

# “Breaking Down the Wall” Patients and *Families* Experience of Multifamily Therapy for Young Adult Women With Severe Eating Disorders

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## Research article

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# Abstract

**Background:** Eating disorders (EDs) are serious illnesses leading to lowered quality of life for the patients and their family. The Regional Centre for Eating disorders (RESSP) at Nordland Hospital in Bodø, Norway has developed an adjunct psychotherapeutic approach for the treatment of young adult patients with severe EDs. The patient's family members take part in the multifamily therapy (MFT) group programme.

**Methods:** The aim of the study was to explore patients and *families* experience of MFT for young adult women with severe EDs. Data were collected by field observations in two MFT groups, qualitative group interviews and qualitative individual interviews with patients and their family members. The analytical method was qualitative content analysis.

**Results:** Two main categories were identified: 'Connectedness and recognition' and 'Open yourself and share'. MFT was described as a space for recognition within which it was possible to speak of things happening in the family with others with similar difficulties. It felt good and freeing, but also painful, to meet others with similar experiences. The participants shared a considerable loneliness because it is difficult for outsiders to grasp what it is like in a home dominated by an ED. The meeting with other families created an underlying safety. The participants received help to distinguish between realistic and unrealistic concerns and learned about openness and communication in relation to their daughter. Some women with EDs said that MFT was most important for the parents but also had been good for them as things had become better at home.

**Conclusion:** The participants reported that their family had become better at talking to each other after having been in MFT. As a result, they were able to speak more openly about difficult things and share feelings. This gave rise to increased understanding. The study shows that MFT was found to be valuable and important. Never before had these families had such an offer, something so directly tailored to them. MFT for adults can be developed further and used in other groups, such as those concerning other chronic illnesses.

## Plain English Summary

Eating Disorders (EDS) are serious illnesses which lead to both sufferers and their families having a much reduced quality of life. The Regional Centre for Eating disorders (RESSP) at Nordland Hospital in Bodø, Norway has developed a MFT- programme for the treatment of young adults with EDs and their families. Here, we present the findings of a study into how they experienced participation in this therapy. The data were collected by a researcher taking part in the groups as a field observer and who interviewed the group members (the young women and their families). The participants said that they found the MFT to be a place of connectedness and recognition where they learned to be open and share their feelings. They told that their family had become better at talking to each other, including about difficult things and feelings. MFT had been valuable and important, and the participants told that they never before had had

something so well-tailored to their needs. We think that MFT will be amenable to further development and applicable to other settings.

## Background

Eating Disorders(EDs) are conceptualised as a constant disturbance in eating patterns or eating-related behaviours leading to modified absorption or consumption of food. EDs persistently and significantly reduce psychosocial functioning and impair physical health (1). The Diagnostic and Statistical Manual of Mental Disorders (1) stipulates diagnostic criteria for six ED types; pica, rumination disorder, avoidant/restrictive food intake disorder, anorexia nervosa, bulimia nervosa, and binge-eating disorder. The national guidelines for ED in Norway from two decades ago (2) show that a prevalence of 0.2 to 0.4 percent for anorexia (AN), 1-2 percent for bulimia (BN), and 3 percent for overeating disorder were registered in young people and adults between 15 and 44 years old. A study by Rosenvinge and Gøttestam (3) found that around 50,000 individuals between 15 and 44 years of age had been established as having ED symptomatology requiring treatment; 600 of those individuals needing specialist mental- and ED-healthcare. Psychiatric comorbidity rates are high in patients with EDs. The most pervasive type of diagnoses are anxiety disorders with a generalised anxiety disorder (4) followed by depression(5), bipolar disorder (6) and obsessive- compulsive disorder (7), to name just a few. Moreover, AN and BN may lead to severe somatic complications with a mortality rate from 1.8 to 5.9 percent (8.9). Since EDs are very difficult to treat and incur high economic costs, around 20-30% of ED patients develop chronic health conditions (10).

Family members of patients with EDs are also affected (11,12). Family members' quality of life is significantly impaired because they carry a burden occasioned by the difficulties their role entails as patients become socially isolated and heavily dependent on them (12 - 14). Family members seek help and information from mental health care providers in order to manage symptoms of EDs within complex family dynamics, because feelings of worry, anxiety, sadness, depression, and helplessness may be overwhelming. Because of this, family members require professional help and treatment to regulate their emotional reactions related to the disorder. Negative, overwhelming feelings within the family dynamics may result in sustained and limited interaction hindering open communication (15). With regard to psychotherapeutic treatment, it is common to include family in the treatment process, in the form of MFT, because the family perspective is crucial to the treatment outcome (16).

MFT was established by Laqueur (17), representing, primarily, a complementary psychotherapeutic treatment for drug abuse, psychosis and neurodevelopmental disorders (18). In Norway, MFT has been used as a treatment for families with one or more members diagnosed with psychosis (19). During the course of MFT, the therapist is guided by well-established clinical practice and the documented experience of mental healthcare professionals (20, 21). Even though MFT had already become established (22) in the treatment of children and adolescents, it is only in the past decade it has been applied to work with adults in the United Kingdom (23), Canada (24) and the US (25) with promising

Loading [MathJax]/jax/output/CommonHTML/jax.js c countries began to collect and share knowledge and

experience in this field. (19, 26, 27). There remains, however, a lack of understanding about the way in which MFT affects EDs, and research is needed into the crucial question of how MFT impacts family dynamics and the quality of life of young adult patients with EDs and their family members.

The Regional Centre for Eating disorders (RESSP) at Nordland Hospital in Bodø in the north of Norway, has developed an adjunct psychotherapeutic approach for the treatment of young adult patients with severe EDs. The patients' family members take an active part in the MFT over a 12-month period. The participatory care model for patients and family members developed and applied at RESSP is unique and is considered, throughout Norway, as being a ground-breaking approach (26, 27).

## Study aim

It is important to understand how patients and family members experience MFT. Our study aims to better understand participants' perceptions of the MFT and its impact on family dynamics and on the quality of family life in participating families. We are looking to both improve and further develop MFT at RESSP. The aim of the study was to explore and describe patients and *families* experience of participating in MFT for young adult women with severe EDs.

## Methods

### Research design

The design of the study was qualitative and exploratory. Data were collected by field observations in two MFT groups at RESSP at Nordland Hospital in Bodø, Norway, and qualitative group and individual interviews with young adult women with severe EDs and their family members. Our chosen analytical method was Graneheim and Lundman's qualitative content analysis (28, 29). The project was managed by the first author (BSB). Two research assistants with lived experience, respectively, as patient and parent in MFT, and two MFT therapists took part in the discussion of the findings.

### Study setting

The MFT at RESSP comprised a sequence of six group gatherings spread over a year, each of either 2- or 3-days' duration. The main topics for these gatherings were: (1) Establishing the group, (2) Communication and communication styles, (3) Care and patterns of caring, (4) Siblings, (5) 'Mind the gaps' concerning transition, and (6) Summing up and ending (30, 31). The participants were six families with a young adult female family member with a severe ED. MFT uses a variety of group settings (large groups comprising patients and family members and smaller ones (mothers, fathers, siblings, and young women with EDs)), and various interventions, including role-play, family mapping and sculptures and other creative work. Both psycho-educational and clinical groupwork sessions focus on relevant and important themes including relationship, communication, conflict management, interactivity, motivation and feelings of guilt (26).

Twelve young women ( from 18 to 22 years old), eight with AN and four with BN, 12 sets of parents (mothers and fathers between 43 and 60 years old), nine siblings ( eight sisters and one brother between 16 and 22 years old), one grandmother and two partners participated in the two MFT groups. The families had in common that each had a daughter suffering a severe ED. Most of the patients were receiving treatment in community-based clinics, but some were hospitalized.

The data for the study were collected by means of 180 hours of field observations in two MFT groups (MFT1 and MFT2), together with both group and individual interviews with the participants: young women and their family members (Table 1). These data were collected by the first author (BSB) between 2015 and 2017. The fieldwork was carried out with BSB present as an *or d ∈ aryparticipant*, writing contemporaneous field notes whilst taking part in the group activities on more or less the same basis as other participants. This fieldwork formed the basis for the questions in the interviews, using keywords rather than an interview guide. These interviews were recorded and later transcribed. The main question was: “Tell me about the MFT and what it means for you both as yourself and for your family?” The collection of data continued until its saturation point – which is to say until further interviews no longer contributed anything new. The research was practice-led, in that the researcher participated as an observer on the group’s own terms. The group interviews had to be conducted during breaks, within the time limits that this imposed. Nor was it always easy to come into conversation with some of the participants in the MFT – this could be the case particularly with the young women with EDs.

## Analysis

Data analysis was undertaken by BSB using Graneheim and Lundman’s qualitative content analysis (28, 29), starting by reading through the fieldnotes and interviews in order to gain an overall sense of their content. Meaning units – words, sentences and paragraphs – were identified and condensed. These condensed meaning units – truncated segments of text – were labelled with codes and categories formed by merging codes denoting similar content (Table 2). There followed discussion regarding preliminary sub-categories and suggested main categories between BSB and the second author, SK. Two research assistants with lived experience, respectively, as patient and parent in MFT, and two MFT therapists took part in the discussion of the findings.

## Results

*I was present, as a researcher, in a family group. Using Playmobil figures, each family member was to show the others how they experienced the situation in their family. The young woman with ED placed the ED (a skeleton) in the centre of the table. She put her siblings at the far end of the table, together with a little dog. Mum and Dad were put far apart from each other (they were divorced). “It’s my fault that the family is destroyed” she said, crying. “Everything would be better if only I were dead.” Her father turned to me and said: “You have to keep hold of that. Now, you have really got to see how things are for us.”* (Fieldnote)

The results can be summarised in two main categories: 'Connectedness and recognition' and 'Open yourself and share'

### **Connectedness and recognition**

The participants described the MFT as an arena where families could meet, a space for recognition where it was possible to speak of things happening in the family with others with similar difficulties who understand. They spoke of different kinds of understanding and fellowship; in the mothers' group, the fathers' group, the young women's and siblings' groups and in the large group with everyone present. Many of the group members said that it felt good and freeing, but also painful, to meet other families with similar experiences. What these families had had in common was a considerable loneliness because it is so difficult for outsiders to grasp what it is like in a home dominated by an ED. Here, at last, they had the experience of meeting others who had the same, and who understood how it was for them. A mother expressed this as follows:

*"The first time, the first meeting of the mothers' group, we sat in our group and as soon as we sat down, I began to cry. I was totally unprepared for that because I do not cry easily. It was a shock, but at the same time, it was a signal that I had now come to some people who... A strange experience, as I felt I wanted to scream. And I think that it was because I realised that at last there were people who understood what I was talking about.... I understood that there was truth in that you said that you understood what I was talking about – and it was quite liberating – good and bad at the same time."* (Group interview 1).

The mothers described powerful shared feelings, with a lot of tears and crying, with them all on the same wavelength. They also found relief together, with the other mothers who had had many of the same feelings as them.

*"I could start a sentence and another of the mothers could finish it for me."* (Group interview 1)

*"That's how it is for me. The crushing sorrow. It's just the same for you."* (Mother 1).

*"We think that it's only us who are going through this, but it's really not so– I don't have to go round and take it all on my shoulders."* (Mother 5).

*"It was fantastic. It was moving. There were family histories. We became just like one big family and everyone opened up."* (Mother 3).

A father said that it was especially valuable for him to talk to the other fathers in the fathers' group. There, the fathers could speak about their issues without the mothers present. MFT led to 'aha-experiences', as well as giving structure to chaos. Another father spoke of his loneliness and frustration when outsiders asked how it was going with his daughter. The answer was often that it was not good with her, but those who had inquired had neither the time nor the possibility of fully grasping the situation. It struck a chord with the other fathers when he said, somewhat humorously:

*"I have a standard answer – it depends on how long you have. Do you have five or six hours?" (Group interview 1).*

A father put it like this:

*"You understood that you are not alone. You know the whole picture. I had felt myself completely set apart. Exactly as if I were alone with it. Other fathers said just the same." (Father 6)*

Several of the young women with ED reported that participation in MFT could be both good and bad. You met others, but could also feel exposed, as it was apparent to everyone why you were there.

*"It was great to meet other girls at different stages of their illness. It gives you hope. If they can do it, then I can do it." (Young woman 2).*

The siblings said that they found it good to meet and talk with other siblings, because there were things that they did not want to discuss with their parents. It was also helpful to see their parents together with their sister in the MFT. Nonetheless, difficult feelings could be brought up, and participation in MFT good and bad at the same time.

*"It's hard being here, my heart gets heavy and I get to know things that are unpleasant. But it has made me much more secure, and I take part for the sake of my sister. (Group interview 2)*

The participants reported themselves as having been treated with respect and having been believed and said that they were taken seriously by both the other group members and the therapists. Some said that they had never had such an opportunity as a family, of something so well-tailored to them. The families challenged each other more than the therapists did. Even though the therapists had both expertise and empathy, they nonetheless did not have the same lived understanding of how it is to live with an ED as did the other families in MFT.

*"The therapists know a lot, but still can't have the same understanding of your problems as do the others who have exactly the same problems. You have the feeling that they don't quite get what you're talking about, even though they know a lot about it. It's, plain and simple, just not possible to understand the pain and anxiety without having been there yourself." (Group interview 2).*

*"I pretty much forgot that the therapists were there, trying to keep us on track. I was in MFT to talk to the group, not the therapists. The therapists were just extras. Those who can really help each other are the girls and the families." (Young woman 1)*

## **Open yourself and share**

In the passage above, we saw how the participants experience their encounter with others with comparable experiences, who understood how it was in their family. The meeting with these other families created an underlying safety in the group. They experienced the MFT group as a place tolerant of Loading [MathJax]/jax/output/CommonHTML/jax.js of valuing receiving help to distinguish between realistic and

unrealistic concerns, and in reflecting over what was sensible and what not. The parents spoke of membership of the MFT group as having been helpful with feelings of guilt, and said that they had affirmation of being good enough, of not blaming oneself but, rather, being proud that one had stayed the course and done one's best. The parents shared with each other the importance of thinking of oneself, and of daring to set one's own needs before those of the daughter. It is vitally important to take care of oneself and of the family, and to live as normally as possible, in order to be able to support your daughter. They reflected, as well, on the importance of openness in relation to the daughter with ED, and the young women got to see how things were for their parents.

*"I have learned something from everyone – things added and things subtracted."* (Group interview 1).

*"We got some extra tools – we learned to work together."* (Group interview 4).

*"It was help with tidying and sorting - what's mine, what's my sister's, what's Mum and Dad's."* (Young woman 2).

MFT works less with ED and its symptoms than with communication and cooperation. Several of the participants talked about being stuck, and about being anxious about triggering the ED and difficult emotions. A father described it as being like a wall between his daughter and the rest of the family, and said that they needed help to tear down this wall in order to make possible communication within the family and in relation to the daughter. At the same time, they were scared of crossing boundaries and anxious and uncertain about what might happen if they were too abrupt.

*"Before we started in MFT it was just as if there was a wall between her and us in relation to the disease, but then something happened in the MFT which meant that the wall was broken down a bit. You knew what we could talk about, have some shared experiences around the illness that we could speak about – because we have been so scared – am I am crossing a boundary here, if I say.... or is it something I mustn't say. You become very watchful. This wall really set a limit in that she didn't really know what to say to us, because we didn't really understand what this was all about. And so you sit on the other side of the wall, afraid that if you say this or that it might be wrong, or there again maybe smart. You sit and wonder what to do: should you try to tempt her with something? Should she get something if she does it? You sit there like a question mark. And you don't start to climb over the wall because you don't know what awaits you on the other side..."* (Father 5)

Several of the group members said that it could be easier to talk about difficult things in the large group with everyone together, than as a family. It was often easier to put difficult questions to the other families.

*"I forgot myself a bit – in the MFT I dared to say things out loud to everybody in the big group that I had never dared to say at home. Here were others who understood, and who gave confirmation – looked at you and nodded whilst you spoke, recognised what you were saying. People had things complementary to yours, it was like that too. We discussed, other families came with suggestions for solutions, how they do things, what others do that is good or not so good."* (Young woman 1)

They also found it helpful to mix up the families, to find oneself another mother or daughter. It felt good to the young women to meet other parents, and they often dared to ask them questions they had struggled to ask their own.

Some of the participants in MFT said that the young women showed more of their healthier side and behaved more openly than they usually did at home or in the hospital where the ED often claimed even more space. At the same time, the young women were quiet and shy, and little forthcoming in the group discussions.

*“Many (girls) think – that’s not relevant, one mustn’t say that. I have nothing to contribute. We are not used to presenting our needs – saying it aloud, and we find all possible reasons not to speak.”* (Group interview 4)

In the fieldnote below, the silence and under-pressure atmosphere in the group are described, as well as how the therapist got the young women to participate more and give more of themselves.

*There was a tense atmosphere in the large group. The participants complained that the young women were very quiet and shared very little. They talked in lowered voices and it seemed that words had to be dragged out of them. They often answered ‘Yes’, ‘No’ or ‘I don’t know’. We divided up into our peer groups, the young women with a therapist. They were asked to write, by themselves, some key words about what their life would be like without an ED. Then they shared between themselves about the words they had written down, and the conversation flowed much more easily. Back in the plenary group, the therapist improvised: “I have agreed with the young women that we will exploit the good atmosphere of our peer group and share with everyone else in the large group. The other participants can ask the young women concrete questions and they will tell you what we have talked about.” It turned out to be a good concrete conversation, neither philosophical nor theoretical.* (Fieldnote).

This simple exercise of writing down keywords, first for themselves then shared with each other in the young women’s group, led to increased safety and openness. What followed was a friendly but firm challenge from the therapist to share the same in the big group.

The concreteness of the task showed itself to be helpful in both the small and large groups. One of the young women spoke of how using Playmobil figures led to openness and insight in the family group:

*“We set them up in such a way that we could see ourselves and the family. Who stood close by and who stood far away, and which way the faces pointed. A light came on for everyone – how we saw things very differently, but also very much the same. I liked that. Lovely to do something other than just sit and talk.”* (Group interview 4).

There were many difficult topics, and difficult thoughts and feelings that came up in the MFT. The fathers, mothers and the young women all mentioned, however, humour as rescuing when difficult topics and questions were taken up.

*“Otherwise, it could have quickly got really serious. It could have made it [the MFT] really dismal.”* (Group interview 1)

Humour loosened things up and was experienced as liberating, it created unity and let the participants relax.

*“It’s important to have humour. If I couldn’t have laughed, I wouldn’t have coped.”* (Group interview 3).

*“It’s almost more important to be able to talk to each other, than moving heaven and earth in trying to get well... Try to live a normal life in so far as one can, talk and have a bit of fun together.”* (Mother 6).

Several of the participants told us that their family had become much better at talking to each other after having been in MFT. They learned to listen to each other, hear what the others were saying, understanding more of their thinking. And they were able to practice speaking about difficult things and sharing feelings. As a result, they were able to speak much more openly about everything. This gave rise to increased understanding.

*“She [her daughter] was like an oyster before. They speak to each other in a completely different way now and dare to take up difficult things. MFT helped to make it possible for them to have a proper sister-to-sister talk, in an entirely different way than before. I am so grateful that we did it!”* (Mother 2).

*“MFT has been most important for my parents but has indirectly been good for me as well as things are better at home.”* (Group interview 3).

*“I believe that MFT has been the most important thing in getting well. I learned that it is important to say what you are feeling; learned to speak. When the family understands more, it’s better equipped to be supportive, so that you don’t have to do the work of getting well completely by yourself. It is so good! We wouldn’t have the relationships we have [in the family] if it hadn’t been for MFT, guaranteed.”* (Young woman 1)

*“It’s the MFT that has helped us the most. I would have liked to have two rounds of it.”* (Father 3)

*“Really, all families could make use of MFT, including those without [illness and] diagnosis.”* (Young woman 2)

## Discussion

The main findings: ‘Connectedness and recognition’ and ‘Open yourself and share’ illustrate the profound significance MFT had for the young women and their families. The families felt themselves to be very isolated but found that in the MFT they met like-minded people with comparable experiences, which they could both learn from, and share all kinds of thoughts and feelings with.

The participants in the MFT had experienced extreme loneliness: *“We think it’s only us in the whole world* Loading [MathJax]/jax/output/CommonHTML/jax.js *s experience of loneliness has been described and highlighted*

in earlier studies of the parents of adults with severe ED. Family members' quality of life is significantly impaired because they carry a burden occasioned by the difficulties their role entails as patients become socially isolated and heavily dependent on them (12 - 14). In a study from 2020 (12) parents spoke of loneliness in their couple relationships and families because the ED splits the parents and leads to conflict between them, as well as between the daughter and them. Many reported that they had lost contact with friends and family as a result of their daughter's illness and spoke also of feeling shut out and isolated in their encounters with the health services. Because their daughter was adult, they were often referred to the duty of confidentiality (12). These experiences of loneliness, and of there being little help and support, are reinforced by society in general having little awareness and understanding of EDs (11). A father in our study had created himself a standard answer to give when outsiders asked how things were going – *"Do you have five or six hours?"* (Group interview 1). Most people, when asking how things are going, have neither the time nor the possibility of involving themselves in a long answer about illness and worries. When this father shared this with the others, there was both chortling and recognition. All had experience of being asked such questions, by people who meant well without understanding just how ill the daughter was, given that she looked apparently fairly healthy. One of the mothers in MFT spoke about how liberating she experienced it to have finally found her own kind, who understood. In MFT the group members met others with similar experiences, leaving them better placed to understand each other. No-one can fully understand another person, but families who have an adult daughter with ED understand a great deal more than those who do not. Different families from differing backgrounds found both camaraderie and connectedness in MFT. They had a common denominator, having an adult daughter with a severe ED.

Studies of group activities for people with personal experience (of mental health problems or substance misuse) also mention such connectedness. An article considered encounters between people with mental illness, and how they experienced that they could be themselves, without having to pretend. Having a bad day was allowed – there was no need for pretence (32). Being able to recognise oneself in the stories of other group members and relief in knowing that someone else shared the same thoughts are important findings in studies of different group activities and group therapy for patients with EDs (33-35). The importance of cohesion is a known phenomenon in group psychotherapy, described in a number of studies of different types of group therapy (36). All people are dependent on others and the significance of this dependence is increased when those closest to us are ill and vulnerable. Even though we are adult, we are nonetheless dependent on our family members and close friends. Families, too, are dependent on others. As individuals we depend on the health care services, and those closest to us and members of our family are dependent on information and support from these services, even though the ill person is adult. When one has felt oneself alone over a long period, the feelings of connectedness, recognition and cohesion are all the stronger.

Some of the young women in MFT were unassuming and found it difficult to share themselves in the big group. They often spoke with lowered voices and answered in monosyllables. Withdrawnness and lack of response may be interpreted as the result of executive function impairments such as cognitive flexibility

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8)) and by extreme dietary restriction (39), but can also be

understood in terms of shyness, or the need for self-protection(40). There are always limits to openness. Others also have a responsibility for not being invasive or violating the individual's integrity. Some of the participants said that they found it easier to speak of difficult things in the plenum group with everyone gathered there, than in their little family. They also found it useful to mix up the families – find themselves another mother or daughter. It felt good for the young women to meet other parents because they then dared to ask those questions that they struggled to put to their own family. This was perhaps the result of communication having become locked in the family, so that it was experienced as being simpler and less threatening to introduce difficult questions in the big group, or with other parents or other daughters. It was easier to intellectualise and distance oneself from difficult feelings and conflicts in one's own family. Again, we are talking here of the limits to openness, and the desire to protect oneself and to protect one's own, and the family's, integrity.

The Danish philosopher and theologian Knut E. Løgstrup introduced the concept of the 'Zone of Untouchability' (41). Each person must lay claim to a zone of untouchability – an innermost psychological space into which no-one shall enter except in that they have been specially invited. It is in this space that important things are formed in us: it is where good feelings develop, and where we work with those things we have no words for. It is to this place we withdraw to when the clamour around us becomes all too much. Respect for this untouchability applies both inwards and outwards: inwards to protect our own needs, outwards as a boundary on the way to the other. Normally, each of us respects the zone of untouchability of the other person. Where it is not respected, relating will not be good (41). The zone of untouchability concerns one's integrity. If the zone of untouchability is not balanced by the need for openness to the other, the person becomes locked in. But if we fail to acknowledge and protect our zone of untouchability, we are in danger of being overly given up to the other. In other words, there is a limit to openness. A person must protect their selfhood, and we all have a duty to not invade or violate the other's untouchability and integrity.

A father described there being a wall between the daughter and the rest of the family:

*"Before we began the MFT it was as though there was a wall between her and us in relation to the disease .... You didn't know what you could talk about .... Because you're so scared of – have I crossing a boundary here in saying - or, is there something I shouldn't say? You become very vigilant".. (Father 5).*

In MFT the group members had the experience of being helped to break down the wall, both inside the group with their own family and among the other families there and outside, after the MFT was over. That the wall was somewhat broken down encouraged openness and increased understanding such that the young women and their families could afterwards be better supported, both from their own family, from the other families in MFT but also from others outside the group.

In MFT the young women and their families had the experience of meeting others who could understand the pain they had been carrying alone for a long time. Group members told that they experienced fellowship and opening up in meeting the others in MFT as both good and bad at the same time. Even

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le, it could also be painful. It was great to meet others with

similar experiences, but they sometimes felt they were exposing themselves. In the MFT, many serious and sad themes are taken up. A number of the participants said that humour was important to lighten the mood of the group. An article about the therapists in MFT also mentioned the importance of humour (26). Humour implies the ability to be playful and have an informal style while retaining a seriousness and earnestness of purpose. One of the therapists said: *“Amidst all the seriousness it is possible for them to see, and to work on themselves with a degree of playfulness. This maybe sounds a little strange, as if one is not taking things seriously. But humour relieves part of the tension, so that it is easier to address difficult matters”* (26, p 1155). Schöpf et al. (42) consider humour to be relationship building and relationship protecting. McCreaddie and Wiggins (43) distinguish between unproblematic and problematic humour. It is essential that humour be used with sensitivity.

MFT helped to establish improved communication and interrelationships in the families. We have found few qualitative studies of participants` experiences of MFT for adults with EDs. One comparable study (25) says: *“Findings revealed that recovery is long, arduous, and marked by many disconnections and intense emotions and that MFT.... promoted communication and connections, helped with identification and expression of emotions, and indirectly helped AN symptoms. These findings add to those of other studies that note the high burden of illness for patients and families. They also suggest the potential promise of MFT...in leveraging its strong therapeutic community to restore intra-and interpersonal connections and foster recovery”* (p. 269).

An MFT therapist in a study of therapists in MFT (26) expressed it like this: *“To bring out the unique capabilities that each family has, and the abilities emerging from the interaction between the families is probably the most special thing.....The things that happen right there and then, some in the big group, some with the mothers, some with the girls. They encourage each other....”* (26, p 1152- 1153).

## Strengths And Weaknesses

There has been little research into the experience of those (young women and families) participating in the MFT of young women with severe EDs. The strength and creativity of this study lies in it being based on extended (2 years) field observations in two MFT groups for adults, supplemented with both group and individual interviews with the participants. The research was practice-led, in that the researcher participated as an observer on the group’s own terms. The group interviews had to be conducted during breaks, within the time limits that this imposed. Nor was it always easy to come into conversation with some of the participants in the MFT – this could be the case particularly with the young women with ED. One might suppose that those who agreed to participate in the group and individual interviews were those best resourced, most verbal and most positive about the MFT, and that therefore less positive experiences are not as well represented. The first author (BSB) (who carried out the field research) has no clinical experience in this field, nor had any expertise with MFT in advance. This could represent both a strength and a weakness. The strength is that MFT has therefore been studied from without, creating the possibility of new perspectives. A potential weakness can be that important themes may have been either

Loading [MathJax]/jax/output/CommonHTML/jax.js d author (SK), however, had clinical experience as a

psychologist of working with young adult women with EDs, those closest to them and of family work. Two research assistants with experience themselves of being a patient and carer respectively (and of participation in MFT), and two MFT therapists have contributed to the discussion of and quality-control of the findings. This adds to the study's validity. The reliability of the study was secured by scrupulously following clearly set out steps in the process of the analysis.

## Conclusion

The study sought to elicit and describe the experience of both young adult women suffering from severe EDS and their family members of having participated in MFT. They described the group therapy as being characterized by connectedness and by recognition. There were others there with similar difficulties and it was possible to speak of one's own family difficulties. This meeting with others in a similar situation created a valuable underlying safety but was both good and freeing, and painful. It made it possible to share the great loneliness of living in a household dominated by an ED, something that outsiders have difficulty in understanding. The parents told that they had been helped to differentiate realistic and unrealistic concerns and had learned the important of openness and communication in relation to their daughter. Some of the young women said that they found it, directly, most important for their parents, but thereby, indirectly, important for them in that homelife became much better.

### Implications for practice and further research

The study shows that participants in MFT (for young adults and families) found it valuable and important, uniquely tailored to their needs. This suggests that MFT can be further developed and used in other therapeutic contexts, perhaps most obviously those involving chronic illnesses or substance misuse. More, qualitative, research is needed to further elaborate the experiences of participating patients, parents and siblings. Quantitative studies into MFT's effects on the patient, the health of family members, quality of life and family functioning are also called for.

## Abbreviations

AN: Anorexia nervosa; BN: Bulimia nervosa; ED: Eating disorder; MFT: Multifamily Therapy; RESSP: Regional Centre for Eating Disorders.

## Declarations

### Ethics approval and consent to participate

The research project was approved by Regional Committee for Medical and Health Research Ethics (REK: reference 2014/1621/REK west). All participants in the MFT groups received verbal and written information regarding the research project and signed a consent form. They were also informed that they could withdraw from the study at any time. The data were treated confidentially and anonymized.

## Consent for publication

Not applicable.

## Availability of data and materials

Please contact BSB for data request.

## Competing interests

The authors declare that they have no competing interests.

## Funding

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## Authors` contributions

BSB was responsible for the study design, data collection and data analysis, and wrote the first draft of the manuscript. SK was responsible for the literature review, and wrote the background. She also contributed in analysis and discussion of the findings. Both authors read and approved the final manuscript.

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## Tables

Table 1. Overview of participants in the qualitative group interviews and individual qualitative interviews.

|                       |   |       |
|-----------------------|---|-------|
| Group interview 1     | 5 mothers, 5 fathers                          | MFT 1 |
| Group interview 2     | 4 mothers, 2 fathers, one sister, one partner | MFT 2 |
| Group interview 3     | 4 young women with EDs                        | MFT 1 |
| Group interview 4     | 3 young women with EDs                        | MFT 2 |
| Individual interviews | 6 mothers                                     |       |
| Individual interviews | 6 fathers                                     |       |
| Individual interviews | 2 young women with EDs                        |       |

Table 2. Examples of meaning units, condensed meaning units, codes and category (“Open yourself and share”)

| <b>Informants</b>                    | <b>Meaning unit</b>  | <b>Condensation</b>  | <b>Code</b>   | <b>Category</b>                |
|--------------------------------------|--|--|---|--------------------------------|
| Group interview 1                    | “Easier to speak to others than to one’s parents. Easier to pose difficult questions with people less close to you.”   | Less threatening to converse with strangers.<br>Swap family /family members / daughters            | Easier to speak about difficult things with other families. | <b>Open yourself and share</b> |
| Group interview 4                    | Playmobil figures;<br>“These were set up so that you saw yourself and your family in them. Who stood close, who stood far away and which way the faces pointed. A light came on for each of us, how we saw things very differently and yet much the same. It opened our eyes because you had these completely concrete figures to relate to. I liked that. Good to do something other than simply sit and talk.” | Working with Playmobil figures brings new insights   | Learn specific techniques for better communication          | <b>Open yourself and share</b> |
| Group interview 4                    | “Many (of the girls) think – that’s not relevant, I mustn’t say that. I have nothing to offer. Not used to presenting their needs, out loud. Find all possible reasons to not speak – it’s not relevant.”  | The girls are shy. Daren’t put themselves forward.   | What I have to say is not important (Young woman)           | <b>Open yourself and share</b> |
| Individual interview (Young woman 2) | “Exchanging advice. Perhaps someone else can put words to that which you could not. Help with tidying and sorting – what is mine? What is my sister’s? What is mother’s?”  | Learning from others.<br>Becoming aware. Whose problem is it?                                      | Tidy and sort   | <b>Open yourself and share</b> |
| Individual interview (Father 5)      | «Before we started there, there was a kind of wall between her and us in relation to the illness. But then something happened in the MFT that meant that the wall was broken down a little.”   | Communication in the family was closed as if by a wall.<br>Learned ways of breaking down the wall. | Better able to talk to each other and understand.           | <b>Open yourself and share</b> |