___ Did the therapist work to introduce therapist ideas?
8. ___ Did the therapist gather relevant information?
9. ___ Did the therapist use an appropriate style of questioning?
10. ___ Did the therapist use child-centered interventions during the session?

End Sessions

1. ___ Did the therapist continue to work towards change at the level of behaviors and beliefs in a manner appropriate with ending session?
2. ___ Did the therapist work with the family towards developing family understanding of the behaviors and beliefs with which they were struggling?
3. ___ Did the therapist review the process and utility of therapy with the family?

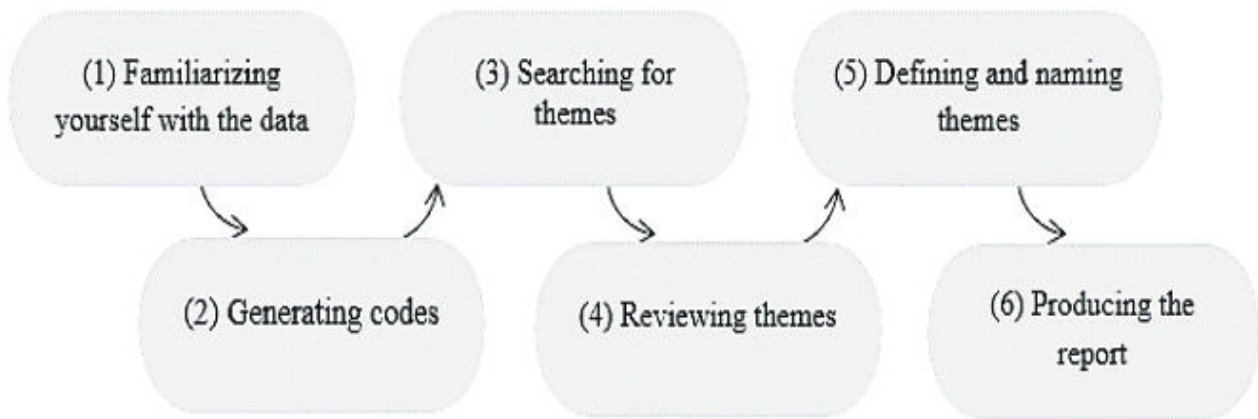
Specific Therapy Techniques

1. ___ Did the therapist use linear questions in talking with the family?
2. ___ Did the therapist use circular questions in talking with the family?
3. ___ Did the therapist use statements in talking with the family?

Proscribed Practice Adherence Items

1. ___ Did the therapist give advice?
2. ___ Did the therapist use psychodynamic interpretations?
3. ___ Was the therapist's practice un-transparent or closed?
4. ___ Did the therapist speak in monologues?
5. ___ Was the therapist consistently siding with one person?
6. ___ Was the therapist working in the transference?
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8. ___ Did the therapist consistently use simple reflections of what the family said?
9. ___ Did the therapist take a polarized position to that of family members?
10. ___ Did the therapist stick within one time frame?
11. ___ Did the therapist agree with all the ideas from the family?
12. ___ Did the therapist ignore information presented by the family?
13. ___ Did the therapist show inappropriate affect?
14. ___ Did the therapist ignore the family's affect?
15. ___ Did the therapist ignore differences?
16. ___ Did the therapist attempt or support externalization regarding anorexia nervosa?
17. ___ Did the therapist attempt to raising parental anxiety about the effects of anorexia nervosa?

Appendix 2.8: Six Stages of Thematic Analysis (Braun and Clarke, 2006)



Appendix 2.9: Coding Example

Quote	Code	Code	Code
<p>FBT would as a core principle argue that we don't tell families what to do, we empower them to make their own decisions, but some families find that very difficult, and want to be told...they can become quite frustrated, when you're not telling them</p>	<p>Empower families to make decisions</p>	<p>Families' wish to be given information</p>	<p>Parental frustration</p>
<p>I think there's something slightly disingenuous about that because...the mantra is that..you fed your child before so...families know how to feed their children, education around eating is one thing, but educating around eating for a child who has anorexia is another</p>	<p>Families have existing skills re feeding</p>	<p>Difference between feeding child with/ without anorexia</p>	<p>FBT may not fully recognise differences in feeding</p>
<p>Sometimes you wonder if you're sticking to model...when you're trying to empower them to make their own decisions, but at the same time they're asking for something quite prescriptive... so I think that can be a fine line to walk.</p>	<p>Adhering to model</p>	<p>Balance of empowering/giving parents answers</p>	

Appendix 2.10: Additional quotes contributing to codes and sub-themes

Code	Quote	Quote
Working with other professionals	“I think that it probably could do with actually, how, how do you work with all those professionals within an FBT model, so to speak...” [Helen]	“I think it doesn’t need just training and awareness within CAMHS, I think it needs, if we’re going to start using it more...paediatricians need to know what FBT is, erm, inpatient need to know what FBT is” [Amy]
Parental mental health	“mum has got a history of mental health problems, and she just isn’t able to be that assertive, and er voice conflict, and this girl just runs rings round her cause actually” [Cara]	“I hear more from parents, now actually about that, about how difficult it is for them as individuals, and actually, trying to support each other, they won’t necessarily tell their partner ‘i’m really struggling.’ To the point of, ‘actually I have suicidal thoughts.’” [Rachel]
Co-morbidities	“if there is co-morbidities, either, OCD is another one that I think can get really tricky, that the more you take control away, the more their OCD is going to flare” [Amy]	“detrimental stuff for the young person would be, when there’s like co-morbidities there” [Sinead]
Lack of focus on cognitive symptoms	“there’s about 30% will, em, need cognitive work following family based treatment...” [Sinead]	“I’ve noticed possibly, it neglects the more cognitive changes... you get to the end and there’s still bits and pieces that you kind of think ‘i’m not ready to discharge you yet” [Amy]
Family meal	“sometimes, I think, that might be something I’d like to change, and I have to say, sometimes I don’t always do a family meal... I don’t always know what I would gain from it.” [Cara]	“I still think the family meal is hard... the hardest part is I think if you can’t get anorexia in the room with you, so the child just sits and eats, I still find that quite difficult...i think it can feel to a family a bit pointless” [Jennifer]

Table 1: Quotations mapping onto sub-themes within the superordinate theme ‘Barriers to implementing FBT’

Code	Quote	Quote
Clinician Experience working with ED	“that just comes with a bit of experience, whereas early on, you’re, you’re really mindful that this is a really serious illness” [Cara]	“it doesn’t always quite go the way that the book wants you to go. And you kinda have to just roll with it, and I think that’s where it helps when you do have eating disorder experience” [Amy]
Adherence	“I’d like to think I adhere to all of, I would like to think that I adhere to the manual as, as best I can, in all the phases.” [Rebecca]	"I think that, erm, initially it was really important to stick to the fidelity of the model...cause I think you’ve got to get a really good grounding, before you can kind of, tweak things” [Cara]
Younger age	“in my experience, it’s where, the family, the age thing as well, for the young person, I think the older they are, it makes the family based treatment more difficult, for the parents em and for the young person, cause they’re like ‘i can do it myself’” [Sinead]	“I do think that FBT with younger people is probably easier as it fits anyway, they are used to parental authority..I think much harder in an older adolescent...” [Jennifer]
Alignment	“Parents who are on the same page, in general, so there’s good already talking between each other” [Jennifer]	“I think if there’s any kind of animosity between parents or parents who are not quite aligned...you’ve got problems. Which is why a huge focus is on aligning the parents, but I think if naturally there’s other issues why they’re not aligned...you kinda sometimes need to think about that, in order to align them” [Amy]

Table 2: Quotations mapping onto sub-themes within the superordinate theme ‘Facilitators to implementing FBT

Code	Quote	Quote
Empowerment	"FBT would as a core principle argue that we don't tell families what to do, we empower them to make their own decisions, but some families find that very difficult, and want to be told...they can become quite frustrated, when you're not telling them" [Jennifer]	"I think it's brilliant that it is about empowering parents and mobilising their own resources, because I think, over time, what happens is that em, you're empowering, empowering the system and the parents" [Helen]
Co-morbid autism	"if there is a hint of autism about, then that's going to make it really slow, and now and again, there is, once again that's difficult, that's difficult to unpick at times..."[Susan]	"But what can happen with that thinking style, is it's like a switch being flicked, and it's like, 'and I'm eating today'... and you're like, see that's the benefit of ASD..."[Rachel]
Single parent status	" think you know you're in for a slightly rougher time if it's a single parent.."[Amy]	"... the single parents...my experience is that I've had families where, where it's absolutely worked, em, but it can be really challenging, it can be really challenging, because, because parents are effectively doing it on their own" [Rebecca]

Table 3: Quotations mapping onto sub-themes within the superordinate theme 'Factors that may act as either barrier or facilitator'

An Investigation of Family Based Therapy in a Clinical Setting for Adolescents with Anorexia Nervosa.

Word Count: 3,403

Abstract: Introduction: Anorexia nervosa is a serious disorder with the highest mortality rate of any psychiatric condition. There are a number of available psychological therapies for anorexia in adolescents; however, a significant minority of patients with anorexia do not recover fully. Family Based therapy (FBT) seeks to include family members in the treatment of these adolescents, with an initial parental focus on weight gain and, once weight is restored, subsequent phases focus on adolescent identity and control over their own eating. This study aims to investigate the outcomes of FBT for adolescents in five health boards across Scotland, and furthermore to explore clinician attitudes to FBT, their perceived fidelity to the model and their experience of factors which may influence clinical outcomes. **Method:** Recruitment for the first aim has been conducted by clinicians trained in FBT and data on 121 cases have thus far been gathered, with this process ongoing. Data on information such as weight, family members attending therapy and duration of illness is recorded by the clinician, whilst the patient completes self-report questionnaires. Statistical analyses will compare weight and number of hospital admissions from baseline to end of treatment. Additionally, where available, comparisons will be conducted on EDE-Q scores across the two time points. The second aim will employ a semi-structured interview with eight to ten FBT clinicians, and patterns within the data interpreted using thematic analysis. **Applications:** This represents an opportunity to evaluate FBT outcomes within a real-world clinical setting, where previous research is largely comprised of randomised controlled trials.

1.Introduction

1.1 Overview

Anorexia Nervosa is a serious psychiatric disorder, with a lifetime prevalence rate of 0.3% in adolescents aged 13-18, and a significant mortality rate of 4% (Swanson et al, 2011). This represents the highest mortality rate for any psychiatric disorder. A number of therapies have been developed and utilised to treat Anorexia, for example, adolescent-focused individual therapy (Fitzpatrick et al, 2010) or enhanced cognitive behavioural therapy (Dalle Grave et al, 2013). However, 20% of people affected by Anorexia do not recover (Steinhausen, 2002), with poor outcomes in terms of comorbidities, amenorrhea, quality of life and mortality risk. It is therefore pertinent that timely and effective treatments are available to adolescents with Anorexia, to reduce the likelihood of the significant consequences of this disorder.

Family Based Therapy (FBT) for Anorexia Nervosa in adolescents has been developed as an alternative to more traditional inpatient and day hospital treatment for this population (Le Grange & Lock, 2012). The use of a family based treatment aims to reduce disruption to the social and educational life of the adolescent, and encourages recovery beyond the initial treatment goal of weight restoration. The inclusion of the family in treatment may reduce the risk of relapse, which is common following an inpatient hospital stay, improve family relations, and encourage growth of personal autonomy for the adolescent within appropriate parental boundaries (Le Grange & Lock, 2012).

The initial phase of family based therapy seeks to increase the adolescent's weight, and thus reduce the physical health effects associated with an eating disorder, for example,

disrupted menses or cardiac dysfunction. The FBT practitioner in this phase assesses the family's typical interaction patterns whilst assisting the parents to re-feed their child. The focus here is on a supportive and empathic response to the adolescent's difficulties, although it is important that the family remain persistent in their attempts to encourage normal eating patterns. The second phase aims to return control over eating to the adolescent, once an appropriate level of weight gain has been established. Issues surrounding the family relationships or the difficulties of adolescence can now be addressed within this phase. In the final phase, a normal weight is maintained and the focus is on establishing a healthy adolescent identity, balancing independence and autonomy with necessary parental restrictions.

Lock et al (2010) conducted an evaluation of adolescent focused individual therapy compared to family based therapy for Anorexia Nervosa. Whilst there were no significant differences between full remission rates (defined as normal weight and Eating Disorder Examination Questionnaire (EDE-Q) (Fairburn and Beglin, 1994) score within 1 SD of published means) at the end of treatment, at 6 month and 12 month follow up FBT was significantly superior to individual therapy on these measures of full remission (49% remission rate at 12 month follow up in the FBT group compared to 23% in the AFT group). This suggests the utility of both treatments for Anorexia Nervosa in adolescents initially, but that improvements on weight gain and EDE-Q scores are more likely to be maintained following FBT treatment. This is in line with other studies of FBT for anorexia in adolescents (Eisler et al, 1997; Lock, Couturier and Agras, 2006; Eisler et al, 2007).

Couturier et al (2013) interviewed forty professionals working with adolescents with Anorexia, half of whom were utilising family based therapy as their intervention. Thematic

analysis indicated that clinicians felt a number of factors influenced treatment outcome, either positively or negatively, including family factors such as parental motivation for FBT, intervention factors such as use of a manualised format, and illness factors such as presence/absence of co-morbidities. Qualitative research may therefore provide us with subjective information regarding factors influencing treatment outcome. Additionally, the experience of clinicians may be of importance for treatment efficacy; Kosmerly et al (2015) note that clinician anxiety and caseload were associated with deviation from FBT protocol, which may impact upon treatment outcomes for the individual.

1.2 Background to the present study

The West of Scotland Child and Adolescent Mental Health Services (CAMHS) Network Family Based Treatment Implementation Steering Group developed a strategic plan in 2015 to support the implementation of FBT across the West of Scotland. 39 therapists were trained in FBT and two FBT therapists and one FBT champion were identified in each of the five health boards (Lanarkshire, Ayrshire and Arran, Greater Glasgow and Clyde, Forth Valley, Dumfries and Galloway). FBT therapists began taking on cases in January 2015 and have so far gathered data for 121 of these cases, which form the basis of the quantitative data for part of this project. The primary component of this research is therefore to evaluate weight change and number of hospital admissions pre versus post FBT treatment. Furthermore, where available, scores on the Eating Disorder Examination Questionnaire, a measure of eating disorder psychopathology and behaviours, will be compared pre versus post FBT treatment. This component will utilise secondary quantitative data analysis by the author of the data collected by the clinicians. This research represents an evaluation of the clinical application of FBT within a generic CAMHS service, and as such reflects an ecologically valid analysis, out-with the

randomised controlled trial environment. As far as the author is aware, this is the first such evaluation in the West of Scotland.

Furthermore, there is a paucity of research on clinician experience of delivering FBT for adolescents with Anorexia. Previous research (Couturier et al, 2013) has examined some elements of clinician experience delivering this intervention. The secondary component of this research provides an opportunity to qualitatively examine clinician's beliefs about the effectiveness of FBT, their fidelity to the FBT model and factors which in their experience can effect treatment outcome, within the West Coast of Scotland generic CAMHS setting. This will be examined using semi-structured interviews with trained clinicians; questions will be based on previous research in this area and on available fidelity tools for FBT, and analysed using thematic analysis. Analysis of this can contribute to a fuller understanding of these issues, and thus enhance clinician and service reflection on the impact of these factors, contribute to the evidence base, and provide insight into the lived experiences of FBT clinicians in the West of Scotland.

2. Aims

2.1 Primary Aims:

2.1.1 To evaluate the extent of change in weight gain from baseline to end of treatment with FBT.

2.1.2 To evaluate the change in number of hospital admissions from baseline to end of treatment with FBT.

2.1.3 Changes in eating disordered psychopathology and behaviours will be investigated using the EDE-Q measure, comparing scores pre and post FBT treatment, where this data is available.

2.2. Secondary Aims:

2.1.1 To examine clinician beliefs about a) the effectiveness of FBT for anorexia

2.1.2 To explore clinicians' perceived fidelity to the FBT protocol,

2.1.3 To examine the individual, family and clinician factors which in clinician experience can effect treatment outcome.

3. Plan of Investigation

This is a mixed methods design comprised of a primary quantitative component, involving secondary data analysis, and a secondary qualitative component, involving semi-structured interviews with FBT clinicians.

3.1 Participants

3.1.1 Primary Component: Data have been collected from across the West of Scotland and thus far 121 cases are included within the database. This is ongoing; suggested total cases estimated at 140 based on average patient numbers seen for this diagnosis in CAMHS services. Recruitment will cease around November/December 2018 to allow time for statistical analyses.

3.1.2 Secondary Component: Eight to ten FBT clinicians will be interviewed.

3.2 Inclusion and Exclusion Criteria

3.2.1: Adolescents with an Anorexia Nervosa diagnosis as defined by DSM-V criteria who have been treated by a Family Based Therapy clinician in the West of Scotland and seen by CAMHS services between 2015-2018, will be included within this project. The majority of participants will be female, however male patients will not be excluded from the study. Given the likelihood of very small numbers of male participants, no comparisons between genders will be possible,

and as such drawing conclusions about male adolescents with anorexia will not be feasible. Participants included in the study will have completed FBT treatment in line with CAMHs guidelines on appropriate attendance of sessions.

3.2.2: The inclusion criteria for the qualitative component is a clinician with relevant FBT training and experience of treating adolescents with Anorexia using the FBT treatment protocol, working within a CAMHs service in the West Coast of Scotland. Given the small number of FBT clinicians in the West Coast of Scotland, clinicians will be included in the research by virtue of their profession and by responding to the email invitation.

3.3 Recruitment Procedures

FBT practitioners in five health boards across the West of Scotland currently implementing FBT for Anorexia Nervosa (Ayrshire & Arran, Dumfries and Galloway, Forth Valley, Greater Glasgow & Clyde, Lanarkshire) are inputting the relevant data from cases within a shared datasheet. Recruitment is ongoing across the health boards.

For the secondary component, the 39 FBT clinicians will be approached across the five health boards via email and invited to take part in a semi-structured interview of 60-90 minutes, exploring their experiences as an FBT clinician. The first eight to ten clinicians who respond to the invitation will be included in the study; thereafter if any clinician can no longer take part, the next available clinician will be re-invited to take part. Suggested interview length is based on previous similar research (Couturier et al, 2013).

3.4. Measures

3.4.1 Primary Aim: For this component, the following information has been, or will be, collected in ongoing data collection by FBT clinicians:

3.4.1.1 Eating Disorder Examination Questionnaire (EDE-Q) (Fairburn and Beglin, 1994) is a 28 item self-report measure of the behavioural aspects of eating disorders e.g. vomiting or laxative use, and eating disorder psychopathology. It includes four subscales which measure Restraint, Eating Concern, Weight Concern and Shape Concern. This measure is the ‘gold standard’ measure for clinical use in this population (Berg et al, 2012).

3.4.1.2 Additional data gathered for inclusion in analysis:

- o Demographic information e.g. age, gender, ethnicity
- o Weight and height measurements at pre-treatment baseline
- o Weight measurements from each treatment session
- o Duration of illness since diagnosis of anorexia
- o Composition of family e.g. single parent/both parent, number of siblings
- o Family members who attended FBT sessions
- o Number of FBT sessions attended
- o Number of and duration of in-patient admissions pre- treatment and during-treatment
- o Duration of FBT treatment

3.4.2 Secondary Aim: Semi-structured interviews will be conducted examining clinicians’ beliefs around the effectiveness of FBT, their perceived fidelity to the FBT protocol, and those individual, family and clinician factors that in their experience can affect clinical outcomes. This interview schedule will be

composed in its entirety at a later date; questions will remain open and broad to facilitate discussion. A FBT fidelity rating form will be utilised for inform the interview schedule regarding this element (Fitzpatrick et al, 2015) (see appendix 5, separate PDF). It may not be possible to include all qualitative findings within the scope of this project; however those findings not included within the body of the report will be made accessible within the appendices.

3.5 Research Design

There are two components to this design: the quantitative element, involving participants completing self-report measures previously and secondary data analyses will be conducted on this data. For the qualitative element, participants will be interviewed and this data will be explored using thematic analysis. Thematic analysis was chosen as it can summarise key features or themes of a large volume of qualitative data, as will be collected in this project, and would be readily accessible to the general public (Braun and Clarke, 2006), although this approach may be vulnerable to researcher bias in interpretation of the data.

3.6 Research Procedures

For the quantitative component, the relevant data has been gathered by clinicians in each of the health boards whilst treating the patient and stored on a shared database. Patients may have completed the EDE-Q at baseline and end of treatment, and if available this will be analysed and provided within appendices. Other data gathered such as weight measurements will be recorded each session by the clinician. Where data is not available within the database, the researcher will examine case files and input into the database any relevant data within the file e.g. EDE-Q scores. It is unlikely that data on weight changes would be unavailable as this is a core component of each FBT session; similarly

in-patient admissions are likely to be recorded by the patient's clinician. However, where data is missing, statistical analyses e.g. regression substitution will be used to provide estimations of missing values.

For the qualitative component, those interested clinicians will be provided with an information sheet detailing the purposes of the research and will have the opportunity to ask any questions. Informed consent will be taken prior to the interview. Clinicians will be reminded that they can withdraw at any time from the interview, or may refuse to answer a particular question. With clinician's permission, the interview will be audio-recorded. This will later be transcribed and coded for themes emerging from the interviews, using Braun and Clarke's (2006) guidelines on thematic analysis.

3.7 Analysis

Previous research has based their analysis on a remission status defined as >95% Ideal Body Weight and an EDE-Q score within 1 S.D. of norms. This was not possible for the full sample within this study due to variable completion of the EDE-Q across individuals; therefore analysis will be conducted on weight measurements and hospital admissions, as this data is readily available and are important clinical outcomes. Further analysis will be conducted on a sub-sample of participants who have completed the EDE-Q measurements. A repeated measures t-test (or non-parametric equivalent) may be appropriate for analysing pre-treatment and post-treatment weight measurements, hospital admissions and total EDE-Q scores.

Thematic analysis will be used to explore patterns found in the data collected from interviews. This will be conducted in line with the six steps outlined by Braun and Clarke's (2006) guidelines on thematic analysis.

3.8 Justification of sample size

For the quantitative component, sample size will be dictated by the number of cases of anorexia in adolescents seen in the five health boards who have utilised FBT. However, there is currently data collected from 121 cases so it does not appear that there will be any significant concerns regarding sample size. Final sample size will be influenced by the practicalities of recruiting within an NHS service, however, a power calculation will be completed with advice from a statistician at the Robertson Centre for Biostatistics.

For the qualitative component, 8-10 clinicians will be recruited. Number of participants for this component is limited by the scope of this doctoral project. The researcher is confident in recruitment of these numbers as this represents less than a third of the total 39 FBT clinicians, who are heavily invested in this project for their own evaluative purposes.

4. Health and Safety Issues

4.1 Researcher Safety Issues

It is unlikely that there will be any safety concerns for the researcher involved given that quantitative data collection has been completed by clinicians. It is also unlikely that there will be any safety concerns for the researcher when interviewing clinicians for the qualitative component.

Clinicians will have their own NHS guidance regarding safety issues when working with patients and their families e.g. risk assessment for domiciliary visits, clinical judgement regarding level of distress for the patient.

4.2 Participant Safety Issues

Participants will be asked to complete measures as part of assessment and intervention

within the Eating Disorder Service, for example, completing the EDE-Q at various time points. This requires additional time and cognitive load for the participant; however this is not excessive in nature and participants will have given informed consent for the information to be gathered. This will have been covered in the initial therapeutic sessions following information on consent and patient rights given by qualified clinicians. Additionally, the clinician can use their clinical judgement to discuss withdrawal from completion of the measures if the patient becomes unduly distressed. This would have no impact on the standard of care they would receive.

5. Ethical Issues

The conduct of the CAMHS service is outwith this project, which is utilizing secondary data analysis. Appropriate ethical concerns will have been considered by the clinicians collecting the data on this study and NHS guidelines on this adhered to.

Ethical advice was sought from the University's research governance officer and from the researcher's NHS R&D department. NHS R&D advised that the quantitative component likely constitutes service evaluation and therefore will not require full ethical approval, but will require registration with clinical governance. It will also require Caldicott approval to access patient identifiable data. Further advice will be sought from the other health boards involved. For the qualitative element, University of Glasgow ethical approval will be sought. Furthermore, as this is a multi-centre project, ethics will be submitted for approval via IRAS, for co-ordination by the NRSPCC. This is exempt from NHS Ethics as participants are NHS staff and are recruited by virtue of their profession. NHS Lanarkshire R&D will be approached to act as sponsor for this project.

Data are stored securely on a restricted access server, and accessed by the researcher on a database held within one of the five NHS health boards, and data is stored for 10 years. For purposes of analysis, data will be anonymised with a unique number and

analysed via SPSS. Once interviews have been transcribed, audio recordings will be destroyed, and clinician's identifiable data anonymised to protect confidentiality. Any further guidance required on confidentiality and data protection issues may be sought from NHS Lanarkshire R&D department.

6. Financial Issues

Expenses are expected to be minimal for this project as questionnaires have been completed via the Eating Disorders Services and, as such, equipment is not required. Interview schedules will be created by the author and printed within the University, as per usual procedure (see appendix two). Any travel costs can be claimed via NHS employer. An audio recorder may be borrowed from the University or from the researcher's NHS health board.

7. Practical Applications

This research project would contribute to West of Scotland health boards' evaluation of the implementation of FBT for anorexia in adolescents, This would include useful information on clinician factors that may influence treatment outcomes in FBT, clinician fidelity to the treatment protocol, and individual/family factors that may impact treatment outcome. This will be of importance to the Eating Disorder teams when planning and developing their treatment strategies within their services. Additionally, the results of this project may inform further implementation of FBT for anorexia in adolescents within health services in other countries when evaluated in conjunction with previous research in this area.

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