

Understanding the Uptake of Family-Based Treatment for Adolescents with Anorexia Nervosa: Therapist Perspectives

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ABSTRACT

Objective: To explore and describe therapists' perceptions of the factors affecting their uptake of family-based treatment (FBT) for adolescents with anorexia nervosa (AN).

Method: Fundamental qualitative description guided the sampling and data collection in this study. A purposeful sample of 40 therapists providing treatment to youth with AN, completed an in-depth interview. Conventional content analysis guided the development of initial codes and categories, whereas constant comparison analytic techniques were used to compare and contrast therapist perceptions across contexts. Summative content analysis was used to provide counts of keywords, phrases, and themes.

Results: Therapists face several barriers to the implementation of FBT, divided broadly into interventional, organizational,

interpersonal, patient/family, systemic, and illness factors. Therapists support the implementation of evidence-based practices, including FBT for AN, but fidelity to this model is not practiced. Specific concerns about the intervention included weighing the patient, providing nutritional advice, and the family meal. Ninety-five percent of therapists requested further training in the FBT model.

Discussion: Further investigation into the barriers and facilitating factors to the use of FBT is warranted. Understanding effective dissemination and training strategies is critical to ensuring patients receive the best possible care. © 2012 by Wiley Periodicals, Inc.

Keywords: family-based treatment; evidence-based practices; qualitative

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Introduction

Characterized by an excessive preoccupation with body weight or shape, eating disorders can have serious adverse physical and psychological complications. The mortality rate, particularly for

anorexia nervosa (AN) is high, and has been shown to increase by 5.6% for each decade that an individual remains ill.^{1,2} The patients who experience AN may experience recurrent inpatient admissions due to the serious medical complications caused by starvation, including cardiac arrhythmias, and electrolyte abnormalities.³ Chronic medical complications include cerebral atrophy, reduced bone mineral density, and cardiac muscle wasting.³ According to the DSM-IV-TR,⁴ the criteria for a diagnosis of AN include a refusal to maintain a current body weight at 85% or higher of the normal expected weight, an intense fear of gaining weight or becoming overweight, a disturbed experience of one's own body weight and shape, and amenorrhea for at least three consecutive months.

Although there remains relatively little research on interventions that address the complex mental and physical health needs of children and adolescents with AN, family-based treatment (FBT) is one form of treatment that has been gaining an evidence base, and is a recommended practice by the American Psychiatric Association.⁵ Developed at the Maudsley Hospital in London, England, this treatment model has been systematically detailed

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and manualized by Lock et al.⁶ FBT is an outpatient, intensive treatment that utilizes the patient's family as the primary resource to renourish the affected child. The intervention has been shown to produce a more rapid recovery compared to individual therapy, both immediately following treatment^{7, 8} and at 5-year follow-up.⁹ FBT has the potential to reduce treatment costs by up to 70% through a reduction in hospitalizations—the most costly form of treatment.¹⁰ Moreover, Lock et al.¹¹ compared 6 and 12 months of FBT in a randomized control trial ($n = 86$) and found that at the end of treatment, 96% no longer met criteria for AN, with long-term follow-up indicating that weight gains were maintained, with no difference between the 6- and 12-month samples.¹² Further, le Grange et al.¹³ tested the model with patients diagnosed with bulimia nervosa (BN) and found that subjects were significantly more likely to be free of binge-purge symptoms when treated with FBT versus those who were treated with individual supportive psychotherapy. Most recently, Lock et al.¹⁴ completed a randomized controlled trial comparing outcomes among adolescents with AN who were treated with either 12 months of FBT or 12 months of adolescent-focused individual therapy. While there were no significant differences in full-remission at the end of treatment, FBT was significantly better than individual therapy at facilitating full-remission at 6- and 12-month follow-ups.

Despite the evidence suggesting that FBT is effective in treating children and adolescents with AN, anecdotal evidence suggests that therapists working with this population do not use this intervention or, if they do, it is not practiced with fidelity. The purpose of this exploratory study, therefore, is to examine therapist perspectives of the process of implementing evidence-based practices (EBP) in general, and more specifically, to explore the factors influencing the adoption of FBT into clinical practice to treat adolescents with AN.

Method

Design

The principles of fundamental qualitative description¹⁵ were used to guide the sampling, data collection, and analyses for this study. Fundamental qualitative descriptions facilitate the description and exploration of a phenomenon of interest that is relatively unknown by drawing from the tenants of naturalistic inquiry—a com-

mitment to studying something in its natural state.¹⁵ Data collection involved completing qualitative interviews with therapists in Ontario, Canada, treating children and adolescents with AN. This study was reviewed by and received ethical approval from the Hamilton Health Sciences/McMaster Faculty of Health Sciences Research Ethics Board.

Sample

To adequately capture perceptions and experiences of adopting and using FBT in clinical practice, a purposeful sample of therapists providing psychotherapeutic intervention to children and adolescents (≤ 18 years of age) with AN were eligible to participate in this study. Purposeful sampling is the process of selecting those individuals who can provide information, typically from their own experience, about issues that are important in addressing the research question.¹⁶ It is a method of sampling that is not random, but instead targets a specific group of people; however, in this case, those individuals most likely to have been exposed to FBT. Therapists were recruited through the Ontario Provincial Network of Eating Disorders, in Ontario, Canada. This ministry-funded provincial network includes a diverse group of therapists who provide treatment to individuals with eating disorders within rural, urban, suburban, academic, and nonacademic settings. The development of this highly specialized eating disorder network was driven in part by a Ministry of Health training program, and acts as a hub for the coordination of training, mentoring, program evaluation, and supervision activities. Given the diversity in membership, we estimated that a sample of ~ 40 therapists would lead to data saturation. Each organization listed on the network's referral list was contacted via e-mail, and an invitation was made to those therapists providing psychotherapeutic intervention for children and adolescents diagnosed with AN to participate in the study. The individual listed as the referral contact within the provincial network was asked to forward the invitation to eligible therapists, or to provide the contact information for eligible therapists to the research assistant.

Data Collection

Each study participant was invited to participate in a single, in-depth, semistructured qualitative telephone interview. The focus of the interview was to explore and describe therapists' current practices with respect to the treatment of AN, their views on EBP, and the barriers and facilitating factors surrounding the adoption of FBT. The interview included a description of the components of FBT as described in the manual to ensure each therapist understood the definition of FBT (see Appendix A).

Piloting of the interview guide was completed with three therapists at the host institution, McMaster Children's Hospital, and slight revisions to questions were made before interviewing the research sample. Semistructured interviews ranged from 1 to 1.5 h in length were completed via telephone by a trained research assistant, and were transcribed verbatim. Field notes were created by the research assistant to comment on any remarkable content that required further elaboration or exploration, as well as the research assistant's perceptions about the effectiveness of the interview. Any other documents related to the content of these interviews were maintained in a study audit trail (i.e., emails regarding inclusion and exclusion from the study, clarification of study purpose), and were provided to the research team to supplement the data analysis.

Data Analysis

The interviews were digitally recorded and transcribed verbatim. The process of conventional content analysis was used to guide the development of the study codebook and to guide the first and second levels of coding. Each transcript was read in its entirety and line-by-line coding was conducted to identify key concepts emerging from the interviews. A codebook with definitions of each code and theme was generated and refined through multiple readings of the transcripts, in consultation with the research team, as well as through the process of theoretical memoing.¹⁷ Memoing is a documenting process that aids in the development of ideas about codes and themes, and their interaction with one another.¹⁷ To ensure dependability of data analysis, 20% of the transcripts were independently double-coded by the principal investigator (JC). Disagreements for particular codes were resolved through consensus-making processes. The initial definition of the code or theme was reviewed, and references to that code or theme were discussed in relation to the initial definition until consensus was reached for the application of the code. As new codes and themes emerged from the transcripts, they were added to the codebook and documented in the study's research audit trail. The collapsing of codes into categories was documented in the same fashion. Then, utilizing the constant comparative technique,¹⁸ codes, quotes, and themes were pulled from the data to reflect the perceptions expressed by the therapists participating in this study. Specifically, one of the authors (MK) gathered, labeled, and compared words across lines within transcripts and across transcripts to tease out common themes. Summative content analysis was used to provide counts of keywords, phrases, and themes.¹⁹ All coding was completed in Nvivo 8, a software program used to organize and store qualitative data for synthesis.

Results

Participants

Forty individuals who provide psychotherapeutic intervention to adolescents diagnosed with AN participated in this study, with 37 identifying as female and three as male. With respect to education, most participants ($n = 19$) identified a Master's of Social Work as their terminal degree, with three others having master's level training in other domains (Psychology, Education). Seven participants had a Doctorate of Philosophy (PhD), four had a Medical Degree (MD), three had a Child and Youth Worker Diploma, and three had Bachelor level terminal degrees. The majority of the participants reported being between 41 and 50 years of age ($n = 15$), with an overall range in age from 25 to 56 years (**Table 1**). Participants' number of years in practice ranged from 6 months to 35 years, with most participants indicating that they had been in clinical practice between 15 and 20 years. In terms of practicing with adolescents with AN, the amount of experience ranged from less than 1 to 20 years. Most participants reported treating between 1 and 5 ($n = 8$) or 6–10 ($n = 8$) adolescents diagnosed with AN per year, with the highest caseload being 36–40 patients per year.

Only two therapists indicated that they provide inpatient intervention only, with the remaining 38 therapists providing a combination of inpatient, day treatment, and outpatient services. With respect to current practice modalities, 10 therapists explicitly identified using an eclectic therapeutic approach, with the remaining 30 therapists indicating that they use a combination of models that are specific to the population they are working with (i.e., individual or family treatment). Among those using a combination of models, the most common models reported were CBT ($n = 16$), FBT ($n = 20$), emotion-focused therapy ($n = 4$), psychoeducation ($n = 11$), and multifamily therapy ($n = 5$). Similarly, 16 therapists indicated working with more than one patient population. Thirteen therapists indicated they primarily work with families, five therapists primarily do group work, and eight therapists reported primarily working with individuals.

Barriers and Facilitating Factors

Several factors mediate therapists' implementation of EBP, and more specifically FBT, in their clinical programs. These barriers and facilitating factors can be classified broadly as interventional, organizational, interpersonal, patient/family, systemic, and illness factors. These themes varied in their intensity, but were consistent among all therapists interviewed. What follows is a reporting of these six major themes,

TABLE 1. Demographic information

Sample Characteristic	N (%)
<i>Age (years)</i>	
26–30	6 (15)
31–35	5 (12.5)
36–40	3 (.75)
41–45	8 (20)
46–50	7 (17.5)
51–55	5 (12.5)
56–60	6 (15)
<i>Discipline</i>	
Social worker	22 (55)
Psychologist	6 (15)
Psychiatrist	4 (10)
Psychometrist	4 (10)
Other counselor or therapist	4 (10)
<i>Number of years in clinical practice (years)</i>	
<1	5 (12.5)
1–5	5 (12.5)
5–10	7 (17.5)
10–15	5 (12.5)
15–20	9 (22.5)
20–25	6 (15)
25–30	2 (5)
>30	1 (2.5)
<i>Number of years in practice with adolescents with AN</i>	
<1	2 (5)
1–5	8 (20)
5–10	19 (47.5)
10–15	8 (20)
15–20	1 (2.5)
20–25	2 (5)
<i>Number of AN patients per year</i>	
1–5	8 (20)
6–10	8 (20)
11–15	6 (15)
16–20	7 (17.5)
21–25	2 (5)
26–30	3 (7.5)
31–35	1 (2.5)
>36	5 (12.5)

which describe the major factors influencing therapists' implementation of FBT in practice. While the following report is not a comprehensive list of the entire subthemes discovered within the data analysis, it is a presentation of those themes which were most frequently reported. For a detailed list of themes within the participants' interviews, please see **Table 2**.

Interventional Factors. When asked to speak to the intervention-specific factors of FBT that allow or inhibit therapists to implement this model within their daily clinical practice, participants made 244 references to the advantages of the FBT intervention and 160 references to the potential disadvantages of the intervention. First and foremost, 33 participants felt that FBT, as a manualized approach, is well scripted with a clear structure to learn and systematically implement within their patient populations. Therapists felt that the focus on parents having control over the refeeding of their child and assisting them back to health was a clear advantage of the model.

Many participants ($n = 25$) reported feeling strongly that separating the eating disorder from

the patient, a tenant of the FBT model, as well as engaging in the refeeding process before addressing underlying issues of disordered eating, both make logical and therapeutic sense. Participants recognized that without addressing the impact of starvation on cognitive brain function, engaging in therapeutic processes is often futile. Separating the adolescent from the eating disorder by using the externalizing techniques from the manual, as well as reiterating that the adolescent is not to blame for their illness, resonated with all 40 of the therapists. Participants felt that reducing the blame and shame that is often associated with eating disorders is imperative to effectively engaging the entire family in the therapeutic process.

In terms of barriers, the demanding nature of FBT, in terms of time commitment for therapists and families, as well as, inadequate attention to comorbid symptoms, need for parental consistency, lack of family meals in the real world context, and the need for sibling involvement were mentioned by therapists. In addition, the FBT model indicates that having dietitians involved in the therapeutic process is not necessary. However, only six of the 40 therapists reported that they felt dietitians do not need to be involved in this treatment. Five therapists explicitly stated that the dietitian is an essential component to the eating disorder treatment team, and that not involving the dietitian in this treatment would require therapists to engage in tasks they felt would be considered as outside their scope of practice. For example, when asked about whether dietitians are needed in this treatment, one participant stated:

I don't like that piece. I'm not a dietitian. That's well outside of my scope of practice, right? So I, I would have to learn all of that stuff and I, and I have not, right? Like I'm not a dietitian, I don't talk about carbs, I don't talk about caloric intake, I don't talk about, I don't know, how many fruits and vegetables. Like I don't ... or portion sizes. Like I don't talk about that stuff, right? Because I don't know that information. So I would feel, I would feel like I'm doing ... I would feel like I'm working outside of my scope of practice to be doing that piece because I don't have that information. That's not where I've been trained.

Moreover, the FBT model asserts that therapists should engage in a consistent pattern of weighing the patient before each therapeutic session. Fifteen therapists explicitly stated that they do not weigh the patient before their therapeutic session, even though these therapists indicated that they follow the FBT model. When asked about weighing the patient, one participant stated:

TABLE 2. Implementation factors

Main Theme	Subtheme	Frequency	
Interventional factors	Advantages	355 References, across 40 participants	
		244 References, across 40 participants	
		Avoid hospitalization	44 References, across 26 participants
		Parents as change agents	58 References, across 33 participants
		Refeeding first—ensures therapeutic readiness	51 References, across 33 participants
		Scripted with clear structure	68 References, across 33 participants
		Reduces blame and shame	37 References, across 25 participants
		It has got evidence	31 References, across 22 participants
		Long-term benefits	20 References, across 17 participants
		Good at involving siblings	36 References, across 23 participants.
		Disadvantages	160 References, across 38 participants
		Demanding on families	47 References, across 24 participants
		Not adequate for sociobehavioral issues in the family	37 References, across 22 participants
		Need for parental consistency	39 References, across 21 participants
Organizational factors	Families do not have family meals	14 References, across 14 participants	
	Siblings are not necessary	23 References, across 14 participants.	
	355 References, across 40 participants		
	Process of therapeutic determination	53 References, across 37 participants	
	Director buy-in essential	58 References, across 30 participants	
	Team buy-in	98 References, across 40 participants	
	Lack of funding	38 References, across 27 participants	
Interpersonal factors	Spatial, resource, and hourly constraints	88 References, across 26 participants	
	Not a specialized ED service	35 References, across 17 participants	
	294 References, across 40 participants		
	Experience in ED treatment	57 References, across 31 participants	
	Comfortable working with teens and families	48 References, across 33 participants	
	Motivation to implement FBT	51 References, across 26 participants	
Patient and family factors	One-size cannot fit all	49 References, across 26 participants	
	Values for family-based approaches	45 References, across 30 participants	
	190 References, across 40 participants		
	Motivation to change	107 References, across 36 participants	
	Need to maintain consistency	48 References, across 26 participants	
	Therapeutic preference	25 References, across 16 participants	
Systemic factors	Patient age/maturity	36 References, across 25 participants	
	Lack of understanding about severity of illness	25 References, across 14 participants	
	72 References, across 31 participants		
	Lack of awareness in community	39 References, across 23 participants	
	Geographic location	30 References, across 16 participants	
Illness factors	Not enough referrals	9 References, across 8 participants	
	34 References, across 27 participants		
	Difficult to treat	26 References, across 21 participants	
	High comorbidity	8 References, across 7 participants	

We've had many hot debates about that one around here and those that have been doing it [FBT] for a while have been saying oh, the dietician does the weight or the family doctor does the weight, we don't really need to know, it's ok. And I was one that said that. And then I started doing it [the weight measurements] and then I thought oh, I'm sort of you know banging your head against a brick wall thinking why didn't I do this before, this is so important.

The FBT model also includes a family meal in the second session, which is observed by the therapist. Only 10 therapists stated that they complete the family meal on a regular basis. Reasons for not doing the family meal included lack of space, or appropriate environment, lack of training in that specific component of the model, and a sense of intimidation and anxiety. In summary, these three

elements consisting of the family meal, weighing the patient, and providing nutritional guidance (without involvement of a dietician) were not practiced consistently, and not one therapist in our study indicated that they follow the model including these three elements with fidelity.

Organizational Factors. A pervasive theme across all participant interviews was the extent to which organizational values and processes impact therapists' ability to adopt, adapt, and implement EBP. Thirty of 40 therapists explicitly indicated that their clinical director/administrator's support for the therapist's model of choice was an imperative factor in their ability to implement FBT in their practice. The remaining 10 participants, although indicating that their director supporting their choice of treatment was not crucial to their adoption of the FBT model, did indicate that if the or-

ganization were to commit to FBT as the practice of choice in the treatment of adolescents with AN, the clinical director/administrator would need to support that commitment to access resources for training. The vast majority of participants ($n = 38$) requested a province-wide training initiative in FBT. One therapist explained:

I think that's where the individual organizations have to make a commitment to supporting their staff because if they're working in eating disorders then they need to actually provide their staff with the training so that they can deliver the best treatment possible, so maybe targeting the people who are heads of those different organizations and the people who make decisions around those things.

Interestingly, therapists directly linked director/administrator support to their team's adoption of a consistent model of treatment within their organization. Twenty-eight participants expressed that team buy-in to a particular EBP was important for implementation within the agency, and that team buy-in was largely influenced by the treatment choice of the director of the clinical service and the clinical supervisor. Thus, the composition of the team, in terms of individual discipline and treatment affinity (e.g., family focused, individual focused) plays a role in therapists' abilities to adopt a new and emerging practice. The vast majority of therapists ($n = 37$) described the process by which their team decides on the type of treatment that a particular patient receives, as involving a team discussion and arriving at a consensus (i.e., therapeutic determination).

Another organizational factor found to mediate therapists' abilities to adopt FBT in their practice is their particular organizational environment. For example, FBT requires space for the completion of family meals and weekly appointments, which was a problem for over 50% of the therapists interviewed. Second, 17 of the therapists interviewed do not work in a specialized mental health unit that is devoted to the treatment of eating disorders. Thus, a number of therapists provide treatment under the purview that only so many hours of their work week can be devoted to this population, putting constraints on the therapist's ability to provide the weekly sessions and lengthy appointments required by the FBT model. Finally, therapists recognize that daytime clinic hours, for the most part, are not conducive to family therapy. Participants expressed concern for families who have to take time off work to attend appointments during the workday, when they may risk

losing their employment position. Interestingly, however, some participants reported that they have little sympathy for families who do not attend appointments during normal work hours, because therapists feel families would not hesitate to attend if their child was diagnosed with a serious physical illness (e.g., cancer).

Interpersonal Factors. Therapists' interpersonal beliefs with respect to the treatment of youth with mental illnesses, as well as their previous training and clinical experience were identified as influencing their willingness and ability to implement FBT. For example, 30 participants explicitly indicated that they personally felt that "parents are the agents of change" in the treatment of adolescent AN. These therapists strongly felt that it is imperative to involve parents in the therapeutic process simply because they are responsible for their child's well being, and to not include parents in adolescent treatment is to do the adolescent and their family a disservice.

Similarly, therapists felt that their previous experience and training, continues to drive their willingness and comfort to learn and implement new EBP. Thirty-one participants reported that their experience working with adolescents with eating disorders largely dictates their practice approach, with 33 participants explicitly indicating that therapists need to be comfortable working with adolescents and their families to implement FBT in practice. Therapists reported feeling that this comfort level was more or less dictated by their training experience and whether or not they had received training in family-based approaches during their undergraduate or graduate training.

Despite the fact that 21 therapists reported being committed to delivering EBP, 26 therapists discussed their reluctance to commit to EBP because of their personal belief in the "one-size does not fit all" ideology. These 26 therapists felt that despite the evidence indicating the generalizable benefits of EBP to a particular patient population, therapists should never fully commit to a particular practice without first considering the context of the family, as EBP do not always fit the clinical patient. For example, one therapist stated:

I don't know, I think that's sort of the million dollar question, right, is how, is how we take this research which is done in this pure kind of way and make it useful for a variety of different families coming to a variety different sites being seen by a variety of different therapists. I mean, I think we're all still kind of figuring out. I don't know that we've got, got the answer to that yet.

Patient/Family Factors. All 40 participants reported family-specific factors influencing their ability to implement FBT with their patient populations. Many therapists ($n = 36$) reported that parental motivation to participate in the change process is a key factor in their willingness and ability to implement a family-based model. Similarly, 16 participants reported that a number of parents do not understand the severity of an eating disorder diagnosis, often attributing their child's low weight to a phase or as something normal for their child's age. Further, therapists reported that parents who have little motivation to change or, do not see the treatment of the eating disorder as a priority, often prefer more individually focused interventions. As one therapist explained:

I think there are some parents who don't *want* to do family therapy. They really don't. They have an *idea* regardless of whether you talk to them about best practice or not, that if only their child would figure out this, that, or the next thing, then everything would be better. So I think there are some parents who really *balk* at family therapy. They don't want to do it.

Thus, if parents indicate that they refuse to take part in treatment, therapists have no choice but to offer individual therapeutic approaches to the adolescent. A number of therapists attributed this parental lack of motivation to a lack of awareness about the nature and severity of eating disorders, particularly their potential morbidity.

Nine participants recognized parental mental health as a significant factor influencing their choice of intervention for their patients. These therapists reflected on the potentially harmful effect of involving a parent who suffers from their own eating disorder in their child's treatment. Therapists felt that involving a parent who may have an active eating disorder may be counterproductive for both parent and child and exacerbate the difficult change process that needs to take place for the child to eat well and achieve a healthy body weight.

Systemic Factors. Therapists indicated that a lack of awareness about eating disorders and eating disorder treatment within the broader community is a factor in treatment implementation. Approximately 58% of the therapists interviewed perceived that the greater community lacked awareness about eating disorders, their manifestations, and the options for treatment. This prevents therapists from being able to effectively access,

assess, diagnose, and treat adolescents with AN. Eleven therapists perceived that physicians in their local community do not know enough about eating disorders, their presentation, and how to effectively engage patients and families in treatment, which is a particular concern as participants indicated that it is physicians who are their largest referral source.

In addition, 16 participants identified their geographic location as a factor in their ability to deliver EBP, and more specifically, an intensive intervention such as FBT. Participants reflected on the intensive nature of the first stage of the FBT intervention and that, given the distances that some families need to travel to seek care, requesting that they attend clinic appointments once per week was unreasonable. Some therapists indicated that some patients have to travel well over an hour to attend an appointment, and to ask the patient and their family members to complete this task on a weekly basis is simply impractical. Moreover, therapists reported feeling that it is important to recognize that therapists themselves can work in isolated areas but asking them to implement such an intensive intervention without team support or regular consultation would be too demanding especially when, because of geographic location, the therapist may see only one adolescent with AN per year.

Illness Factors. Approximately 68% ($n = 27$) of the participants reported that the sheer complexity of AN influences their therapeutic approach with their patients. Therapists discussed the pervasive and complex physical and psychological symptoms of AN, which make it difficult to commit to any one specific EBP with full fidelity. Moreover, participants reflected on how EBP are often studied in subjects with only one specific formal diagnosis, and that patients without any comorbidity are not representative of their patient population, as they frequently see patients with comorbid mood and anxiety disorder diagnoses. For these reasons, participants indicated that they find it difficult to stick to a method that only addresses the eating disorder when patients' comorbid mental illness may be a factor in the maintenance of eating disorder symptomatology.

Discussion

This is the first study to examine the uptake of FBT in clinical practice using a rigorous qualitative design. Our study indicates that therapists face several barriers to the implementation of EBP, and

more specifically the implementation of FBT. These can be divided broadly into interventional, organizational, interpersonal, patient/family, systemic, and illness factors. Interventional factors most frequently cited as barriers included the demanding nature of FBT in terms of time commitment for therapists and families, inadequate attention to comorbid symptoms, need for parental consistency, lack of family meals in the real-world context, and the need for sibling involvement. The most common organizational factors mentioned included therapeutic determination (i.e., the process by which a team decides on a particular treatment modality), director support, team buy-in, funding, and resources (space, wages, and training). Therapist factors included experience in the field of eating disorder treatment, comfort in working with adolescents and families, motivation to adopt FBT, the belief that “one size does not fit all” (lack of generalizability to their patient population), and a belief in the value and efficacy of family-based approaches. The most common patient/family factors included motivation to change, parental ability to maintain consistency, therapeutic preference of the patient/family, patient age/maturity, and understanding of the illness. Illness factors included viewing AN as an illness that is difficult to treat and often comorbid with other mental disorders, suggesting that more intensive treatment, such as inpatient or day treatment, might be more effective.

Previous surveys of therapists treating clients with eating disorders have found similar results. For example, a questionnaire completed by members of the Academy for Eating Disorders, a large, international organization for clinicians interested in eating disorders, revealed that ~50% of 268 participants indicated they did not use manualized therapies.²⁰ The most frequently cited reason was that they are too rigid and not a good fit for their clients. Other barriers included an opinion that the manuals were not helpful and participants indicated that they did not have proper training. Haas and Clopton²¹ also found almost half of their survey participants who were all psychologists, did not use empirically validated treatments and cited the complexity of individuals with eating disorders as a barrier to the use of EBP. A telephone survey of AN therapists also indicated that therapeutic approach is based on preference and education level, with eclectic approaches being most popular.²²

Other research focused on children’s mental health organizations has revealed similar results. Barwick et al.²³ surveyed executive directors and practitioners within 80 organizations. Barriers to

research utilization included time, money, staff, access to the evidence base, conflicting priorities, organizational commitment, availability and quality of research, and formats and venues for knowledge exchange. Practitioners cited that research is not generalizable to their patient population, and that in general there is much conflict in the nature of research information. In addition, there is a lack of specific implementation assistance. These individuals also expressed a belief that EBP are not intended to be modified, and that if they are modified they are likely to lose effectiveness. Many expressed a belief that EBP are too top down and prescriptive. Less than 10% of directors and practitioners perceive their organizations as doing “very well” in the adaptation and application of research evidence in practice.²³

Similarly, in a subsequent study involving front line and management staff within a large, multidisciplinary children’s mental health agency, Barwick et al.²⁴ used a detailed qualitative analysis to examine the change processes involved in shifting services to EBP. The practitioners voiced clinical concerns about comorbidity when EBP are designed to treat one disorder. As in the current study, themes included consideration of stakeholder involvement and costs. The multidisciplinary nature of the organization was highlighted, with clinicians having varying clinical competence and education levels. Staff participation in training, as well as credentialing, were concerns, as were measures of fidelity and transparency in decision making.

Of note in our study was the importance therapists placed on team buy-in to the therapeutic model. This has not been commented on in other areas of healthcare, or mental health, especially with respect to the uptake of established effective treatments. The value placed on team cohesion is high within this field, perhaps due to the overlapping nature of the multidisciplinary roles within the team and the need for a consistent message coming from team members when dealing with families with eating disorders. A belief or conviction held by a team regarding the effectiveness of a treatment may be more important than the evidence itself. Perhaps, this is one of the reasons why practice change is so difficult. Using a cancer analogy, it would be difficult to argue against providing an effective chemotherapeutic agent, simply because the team did not believe in it. Why does this happen in our field? The answers are elusive and likely require further study. Perhaps, more exposure to protocols and best practice guidelines, which are common ways of informing practice in

other areas of medicine, would be essential. In addition, many of the therapists involved in our study practice in very remote areas and have to meet the diverse needs of their clients given the overall lack of resources such as funding, and access to other clinicians or physicians, so they may not be able to afford the luxury of sticking to one treatment modality, instead playing the role of a “jack of all trades”. These circumstances would perhaps suggest more willingness to adopt other skills necessary in FBT, such as weighing the patient and discussing the basics of nutrition, especially if a dietician is not available; however, these were contentious issues for our study participants. In many ways, FBT is highly suited to remote areas as it does not rely on a team, only one therapist along with a medical doctor, but this aspect was not commented on in our data.

In addition to the elements of weighing the patient, and providing nutritional support, many therapists in our study reported discomfort, or inability to include the family meal in their treatment. A significant portion of the manual is devoted to the family meal, indicating it is an important component of FBT. Not one therapist in our study was practicing FBT with fidelity when we examined these three components. Future studies might aim to discern whether these three elements are critical to treatment success. Although such a dismantling study would help to define which elements are critical to achieve good outcomes, the practicalities of a study such as this would likely be insurmountable, as the sample size required would be quite large. In the absence of such studies, one must decide how important it is to stick to the manual as prescribed, versus risk the situation where therapists will reject the model completely if they find it unpalatable. As the vast majority of therapists requested further training in the model, perhaps further training is the key to buy-in, and treatment fidelity would then follow. In fact, more exposure to the evidence, and further training, might dispel some of the barriers cited by therapists. Compared to inpatient and day hospital settings, FBT is actually a rather low intensity and cost-effective method for successfully treating adolescents with AN.¹⁰ In addition, studies examining the efficacy of FBT have included a significant number of patients with comorbid disorders, and these factors have not been found to predict, or moderate, treatment response.^{11,14} Furthermore, family meals and the inclusion of siblings are not part of the separated form of FBT, which has been found to have similar outcomes as traditional conjoint FBT.^{25,26}

Limitations of our study include the nature of our sample and their recruitment. Although a diverse sample of rural, urban, suburban, academic and nonacademic therapists was involved, as well as those from diverse training backgrounds, therapists in private practice were not recruited for this study. It is suspected that those in private practice would have a different view of how to incorporate EBP. In addition, although disciplines were varied, most of our sample consisted of masters level clinicians. This might have been a source of bias. It is important to note that the participants had not undergone extensive training in FBT. Most had been exposed to a 2-day training event sponsored by the Ontario Provincial Network of Eating Disorders ~4 years ago. It is possible that more exposure to the model could have resulted in different attitudes toward FBT. Our sample was not random, but attempted to include all therapists who work within a Ministry of Health funded eating disorder provincial network. This network represents a highly coordinated and collaborative system of specialized eating disorder care. The therapists working within this network have ongoing access to highly specialized training and mentoring in the field of eating disorders (see www.ocoped.ca). Thus, our findings may not be generalizable to health systems that are not government funded. The factors most likely impacted by a government funded healthcare system are organizational and systemic. However, many personal views held by participating therapists may be held by therapists all over the world.

Conclusion

This study demonstrated many barriers to the implementation of EBP and FBT in clinical practice. Perhaps most striking was the need for further training and support from administration. As in other studies, the results of this study indicate that the adoption or adaptation of EBP into clinical practice is a complex and multifaceted process. Adaptation of the evidence requires some element of reinvention, a process that would maintain the active ingredients of a therapy while allowing modifications according to the context. The complexity of this issue is compounded by the argument that the controlled environments in which EBP are typically evaluated are not conducive to the dynamic and everchanging nature of developing youth in real world contexts. We know from previous implementation research that therapists do not readily change their methods of practice. The complexities

of implementation and the lack of motivation to change are compounded by the fact that mental health organizations are often staffed by individuals who vary in clinical competency and training. Very few child and youth mental health organizations are staffed with individuals who have skills in research or evaluation, and fewer still with expertise in implementing practice change. These important gaps can make it particularly difficult for service provider leaders to implement EBP and ensure their fidelity and sustainability.

Implementation of EBP takes place within a broad context of a large system with many layers, from the individual to the healthcare system. In fact, many therapists indicated that support from executive directors would be critical in obtaining funding and resources for training. Although participants expressed a clear and definite commitment to providing their patients with the best possible care, there remains not one participant who reported practicing FBT with fidelity to the model. Further exploration into the decision-making processes inherent in EBP adoption, adaptation, and implementation within the eating disorder field at the organizational level is needed. Development of context-specific training and administrative processes for the implementation of EBP and FBT is warranted. The involvement of all the stakeholders affected by the implementation process, namely therapists, administrators, physicians, patients/families, and advocacy organizations is essential.

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APPENDIX A: Semistructured Interview Guide: Family-Based Treatment for Children and Adolescents with Anorexia Nervosa

Introduction

Thank you for agreeing to participate in this interview today. The purpose of this interview is to learn about your beliefs and attitudes about psychotherapeutic treatments for children and adolescents suffering from anorexia nervosa, particularly family interventions.

Clinician Role

- (a). Can you please describe the type of community-based practice you work in and your role in the practice?
- (b). Can you briefly share with me your experiences in working with adolescents with anorexia nervosa and their families?

1) Identification of the Problem

- (a). Can you describe your current psychotherapeutic approaches to treating patients with anorexia nervosa?
- (b). What are your perceptions of the effectiveness of these approaches?
- (c). To what extent does the research literature on treatments for anorexia nervosa influence your treatment decisions?
 - (i) What other types of information influences the types of treatments you use to treat anorexia nervosa?
- (d). Do you think there is a need to develop standard protocols based on research evidence in this field?

Before proceeding further, I will just give a brief description of what I mean by the term “family-based treatment”.

Family-based treatment is a manualized form of family therapy for children and adolescents with anorexia nervosa written by primary authors James Lock and Daniel LeGrange. In this treatment, parents play an active role in the task of refeeding their daughter and are encouraged to take control of their child's food intake to nourish them back to health, particularly early on in the treatment. The approach is individualized for each family and they are encouraged to set up a system of incentives to encourage weight gain. This treatment typically has

a duration of approximately one year and the initial focus is on weight restoration with a delay of discussion of other issues until later in the therapy. As mentioned, the first phase focuses on mobilization of parents to take charge of refeeding, and involves a family meal observed by the therapist. The second phase focuses on transfer of control over food intake, and exercise back over to the adolescent. The final phase addresses general adolescent issues.

2) Adapt Knowledge to the Local Context

- (a). What are your views on family-based treatment for anorexia nervosa?
- (b). How useful do you think family-based treatment for anorexia nervosa is/would be in your clinical setting?
- (c). What have been/would be the advantages of adopting family-based treatment for anorexia nervosa in your clinical setting?
- (d). What have been/would be the disadvantages of adopting this treatment?

3) Assess Barriers to Knowledge Use

Individual Factors

- (a). As a clinician what factors positively influence your ability to adapt and adopt family-based treatment for Anorexia into your practice?
- (b). As a clinician, what factors at an individual level may be barriers to your ability to adapt and adopt this treatment into your practice?

Organizational Factors

- (a). Within your organization, what factors at that level would influence (positively or negatively) the successful adoption of this treatment?

Patient and Patient's Family Factors

- (a). Imagine that you were to describe the option of family-based therapy to your adolescent patients with anorexia nervosa and their families.
 - (i) What elements of the treatment do you think would be perceived positively by patients and their families?
 - (ii) What elements of the treatment may act as barriers to having the patient and the family fully participate in this treatment modality?

Characteristics of the Treatment Modality

- (a). In thinking about the actual treatment, what aspects of this modality will make it more or less likely to be used as a treatment for anorexia nervosa?

- (b). Are there any relative advantages about this treatment modality compared to others? (Relative advantage is the degree to which an innovation is perceived as being better than the idea it supersedes.)
- (c). Is this treatment compatible with your existing values about how to treat anorexia nervosa and your experiences in treating this condition?
- (d). What is your assessment of the complexity of this intervention?

4) Tailor the Intervention

- (a). What changes could be made to family-based treatment, as it currently exists to make it more feasible for implementation in your practice?

- (b). Could family-based treatment be used for adolescents with all types of eating disorders including bulimia nervosa?

5) Knowledge Translation Strategy

- (a). In your ideal work world, what would be the best strategies for increasing your awareness of family-based treatment?
- (b). Who would be the most credible messengers for this information (peers, researchers, and local experts)?
- (c). Is there anything else you would like to share about the process of integrating family-based treatment into your clinical practice, or about how information can be communicated to clinicians in your field?