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Eating disorders traditionally develop during adolescence and have the highest mortality rate of any psychiatric illness. Rapid recognition, diagnosis, and subsequent treatment are essential components of an effective course of treatment. Parental involvement is a key aspect of treatment for adolescents with eating disorders, and is the distinguishing characteristic of the Maudsley approach, in which the parents assume all control. Several quantitative, longitudinal studies have shown that the Maudsley treatment process has effective outcomes. However, subjective parental experiences of a Maudsley-based treatment process are largely absent from scholarly literature.

This study utilized a phenomenological qualitative method, in which 11 parents of adolescents within a modified Maudsley treatment approach participated in two semi-structured interviews. The research question for this study was: What are the experiences of parents of adolescents with eating disorders who engage in Phase I of a modified Maudsley based treatment process?

Three distinctive themes emerged from this study: empowerment, all-consuming, and community. Themes were explored within the context of promoting further understanding of the process of Phase I of a modified Maudsley approach. The themes
were compared and contrasted with literature, implications for the eating disorder
treatment community were suggested, and direction for future research was proposed.
The results of this study provide avenues to understand the experiences of parents within
a modified Maudsley treatment approach and may encourage continued conversation and
research within the clinical practice of the treatment of adolescents with eating disorders.
ACKNOWLEDGMENTS

This process has been one full of both laughter and tears. I’m overwhelmed with the ways in which I have been blessed during my time at Kent State and the Cleveland Center for Eating Disorders.

Thanks goes to my advisors, Dr. Jane Cox and Dr. Jason McGlothlin. Thank you for all of the guidance and careful editing over the past several years. You have been steadfast in your encouragement and support, both academically and professionally, and for that I am grateful. I’m also extremely thankful to Dr. Travis Schermer who took on the task of being my peer reviewer. I also appreciate Dr. Donna Bernert, who was invaluable in guiding me within this qualitative research.

I am in awe of the families who so graciously and eloquently shared their stories with me. I cannot express my appreciation and admiration for your courage in the face of your child’s eating disorder. It was a true pleasure to be permitted access into your experiences with the Maudsley approach, and it is my sincere hope that through this document, as well as other research, that other parents might find further respite and support within the treatment of their adolescent’s eating disorder. I feel honored to have been even a small part of your experience.

I also must say an enormous “thank you” to the entire staff of the Cleveland Center for Eating Disorders. Your acceptance and encouragement were at many times the fuel that propelled me through this process. My greatest of thanks must go to Dr. Lucene Wisniewski and Dr. Mark Warren, without whom CCED would not exist. Also,
to Dr. Jorey Beegun, words cannot effectively communicate my admiration, respect, and appreciation for the support you have provided me throughout this process.

I’m indebted to my parents, Doug and Joyce Boyette. As I reach this point in my educational career, nothing could have happened without your unyielding support. To be raised in a household that places such emphasis on the value of education is irreplaceable. I look up to and respect both of you more than you know. Thank you for loving me and for teaching me the value of both education and serving others. You are the inspiration for this study and I love you dearly. Also, to my sisters, thank you for loving your older sister and putting up with me. I love you both. You’re both so much cooler than I am.

Finally, I must thank my husband, Dr. Devin McCullough. Thank you for everything over these past 12 years. I thank you for your profound levels of love, forgiveness, encouragement, and patience. You are the steadfast presence in my life. I look forward to what our future holds. Your unconditional love humbles me, and I love you dearly.
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CHAPTER I
INTRODUCTION AND REVIEW OF THE LITERATURE

Eating disorders, primarily anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified, are quite prevalent within adolescents in the United States. Eating disorders are the third highest most chronic illness amongst adolescent females after asthma and obesity (Golden et al., 2003). Described within scholarly literature as “epidemic,” eating disorders have permeated the fabric of Western culture (Levenkron, 2001).

The consequences of eating disorders are dire, as the mortality rate of anorexia nervosa alone is higher than any other psychiatric disorder or diagnosis (Berkman, Lohr, & Bulik, 2007; Harris & Barraclough, 1998; Klump, Bulik, Kaye, Treasure, & Tyson, 2009; Sullivan, 1997). Pomeroy (2004) suggested anorexia nervosa is the leading cause of death in young women ages 15 to 24 years of age, a mortality rate which is 12 times higher than the yearly death rate from all causes of death for the aforementioned population (Signorini et al., 2007). Individuals with bulimia nervosa are also at great risk of death, as electrolyte imbalance, particularly low levels of potassium (hypokalemia), has the propensity to cause fatal heart arrhythmia (Pomeroy & Mitchell, 2002). However, other research continues to purport differing data, particularly because the cause of death with individuals with eating disorders is often difficult to determine due to the medical, psychological, and longitudinal processes of the individuals (Neumarker, 2000). Therefore, some controversy within research exists concerning the mortality rates for individuals with eating disorders (Crow, Praus, & Thuras, 1999). Despite
discrepancies within literature regarding mortality rates of individuals with eating disorders, high levels of social, functional, and medical disability are also highly associated with eating disorders (Klump et al., 2009).

The majority of eating disorders develop within adolescence rather than childhood or adulthood (Smolak & Levine, 1996). Limited clinical trials have been conducted to understand effective treatment modalities for anorexia nervosa in adolescence (Lock & Le Grange, 2005). Some therapeutic modalities that are utilized for the treatment of eating disorders include cognitive behavioral therapy, behavioral therapy, family therapy, and interpersonal psychotherapy (Fairburn & Brownell, 2002). Despite various therapeutic approaches within scholarly literature, the recovery rates for adolescents with eating disorders remain quite low.

Through research, clinicians understand rapid recognition and subsequent initiation of treatment, both medically and psychotherapeutically, are essential components to the treatment of individuals with eating disorders (Sullivan, 2002). For children and adolescents with eating disorders, family involvement is a key component of treatment (Dare & Eisler, 2002). Of additional import is parental understanding of the seriousness of, as well as the various treatment options for, the eating disorder. Because the prognosis for adolescent eating disorders is considered “less than satisfactory” (Fairburn & Brownell, 2002, p. 212), the most effective treatment approach for adolescents with eating disorders is typically multi-faceted. Utilization of family and individual therapy, nutritional consultation, medical management, and possible psychotropic intervention is often the basic crux of treatment (Kaplan, 2002).
Over the past several decades, researchers and clinicians at the Maudsley Hospital in London, England, have pursued a different approach for treating adolescents with eating disorders. The Maudsley treatment approach emphasizes the importance of overtly involving parents in providing support and problem solving skills for their adolescent with an eating disorder (Dare, 1985; Dare & Eisler, 2002; Lock, 2004; Lock & Le Grange, 2005). The Maudsley treatment approach differs from the historically accepted treatment approach for adolescent eating disorders, which often pathologises the family structure and limits parental involvement in their child’s treatment (Fairburn & Brownell, 2002; Lock & Le Grange, 2005). Research has indicated increased rates of both physical and psychological recovery amongst adolescents who are involved in the Maudsley family based treatment approach versus that of a traditional family or individual therapy approach (Le Grange, 1999; Lock, 2004; Lock & Le Grange, 2005; Lock et al., 2010; Robin & Le Grange, 2010).

**Purpose**

Because eating disorders traditionally develop within adolescence, parents of the adolescents with eating disorders often are the primary caregivers (Haigh & Treasure, 2003), particularly within the confines of a Maudsley-based treatment approach. Research regarding the Maudsley treatment approach is quite limited due to the relatively short amount of time this treatment has been utilized within the eating disorder field. Of particular note is the absence of literature or research regarding the subjective experiences of parents as they initiate the Maudsley treatment approach with their adolescent. Parental involvement is the distinguishing aspect of the Maudsley treatment
approach, as the parents are viewed as being the head of their child’s treatment team and are in charge of, and implement, all decisions surrounding food, weight, and behaviors contributing to the eating disorder. Therefore, the importance of understanding the experiences of parents is key within the eating disorder treatment community in that this understanding may provide clinicians and other treatment providers a more thorough conceptualization of the Maudsley treatment approach. This understanding may help to better enable clinicians to engage and support parents as they navigate the Maudsley treatment process. Furthermore, understanding the parental experiences of the Maudsley treatment process may spur further clinical research, ultimately lending to a broader research base from which clinicians and parents work as the Maudsley treatment process is initiated and implemented. In this study, a qualitative, phenomenological approach was utilized to explore the experiences of parents of adolescents with eating disorders who initiate and participate within Phase I of a modified Maudsley treatment process.

Review of the Literature

The review of the literature begins by defining basic terminology used in this study. Next, the history and popular culture surrounding eating disorders and subsequent professional and public understanding of the disorders is discussed. This is followed by a review of eating disorder diagnoses and prevalence across gender and ethnicity boundaries. Further areas explored surrounding eating disorders in adolescence including etiology within the family system and biological and development issues. Various therapeutic modalities were explored across several domains (medical, psychotropic, psychotherapeutic, and course and outcome of eating disorder treatment). Lastly, an
overview of the Maudsley treatment approach, efficacy and outcomes, and treatment centers that utilize this approach is provided.

Definition of Terms

This section provides the reader with terminology used within the eating disorder treatment community and within this dissertation.

- **Binge** behaviors are characterized by an individual consuming an amount of food that is larger than what most people eat within a discrete amount of time, as well as a sense of loss of control, traditionally within a 2-hour span (Franko, Wonderlich, Little, & Herzog, 2004).

- **Caloric restriction** is self-induced avoidance of certain foods and choosing low-calorie foods in order to attain or maintain a body weight less than expected for age and height (Sullivan, 2002).

- **Eating disorders** often emerge with an individual exhibiting a range of behaviors that have a direct effect on the eating habits, weight, and overall health and functioning for the individual. Some behaviors may include caloric restriction, binge, purge, exercise, or the use of pills (Fairburn & Brownell, 2002).

- **Modified Maudsley Treatment** is a combination of parents taking full control of their child’s eating disorder treatment and meals as well as the adolescent participating in the day treatment (DTP) or intensive out-patient (IOP) programming. The DTP and IOP programming is a group-based treatment
approach that meets multiple days per week and includes meals and therapeutic group settings (Cleveland Center for Eating Disorders, n.d.).

- “Pure” Maudsley Treatment is defined as the parents taking full control of their child’s eating and behaviors, through finding support in once-a-week Maudsley family therapy sessions with a Maudsley family therapist. “Pure” Maudsley treatment is thought to be effective with families with young children (traditionally younger than 10 years old) with eating disorders (Cleveland Center for Eating Disorders, n.d.).

- *Purge* behaviors are often defined as an individual engaging in self-induced vomiting or other compensatory behaviors, such as excessive exercise or pill use (diuretics, diet pills, or laxatives; Thompson, 2004).

**History of Eating Disorders**

The understanding and diagnosis of eating disorders is a developing phenomenon within the past several decades. The earliest reference to disordered eating is Richard Morton’s *Phthisiologia seu Exercitationes de Phthisi Tribus Libris Comprehensac* in 1689 (Pearce, 2004). Through descriptions of a wasting away of body via nervous eating habits, Morton’s explanation of disordered eating is one of the first references to address the phenomena of caloric restriction.

Further literature developed within the past few decades includes Binswanger’s (1958) case of Ellen West, which is viewed as an early contribution to the field of eating disorder research (Vandereycken, 2002a). Ellen West’s death from suicide after years of anorexia nervosa, the subsequent development of bulimia nervosa, and laxative abuse,
continues to permeate literature today as the initial and paramount explanation of eating disorders within modern literature. Binswanger (1958) described West’s life as dedicated to mortality and her body as a corpse. The exploration of existential questions, death, and death themes surrounding Ellen West’s case continues to be a conversation within the eating disorder treatment field (Jackson, Davidson, Russell, & Vandereychen, 1990).

Bruch (1985) continued the conversation regarding eating disorder pathology within scholarly research. Her work was primarily written for those within the treatment realm and was not readily accessible to the general public. However, Bruch highlighted the seriousness of eating disorders, and increased integration of eating disorders in public knowledge. Bruch worked to emphasize the manifestations of eating disorders within the academic sphere and continued the impetus towards further research within the treatment community.

Anorexia nervosa was the first eating disorder to be diagnostically described, with specific diagnostic criteria noted by Russell (1970). He placed specific emphasis upon behavioral disturbance of caloric restriction, characteristic psychopathology, and endocrine abnormalities. He noted that behavioral disturbances lead to decreased body weight. He characterized psychopathology as an intense fear of becoming overweight, and also included the development of endocrine abnormalities due to anorexia nervosa, which leads to amenorrhea in females, and loss of sexual interest.

The defining diagnostic criteria of bulimia nervosa were binge eating and subsequent compensatory behaviors (Russell, 1979). Russell noted the feeling of loss of
control regarding food intake paired with compensatory behaviors, such as exercise, purging, and diuretic use.

Anorexia nervosa and bulimia nervosa diagnoses have evolved into the criterion set forth by the current *DSM-IV-TR* and *ICD-10*. The *Diagnostic and Statistical Manual, 4th edition, Text Revised* (APA, 2000a) currently denotes three classifications of eating disorders: anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified (APA, 2000a; see Appendixes A, B, and C). Recent scholarly literature debates current diagnostic criteria for anorexia nervosa in children and adolescents as well as discusses the possible addition of binge eating disorder and night eating syndrome in the *DSM-V*, (APA, 2000a; Knoll, Bulik, & Hebebrand, 2011; McElroy & Kotwal, 2006; Striegel-Moore et al., 2006; Allison & Lundgren, 2010). These two proposed diagnoses surround binge eating behaviors with the absence of compensatory behaviors, and eating a large percentage of daily caloric intake during the night-time hours with a perceived loss of control (Garfinkel, 2002; Grilo, 2002; Stunkard, 2002).

**Classification and Diagnosis of Eating Disorders**

Cantwell and Baker (1989) suggested a framework for the diagnosis of any psychological disorder that includes the following: (a) a diagnostic process of inquiries about the client, (b) utilization of diagnostic tools for systematic data collection, (c) employment of a diagnostic system, and (d) assimilative processes to interpret data and subsequent determination of a particular diagnosis.

Through the utilization of the aforementioned diagnostic framework, the process of determining the presence of an eating disorder includes several aspects of assessment
and data collection. The practitioner often uses information such as the client’s weight and dietary history, menstrual and sexual history, information regarding the client’s mental status, social and developmental history, family history, prior eating disorder treatment, self-report measures, and standardized interviews (Crowther & Sherwood, 1997; Hsu, 1990; Palmer, 2000, 2002; Anderson & Murray, 2010). Self-report measures may include a personal account of a typical day of food and caloric intake, subjective reports of binge or compensatory behaviors, and the client’s perception of the level of personal distress the eating disorder is causing (Garner, 2002).

Clinicians may also utilize self-report assessment scales to better understand the clinical presentations of individuals with eating disorders. One assessment instrument is the Eating Disorder Inventory (EDI), which measures the client’s attitude regarding eating, weight, and body shape (Garner, 1991). Also, the Eating Attitudes Test (EAT) is a 40-item self-inventory that measures symptomology associated with anorexia nervosa (Garner & Garfinkel, 1979). The Bulimia Test (BULIT-R) is utilized to best understand symptomology associated with bulimia nervosa (Thelen, Farmer, Wonderlich, & Smith, 1991). Also, the Eating Disorder Diagnostic Scale (EDDS) is a 22-item measure that may help diagnose binge eating disorder, bulimia nervosa, and anorexia nervosa (Stice, Telch, & Rizvi, 2000).

Some problems with self-report measures, particularly for individuals with a very low body weight, may include an inability to accurately report levels of behaviors and gross disturbances regarding food intake, and body shape and size (Anderson & Paulosky, 2004). Also of import are clinical interviews and observations of the client’s
family or spouse, as the individual with an eating disorder may not be able to accurately report symptomology and behaviors due to the innate and often grossly distorted reality of the individual with an eating disorder.

It is essential that clinicians have a comprehensive understanding of the client’s physical and medical state in order to diagnose and treat the client with an eating disorder. A complete physical examination by a knowledgeable medical doctor should include analysis of the client’s blood count, electrolytes, creatinine, blood urea nitrogen assessment, urine assessments, and an electro-cardiogram (Halmi, 2002). Hsu (1990) asserted approximately 5% of clients with eating disorders have a co-occurring major medical illness. Therefore, understanding the comprehensive physical status of the client is paramount in the diagnosis and subsequent treatment approaches of the clinician.

**Anorexia Nervosa**

Anorexia Nervosa, as defined by the *DSM-IV-TR* (APA, 2000a), is characterized by a body weight less than 85% of expected, overwhelming fear of gaining weight, body image disturbance, and amenorrhea in postmenarcheal females (see Appendix A). Individuals with anorexia nervosa often experience a great amount of weight loss as a result of decreased caloric intake, and grave disturbance in body weight and shape. Anorexia nervosa has two specifying types, restricting type and binge-eating/purging type. The restricting type of anorexia nervosa describes individuals with behaviors surrounding under-eating and refusal of high-caloric and high-fat foods. Anorexia nervosa, purging type, includes food restriction, as well as compensatory behaviors such as purging, and laxative and diuretic abuse.
Bulimia Nervosa

The diagnostic criterion for bulimia nervosa in the *DSM-IV-TR* (APA, 2000a) is characterized by individuals engaging in binge eating behaviors in which the individual reports a loss of feeling in control of food intake. Individuals also engage in subsequent compensatory behaviors, such as purging, laxative use, or over-exercise. Often individuals with bulimia nervosa have a body weight that typically falls within approximately 10% of expected body weight (see Appendix B). There are two specifying types of bulimia nervosa: purging type and non-purging type. Within the purging type, individuals engage in self-induced vomiting or laxative-use behaviors. The non-purging type of bulimia is noted by compensatory behaviors surrounding exercise.

Eating Disorder Not Otherwise Specified

The third diagnosis of eating disorders in the *DSM-IV-TR* (APA, 2000a) is that of Eating Disorder, Not Otherwise Specified (EDNOS). EDNOS serves as a categorization for individuals who do not meet the full criterion for anorexia nervosa or bulimia nervosa, but do engage in disordered eating behaviors that interfere with daily functioning and activities (see Appendix C). The diagnostic criterion for anorexia nervosa and bulimia nervosa is quite specific, such as amenorrhea for females with anorexia nervosa. Therefore, often individuals are diagnosed as having an eating disorder, not otherwise specified (Franko et al., 2004).

Gender and Ethnicity Within Eating Disorders

Eating disorders are disproportionately more prevalent in girls and women than among boys and men. A recent study purported one in four of those with eating disorders
are male (Hudson, Hiripi, Pope, & Kessler, 2007). Reasons purported in scholarly literature include both the genetic and environmental factors surrounding an individual (Schmidt, 2002). Primarily, research exploring eating disorders and gender has focused on cultural factors, which may contribute to the development and maintenance of eating disorders. Special consideration has been placed on the subordinate position females hold in society, the socialization of the female role, and the modern conception of beauty lying within thinness (Striegel-Moore & Smolak, 2002).

Some scholars suggested eating disorder prevalence has increased among Caucasian women throughout the last century due to socio-cultural changes and shifts (Anderson-Fye & Becker, 2004; Striegel-Moore & Smolak, 2002). However, the elevated prevalence of eating disorder diagnoses may best be understood by the increased awareness, diagnosis, and treatment by clinicians surrounding eating disorders rather than an actual increase of prevalence within a population (Striegel-Moore & Smolak, 2002).

Eating disorders occur significantly less among females living in non-Western, non-industrialized areas and nations, as well as particular ethnic minorities within Westernized cultures (Anderson-Fye & Becker, 2004; Hsu, 1990). The exact prevalence of eating disorders among non-Caucasians in Western societies is largely unknown. Some clinicians feel that eating disorder prevalence is culture-bound in that the problem is predominantly present in Caucasian females in Western, industrialized countries and societies (Striegel-Moore & Smolak, 2002). Studies concerning eating disorders and eating disorder treatment have also been conducted primarily in Western, industrialized nations and cultures as the prevalence of eating disorders is concentrated in these nations.
Therefore, understanding and conceptualization regarding diversity across ethnicities and nationalities are largely absent from scholarly literature (Anderson-Fye & Becker, 2004).

Ultimately, researchers and clinicians agree that the risk factors for the development of an eating disorder within individuals are multifaceted. Emphasis on culture and gender is just one component in understanding, addressing, and subsequently treating, eating disorders (Costin, 1999; Hsu, 1990; Keel & Klump, 2003).

**Popular Culture’s Views of Eating Disorders**

As dialogue continued to emerge within the clinical eating disorder field, conversations about eating disorders also began to infiltrate popular culture and the public at large. Western culture began to understand and recognize eating disorders during the 1970s. The publication and subsequent made-for-television movie of Levenkron’s (1978) book *The Best Little Girl in the World* began to educate the public about eating disorders and their emergence within the psychiatric population of Western society at large. The death of popular singer, Karen Carpenter, in 1983 of complications resulting from anorexia nervosa, made headlines when the “emaciated picture of the famous and talented singer haunted the public from the cover of *People* magazine” (Costin, 1999, p. 1). For the first time, the general public was faced with, and therefore began to understand, the throes of eating disorders and possible fatal consequences.

Various other women’s magazines and media began to discuss eating disorders, and famous individuals such as Jane Fonda, Princess Diana, and Paula Abdul chose to disclose their personal struggles with anorexia nervosa and bulimia nervosa (Costin, 1999; Liu, 2007). The present culture within the 21st century continues to dialogue
about eating disorders and weight loss. Both text media and pictures within advertising reinforce the idealized thin model, which pervades the present Western culture (Grieve & Bonneau-Kaya, 2007).

Furthermore, contributing factors for the possible development of eating disorders have expanded as mass media, such as the fitness, weight-loss, and cosmetic surgery industries, infiltrate gender, social, and ethnic lines (Hesse-Biber, Leavy, Quinn, & Zoino, 2006). In one study, adolescent girls described the ideal female appearance to be 5’7” with a body weight of 100 pounds with long blonde hair and blue eyes (Nichter & Nichter, 1991). The marketing of the aforementioned industries also takes aim at impressing younger audiences (M. Levine & Harrison, 2004).

Perceptions of psychopathology by the general public place a great amount of stigmatization upon individuals with mental and emotional disorders (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Public opinions often stigmatize those with mental disorders via recognition, separation, discrimination, and attribution of undesirable characteristics (Link & Phelan, 2001). These negative opinions may cause individuals with mental and emotional disorders to experience levels of social isolation, distress, and difficulty with employment. Regarding specific perceptions of individuals with eating disorders, negative attitudes are prevalent. Public opinion may also place levels of stigmatization upon individuals with eating disorders, particularly considering those with eating disorders to be self-centered or socially distant (Crisafulli, Thompson-Brenner, Franko, Eddy, & Herzog, 2010; Mond, Robertson-Smith, & Vetere, 2006; Stewart, Schiavo, Herzog, & Franko, 2008).
Eating Disorders in Adolescence

Eating disorders often develop during the adolescent years, rather than during childhood or adulthood (Smolak & Levine, 1996). Adolescent eating disorders have received increasing visibility as a dangerous public health issue (Miller-Day & Marks, 2006). Eating disorders in adolescent males and females, which can result in high mortality rates, are becoming increasingly identified and diagnosed. Anorexia nervosa is the leading cause of fatalities in women ages 15 to 24 years of age (Sullivan, 1997). Risk factors for adolescent development of eating disorders lie within biological, psychological, and social development factors (Steiner et al., 2003).

Research has identified risk factors for the development of eating disorders, though data surrounding protective factors is limited at this time. Protective factors to contradict the development of an eating disorder need to be explored in scholarly literature to better understand, detect, and prevent the development of devastating, and sometimes chronic, eating disorders (Schmidt, 2002). The importance of early detection, diagnosis, and treatment is vital to a positive prognosis for the adolescent with an eating disorder. Biological and developmental issues for adolescents with eating disorders, particularly bone density development and aspects of puberty (menses for females), suggests swift and intensive treatment, which is key to the overall future health of these adolescents.

Etiology Within Parents and Family

Little is known or understood concerning the exact etiology and development of adolescents with eating disorders. At this point, researchers understand the
developmental course of eating disorders is multidimensional, rising from various factors (Miller-Day & Marks, 2006; Polivy & Herman, 2002). The development of adolescent eating disorders stems from a multitude of possible contributing factors, such as cultural, biological, genetic, and environmental factors (Fairburn, Cooper, Doll, & Welch, 1999; Keel & Klump, 2003; Wade, 2010).

Research suggests that neither birth order nor the size of the family has clinical significance concerning the development of adolescent eating disorders (Field, 2004; Vandereycken, 2002b). However, if a child has a special role in the family, such as the scapegoat or mascot role, the development of an eating disorder may have some correlation with this position. Adolescents with eating disorders perceive their families as having lofty expectations for achievement and being excessively focused on outside appearance within the community (Vandereycken, 2002b). Adolescents with eating disorders also experience their families as being more rigid in family structure and organization with fluid interpersonal boundaries and role expectation, meaning a level of enmeshment is perceived to exist within the family relationships.

Research concerning the family systems surrounding adolescents with eating disorders has often focused on the mother-child relationship (particularly the over-bearing mother figure) and the notion of the absent or distant father (Vandereycken, 2002b). However, current research does not support this notion (Lock, 2004). Families with various relationship roles and communication styles all are prone to the development, maintenance, and treatment of an eating disorder within adolescent family members (Nicholls, 2004).
Parental encouragement of their child dieting has been shown to have influence upon an adolescent’s drive for thinness and dissatisfaction with body size and shape. Mother’s dieting also has been shown to advance the adolescent’s drive for thinness and weight loss (Wertheim, Martin, Prior, Sanson, & Smart, 2002). Mothers with adolescents with eating disorders may also illicit higher levels of perfectionism (Woodside et al., 2002).

Children of mothers with a history of an eating disorder have higher risk for the development of an eating disorder. Research suggests a greater prevalence of individuals with eating disorders among first-degree relatives with eating disorders (Strober, Freeman, Lampert, Diamond, & Kaye, 2000). Ultimately, children may have the tendency to internalize the experiences of their mothers (Barnett, Buckroyd, & Windle, 2005). During the treatment of their adolescent, these mothers are often encouraged to modify their behaviors and communicated belief systems regarding food and diet in an attempt to curb their adolescent’s interpretation and internalization of eating disorder tendencies. Largely, parents do not understand how their behaviors and suggestions regarding weight and food intake contribute to the pathology adolescents have regarding their size, shape, and diet (Collins, 2005; Lock & Le Grange, 2005).

**Family Identification of the Presence of Eating Disorders**

Adolescents often report actively dieting more than their parents report their children are dieting, which suggests parents are mostly unaware of the extent to which their children restrict food intake (Wertheim et al., 2002). Therefore, initial parental recognition of an eating disorder in their child may be inhibited by the parents’ lack of
awareness of the true dietary intake of their child. The parent may not be able to identify changes in dietary intake or caloric restriction, which hinders initial parental assessment of the development of an eating disorder within their child (Lask & Bryant-Waugh, 1993).

For most parents of adolescents with eating disorders, the recognition of the disorder in their child is a slow process (Cottee-Lane, Pistrang, & Bryant-Waugh, 2004). Most parents report not having an understanding of eating disorder symptomology and subsequent behaviors as contributing to their difficulty in recognizing the disorder in their children (Lock & Le Grange, 2005). Subsequently, parents often experience a great amount of guilt and anxiety regarding their response to the eating disorder presence.

Upon the recognition of the eating disorder in their adolescent, parents often report experiencing an extreme change in their adolescent’s personality and presentation (Collins, 2005; Lock & Le Grange, 2005). An example of this may be the adolescent who goes from being fairly agreeable to being quite argumentative and confrontational, particularly surrounding situations in which parents institute expectations and limitations within the eating disorder recovery process. Parents also experience, often for the first time, an inability to trust their child due to the child’s manipulation and deviant behavior regarding avoidance of weight gain (Cottee-Lane et al., 2004). This overt change in their experiences of their child often causes confusion, anger, and anxiety for parents.

**Siblings of Adolescents With Eating Disorders**

Siblings of adolescents with eating disorders are often the least researched and supported group within the family structure and treatment modalities (Vandereycken,
The siblings of adolescents with eating disorders have been shown to elicit a higher likelihood of the development of weight, eating, and other psychological disorders. Research does not suggest the eating disordered habits of the identified adolescent with an eating disorder contributes to the development of an eating disorder in a sibling, particularly compared to the environmental and genetic contributions that may contribute to the development of an eating disorder. Sibling rivalry has been identified as present within families experiencing eating disorders, particularly anorexia nervosa (Vandereycken & Van Vreckem, 1992). Within the treatment process of an adolescent with an eating disorder, the importance of a positive and supportive role of a sibling has been largely understudied.

**Biological and Developmental Issues**

Adolescents with eating disorders present with much the same clinical psychological and medical presentation as adults with eating disorders, such as metabolic, cardiac, and psychological distress. However, the consequences of the eating disorder throughout the physical development period of puberty can result in specific abnormalities and long-term medical consequences for adolescents (Nicholls & Stanhope, 2000). Many of the medical problems that arise due to the eating disorder in adolescents are reversible with increased caloric intake and nutritional stability. Because the medical difficulties within adolescents with eating disorders can result in permanent consequences, the threshold for swift and intensive intervention may be lower than that of adults (Nicholls, 2004).
One continued consequence of adolescent eating disorders, and subsequent development of amenorrhea (the absence of menses) and metabolic abnormalities, is long-term bone density loss (osteoporosis and osteopenia) and increased bone fracture risk. The extent of the bone deficiencies has been shown to correlate with the length of illness (Pomeroy & Mitchell, 2002).

**Symptoms and Treatment Approaches for Adolescents**

Treatment approaches for adolescents with eating disorders often mirror the traditional treatment modalities for adults with eating disorders. In particular, medical stability and weight restoration are the most important initial aspects of treatment. Individual, group, psychopharmacological, and nutritional therapy, with consideration of developmental issues, continue to be aspects of the assessment and treatment of adolescents (Guarda & Heinberg, 2004; Lask & Bryant-Waugh, 1993; Huemer, Hall, & Steiner, 2011).

Unlike the treatment of adults with eating disorders, adolescents with eating disorders are still under parental control and authority. Therefore adolescents (being minors) do not have an overt choice regarding type of, and participation in, treatment. Medical management and treatment decisions largely lie within the parental control, particularly as adolescents with eating disorders have gross disturbances in their perceptions of eating, diet, and body shape and size. Adults with eating disorders may elect not to seek treatment, as they are no longer minors and are able to make their own choices regarding medical and psychological care.
Treatment for anorexia nervosa and bulimia nervosa is ideally multi-disciplinary in nature (Guarda & Heinberg, 2004; Kaplan, 2002; Kaplan & Olmsted, 1997; Lask & Bryant-Waugh, 1993). Often a treatment team approach to eating disorder treatment has been indicated as most efficacious, including a psychiatrist, counselor, and other clinicians trained in evidence-based psychotherapeutic approaches; a nutritionist to assist with the dietary needs of the clients; a social worker; and a primary care doctor to manage the medical needs of the individual (Kaplan, 2002).

Treatment options are numerous in regard to the severity and chronicity of an individual with an eating disorder (Guarda & Heinberg, 2004). A particularly difficult aspect of treatment is that the symptoms of the eating disorder manifest themselves both psychologically and physiologically. Of primary importance is the assessment and treatment of potentially life-threatening physiological maladies, such as cardiac arrhythmias and decreased potassium levels (Halmi, 2002; Birmingham & Treasure, 2010).

As the medical management aspect of treatment for an individual with an eating disorder is initiated, various avenues for treatment of an eating disorder arise. Individual psychotherapy, nutritional consultation, psychopharmacological intervention, family therapy, and group therapies may be helpful in treatment (Costin, 1999; Hsu, 1990; Kaplan, 2002; National Institute of Mental Health, 2012). With regard to age of onset and level of severity of the eating disorder, an individual may benefit from in-patient or residential treatment to address engrained cognitions, behaviors, and manifestations of an
eating disorder not best addressed in out-patient therapy. The following sections provide reviews of various eating disorder treatment approaches.

**Medical Complications and Medical Management**

Although scholarly literature increasingly addresses the various medical complications of anorexia nervosa and bulimia nervosa, providers, families, and those in treatment historically focused most upon the psychological and psychiatric aspects of eating disorder treatment. Ultimately, the medical complications have been largely under-addressed and overlooked by providers, families, and those with the eating disorders (Pomeroy & Mitchell, 2002). The medical complications that arise as a consequence of an eating disorder are potentially life-threatening. Treatment providers for individuals with eating disorders must ensure physiological complications and medical management are adequately assessed and addressed (J. Walsh, Wheat, & Freund, 2000; Birmingham & Treasure, 2010). Medical complications often manifest differently across individuals with eating disorders, indicating an increased need for provider education and knowledge concerning symptomology, and need for a full physiological assessment (Pomeroy, 2004).

Individuals with decreased caloric intake, as well as those engaging in purging behaviors, such as vomiting, diuretics, and laxative abuse, often experience electrolyte imbalance (R. Levine, 2002). Most frequently, clients present with hypokalemia, a low level of potassium, which can result in cardiac arrhythmias, resulting in heart attacks, a major and sudden cause of death for those with eating disorders (Costin, 1999; Pomeroy, 2004; Pomeroy & Mitchell, 2002). Further research has indicated chronic hypokalemia
can result in nephropathy, leading to chronic renal (kidney) failure at times severe enough
to indicate the need for dialysis (Pomeroy & Mitchell, 2002). Treatment for hypokalemia
typically consists of careful monitoring of potassium and other electrolyte levels (blood
draws several times per week) and possible daily potassium supplements (Mitchell,
Pomeroy, & Adson, 1997; Pomeroy, 2004).

Cardiovascular abnormalities and difficulties often arise in clients with eating
disorders, particularly for those with severe weight loss due to anorexia nervosa or clients
engaging in frequent purging behaviors (Pomeroy, 2001; Birmingham & Treasure, 2010).
Anorexia nervosa can cause low blood pressure and sinus bradycardia, indicating a
physiological response to a hypometabolic rate of starvation (Halmi, 2002; Pomeroy &
Mitchell, 2002). Clients who restrict caloric fluid intake or engage in frequent purging
behaviors may become dehydrated, ultimately leading to hypovolemia and orthostatic
hypotension, which causes dizziness and fainting (Pomeroy, 2004). In order to best
understand a client’s cardiac state, electrocardiogram (EKG) and other analytic tests may
be used, particularly for those with chronic eating disorder behaviors or radical weight
loss (Seim, Mitchell, Pomeroy, & de Zwaan, 1995).

Gastrointestinal complications frequently manifest for individuals engaging in
purging behaviors such as self-induced vomiting, diuretics, and laxatives. Within
individuals who purge via self-induced vomiting, esophageal problems often arise
(Costin, 1999; Pomeroy & Mitchell, 2002). Mild esophagitis may lend itself, if chronic
purging behaviors continue, to potentially fatal esophageal rupture. Consequences from
continual exposure to gastric acid via vomiting can result in esophagitis, erosions,
ulcerations, and, if purging behaviors chronically continue, esophageal strictures, also known as Barrett’s esophagus (McClain, Humphrise, Hill, & Nickl, 1993). Recurrent self-induced vomiting may also produce Mallory-Weiss tears, which can lead to significant gastrointestinal blood loss (Mitchell et al., 1997; Pomeroy & Mitchell, 2002).

Endocrine abnormalities are also hallmark results of anorexia nervosa and bulimia nervosa. These abnormalities result in dysregulation of the hypothalamic-pituitary (HP) axes, the HP-gonadotropin (HPG), the HP-adrenal (HPA), and HP-thyroid (HPT) axes (Mitchell, Pyle, Eckert, Hatsukami, & Lentz, 1983; Mitchell, Seim, Colon, & Pomeroy, 1987). The HPG axes are responsible for the cessation of menstrual cycles in females, which is an overt symptom often recognized within the anorexia nervosa diagnostic criterion. Arrest in regular menstrual cycles is detrimental in the developmental process of females, particularly for adolescents (Devlin et al., 1989; Pomeroy & Mitchell, 2002).

Metabolic abnormalities often are another physiological response to an eating disorder (Lennkh et al., 1999). Osteopenia, the loss of bone mass and bone density, may be as severe as that found in women with post-menopausal osteoporosis and can result in long-term increased bone fracture risk (Baker, Roberts, & Towell, 2000). The extent of the bone demineralization has been found to be correlational with body mass index, lowest point body weight, and duration of the eating disorder (Pomeroy & Mitchell, 2002).

Individuals experiencing eating disorder symptomology also experience dental and dermatological difficulties (Milosevic, 1999). When a client regularly engages in self-induced vomiting, erosion of teeth due to gastric acid can result in extensive dental
enamel erosion and decalcification (Milosevic, Brodie, & Slade, 1997). The manifestations of self-starvation of individuals diagnosed with anorexia nervosa include brittle skin, loss of hair, and brittle nails. Lanugo, fine downy hair, also develops as a protection mechanism to guard against low body weight and increased vulnerability to cold environments (Glorio et al., 2000). Regarding those with bulimia nervosa, individuals often display calluses and abrasions on the hand or fingers as a result of self-induced vomiting. This damage to the skin occurs when an individual uses a hand or fingers to trigger purging behaviors (Pomeroy, 2004).

**Psychotherapeutic Intervention**

Therapeutic intervention within eating disorder treatment can vary across the continuum of severity and treatment options available (Fairburn, 2005). Various treatment approaches may utilize any combination of therapeutic modalities, such as individual, group, and family therapy, in order to ensure the most effective approach for those with an eating disorder.

**Individual therapy approaches.** Individual therapy is largely utilized in order to specifically address eating disordered behaviors and cognitions (Pike, Devlin, & Loeb, 2004). Specifically, cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT) have been shown to have some efficacy with individuals with anorexia nervosa and bulimia nervosa (Fairburn, 2002; Vitousek, 2002). CBT is often cited as being the treatment of choice for bulimia nervosa in efficacy (not effectiveness) studies. However, for individuals with bulimia nervosa who engage in CBT, a significant subgroup continues to engage in symptomatology of the disorder (Wilson, 1999). With
regards to CBT for individuals with anorexia nervosa, little data exist supporting efficacy within this treatment approach (Fairburn, 2005; Pike, Walsh, Vitousek, Wilson & Bauer, 2003). Therefore, clinicians often utilize CBT but do not have empirically founded data to indicate effectiveness of this treatment approach.

Cognitive behavioral therapy with clients with eating disorders includes encouraging learning, insight, and corrective emotional experiences by allowing the individual to repair flawed patterns of thought. Through internalization of this experience, the client works towards the manifestation of a more healthy belief system (Costin, 1999; Vitousek, 1996; Wilson, Fairburn, & Agras, 1997). Cognitive behavior therapy (CBT) for eating disorder treatment, originated by Christopher Fairburn, aims to change the disordered patterns of eating and then address erroneous and detrimental cognitions associated with the eating disorder (Fairburn, Cooper, & Safran, 2002). CBT works towards establishing behavioral patterns (such as eating meals at regular times of the day) and refuting negative cognitions (such as automatic thoughts such as “I’ll become fat if I complete this meal”) in order to prevent a relapse (Fairburn, 1997a). CBT is effacious with the treatment of adolescent eating disorders within the context of parental involvement in the treatment modalities.

Dialectical Behavioral Therapy (DBT) is another therapeutic approach that has been utilized within individual treatment of eating disorders. DBT, developed by Marsha Linehan for working with people diagnosed with Borderline Personality Disorder (BPD), utilizes various skills in order to help the client be most effective within difficult situations. Researchers have noted the skills lacking within those with BPD diagnoses
are often very similar to the skills relevant to those needed with eating disorder diagnoses (McCabe, LaVia, & Marcus, 2004). These skills include emotion regulation, distress tolerance, interpersonal effectiveness, and mindfulness. The skills provide ways through which the individual can best navigate various situations that arise within both their eating disorder recovery (such as a difficult meal) and overall quality of life (Linehan, 1993a, 1993b; Wisniewski & Kelly, 2003; Chen & Safer, 2010).

**Group therapy approaches.** Group therapy within the treatment of eating disorders has been shown to be particularly effective, via motivational commitment towards reduced eating disorder behaviors as well as behavioral compliance with treatment (Fettes & Peters, 1992; McKisack & Waller, 1997). Group therapy for individuals with eating disorders focuses on the following: (a) motivation and recovery-focused milieu, (b) engagement of ambivalence towards eating disorder recovery, and (c) help for newly admitted clients to cease their eating disorder behaviors and comply with meal plan expectations (Guarda & Heinberg, 2004).

Within day treatment programs or partial-hospitalization programs for eating disorder treatment, group therapy is often effectively utilized to address aspects of the eating disorder such as body image, management of intake, medical stability, or interpersonal effectiveness (Goldstein, Peters, Baillie, McVeagh, Minshall, & Fitzjames, 2011; Olmsted, 2002). The group members often work towards taking risks together through regimented structure and support. Many in-patient and partial-hospitalization programs require group therapy as a part of the therapeutic experience as a way for group members to provide one another with support, feedback, and accountability for the eating
disorder behaviors (Guarda & Heinberg, 2004). Individuals in out-patient eating disorder treatment may also benefit from group therapy, such as a support group, body image, nutritional therapy, or psycho-educational group (Costin, 1999; Fairburn & Brownell, 2002; Thompson, 2004). In a group setting, the group leader must ensure behavioral protocol is met, such as eliminating “fat talk,” and competitive and comparative aspects regarding eating disorder behaviors (Guarda & Heinberg, 2004).

**Psychotropic treatment.** A vast amount of research has been conducted asserting the efficacy of pharmacotherapy within the treatment of bulimia nervosa (APA, 2000b; Attia, Haiman, Walsh, & Flater, 1998; Mayer & Walsh, 1998; B. Walsh et al., 1997). Conversely, the therapeutic benefit of psychotropic medication has been questioned regarding anorexia nervosa (B. Walsh, 2002). Traditionally, psychiatrists have focused clinical attention on the symptomology of mood disturbance within anorexia nervosa, primarily depressed mood and presentation. Through the utilization of antidepressant medication, serotonin selective reuptake inhibitors (SSRIs), and tricyclic antidepressants, several studies noted both mood improvement and increased appetite and weight gain (Mayer & Walsh, 1998; B. Walsh, 2002).

Conversely, several trial studies noted the SSRI fluoxetine (name brand Prozac) had little to no efficacy, particularly for individuals with anorexia nervosa presenting at a very low body weight (Attia et al., 1998; Ferguson, Via, Crossan, & Kaye, 1999; B. Walsh, 2002). Clinicians have shifted focus of psychotropic intervention from the weight-gaining phase of treatment to the maintenance and recovery phase. The results of
one controlled study indicated fluoxetine has some benefit for treatment of obsessive thinking and mood disturbance (Kaye et al., 2001).

Psychotropic intervention for the treatment of bulimia nervosa has been shown to be beneficial for mood disturbance, negative body image issues, and preoccupation with weight (Devlin, 2002; B. Walsh et al., 1997). Antidepressant medication, particularly tricyclic antidepressants, monoamine oxidase inhibitors, as well as atypical antidepressants such as bupropion and trazodone, have proven to be effective within placebo trials (Corcos, Flament, Atger, & Jeammet, 1996; Freeman, 1998). For clients who have adverse reactions to anti-depressant medications, changing medications to an alternative anti-depressant may be beneficial (De Zwaan, Roerig, & Mitchell, 2004).

Ultimately, the effectiveness of psychotropic medication for the treatment of individuals with eating disorders is not conclusive. Despite various trials indicating the efficacy of antidepressant medication, particularly SSRIs, psychiatrists and clinicians alike remain unsure of immediate benefits and long-term efficacy of pharmacological treatment for anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified (De Zwaan et al., 2004; B. Walsh, 2002).

**Family therapy approaches.** The specific use of family therapy approaches in the treatment of eating disorders has been a source of debate within the eating disorder treatment community. However, several traditional approaches to family therapy often are utilized in the historical treatment of eating disorders: structural family therapy, strategic family therapy, and Milan systems therapy (Lock, 2004). Minuchin developed structural family therapy for eating disorder treatment during the 1970s. Structural
family therapy purported the family structure and style of problem-solving need to be altered in order to manage the individual with an eating disorder (Minuchin, Rosman, & Baker, 1978). Another traditional approach to family therapy for the treatment of eating disorders is strategic family therapy, in which the family therapist purports an agnostic, or unassuming, approach to the cause of the eating disorders (Haley, 1973; Mandanes, 1981). Milan systems therapy is similar to strategic and structural family therapy, but views the family as being homeostatic and resistant to change. Therefore, the Milan family therapist works towards utilizing a neutral stance within therapy in order to circumvent provocation of the homeostatic family system, which ultimately lends to resistance from the family towards change (Selvini-Palazzoli, 1974; Selvini-Palazzoli & Viaro, 1988).

Traditional family therapy approaches for the treatment of adolescents with eating disorders have largely been incorporated within the treatment plan and been seen as quite valuable since the 1970s (Lock, Le Grange, Agras, & Dare, 2001; Russell, Szmukler, Dare, & Eisler, 1987). The American Psychiatric Association (2000a) includes family therapy within the current therapeutic guidelines for working with adolescents with eating disorders.

Traditional family therapy for eating disorders is often useful, as the individual with an eating disorder affects those within their immediate family system (Lock, 2004). Despite the effectiveness shown from family therapy outcomes, traditional family treatment approaches encourage the parents to remain separate from the direct monitoring of weight, food, and eating of their adolescent with an eating disorder (Pike & Wilfley,
Largely, the weight and eating disorder behavioral treatment and monitoring has been left to clinicians which ultimately excludes the parents from complete understanding and direct access to their child’s eating disorder treatment. Reasoning for this clear separation of parents from their child’s eating disorder treatment stems from historical theoretical thought that adolescents with eating disorders are expressing a desire to separate from controlling familial environments (Bliss & Branch, 1960; Bruch, 1985; Morgan & Russell, 1975). This desire for control and separation from parents exerting excessive power and suppression of their child’s independence has been long thought to be a significant contributor to the development of eating disorders (Lock, 2004; Minuchin et al., 1978).

One differing approach to family therapy for the treatment of eating disorders was developed by Dare and Eisler at the Maudsley Hospital in London (Lock, 2004). The Maudsley family treatment approach for adolescent eating disorders holds a different view of family therapy than does the traditional lens. Maudsley family therapy includes the family in all decisions, even relinquishing complete control of eating, weight, and eating disordered behavior monitoring to the parents (Dare & Eisler, 2002; Le Grange & Rienecke Hoste, 2010). This treatment approach is relatively new in the eating disorder treatment field, as it was developed throughout the early 1990s (Lock & Le Grange, 2001).

**Considerations of caregiving roles.** The caregiving role for those with either mental or physical impairments can be difficult and demanding, and cause great amounts of distress (Stenberg, Ruland, & Miakowski, 2010). In literature that describes the
caregivers of patients with cancer, levels of anxiety, depression and distress is discussed. However, psychosocial and educational interventions aid caregivers of family members with cancer to more effectively manage distress (Bultz, Speca, Brasher, Geggie, & Page, 2000; Nijboer, Tempelaar, Triemstra, Van den Bos, & Sanderman, 2001). High levels of distress have been reported amongst parents of children with rare diseases, but through intensive interventions, levels of distress decreased (Dellve, Samuelsson, Tallborn, Fasth, & Hallberg, 2006). Regarding support and interventions for caregivers of individuals with mental disorders, online support has been suggested to be beneficial (Perron, 2002).

Compared with insulin-dependent diabetes mellitus (Sim et al., 2009) and psychotic disorders and schizophrenia (Graap et al., 2008; Treasure et al., 2001), parents of adolescents with eating disorders report higher levels of family stress, emotional distress, and perceived burden upon the family system. Research suggests that family members of adolescents with eating disorders similarly experience a great amount of distress, as the process of care-taking of the adolescent can be burdensome and affect the health of the family members (Nilsson, Engstrom, & Hagglof, 2012; Perkins, Winn, Murray, Murphy, & Schmidt, 2004; Santonastaso, Saccon, & Favaro, 1997). Mothers of adolescents with eating disorders may experience more depressive symptomology, family conflict, and difficulty aligning with the adolescent’s father (Sim et al., 2009).

Caregivers for those with eating disorders have expressed elevated levels of perceived unmet needs, particularly wanting support in their practical and emotional management of the eating disorder (Graap et al., 2008). Haigh and Treasure (2003) found caregivers of individuals with eating disorders disclosed a high need for:
Pragmatic detail such as information about what treatment was available, information about the prognosis and plans for future treatment. Carers expressed a need for help with coping strategies [as well as] an unmet need to meet other carers and share experiences. (p. 130)

Additionally, caregivers expressed an unmet need for assistance with meal times as well as practical, emotional support and developing coping strategies. One hypothesis regarding the importance of supporting caregivers of those with eating disorders has been an increased amount of practical information may decrease levels of caregiver distress, which may allow for the caregiver to be more effective in assisting the loved one within the eating disorder treatment process (Haigh & Treasure, 2003).

**Course and Outcome of Treatment**

Course and outcome of individuals with eating disorders is difficult to quantify, particularly as eating disorders have longitudinal, medical, and psychological components. Within the past several decades, the mortality rate from eating disorders has reduced, possibly due to the increased awareness and detection of eating disorders, both from a societal and clinical standpoint (Pomeroy, 2004; Sullivan, 2002). One study suggested mortality rates for anorexia nervosa to be 4.0%, bulimia nervosa 3.9%, and eating disorder, not otherwise specified 5.2% (Crow, Peterson, Swanson, Raymond, Specker, Eckert, & Mitchell, 2009).

Eating disorder recovery is difficult to objectively define, and has not been clearly delineated within scholarly literature, as eating disorders have both physical and psychological manifestations that are not easily quantifiable (Couturier & Lock, 2006).
Therefore, rates of recovery vary greatly as criteria for recovery is difficult to ascertain, depending on the working definition of recovery utilized within research studies (Sullivan, Bulik, Fear, & Pickering, 1998). Also, individuals who recover from full diagnostic criteria for an eating disorder often continue to have “shadows” of the eating disorder, such as a pervasive drive for thinness, cognitive rigidity, and perfectionistic attitudes (Sullivan, 2002).

Individuals with a history of eating disorders also have a higher prevalence of other psychological disorders, primarily depression and anxiety, as well as personality disorders, substance abuse, and obsessive-compulsive disorder (Bulik, 2002; Dennis & Sansone, 1997; Herzog, Nussbaum, & Marmor, 1996; Steinhausen, 2002). Most clinical descriptions of anorexia nervosa and bulimia nervosa often include the presence of anxiety and depression. Often the “chicken and egg” debate pervades scholarly literature regarding eating disorders and mood disturbance and anxiety problems (Herzog, Keller, Sacks, Yeh, & Lavori, 1992).

**The Maudsley Approach**

The Maudsley treatment approach to eating disorder treatment for adolescents originated at the Maudsley Hospital in London, England, by a team of child and adolescent psychiatrists and psychologists. Dare and Eisler, two clinicians at the Maudsley Hospital, worked towards integrating various aspects of the traditional treatment approach with an emphasis on empowering the family towards change and the recovery process (Dare & Eisler, 2002). Unlike the traditional treatment models for eating disorders in adolescence, which focus on individual treatment and traditional
family therapy, the Maudsley approach works towards empowering the family to find solutions to the problems the eating disorder presents, based upon the strengths of the family (Lock, 2004). The family is viewed as being the most valuable resource within the eating disorder recovery process (Lock et al., 2001). Additionally, the utilization of parents within the treatment process of adolescents with eating disorders may effect the attrition rates, as approximately 15% drop out of treatment, compared with a 50% drop-out rate for adults (Halmi et al., 2005).

The Maudsley treatment approach differs from other family therapy approaches to eating disorder treatment in three distinct ways. First, the adolescent with the eating disorder is not regarded as having control of the eating disorder behaviors. Rather, the eating disorder drives the adolescent’s maladaptive behavior. Second, the crux of the Maudsley approach is to rectify the maladaptive eating disorder behaviors by increasing parental control over the adolescent’s eating habits. Third, the therapy is primarily focused on weight gain, particularly within the initial throes of the treatment (Lock et al., 2001).

The clinicians working with the Maudsley treatment approach assume a non-authoritarian position while working with the family collaboratively in order to facilitate the recovery process (Lock & Le Grange, 2005). The Maudsley approach regards the individual with the eating disorder as being compromised because of preoccupation with weight, food, body shape, and exercise rather than the traditional sense of eating disorders being a result of familial pathology, prior trauma, or delayed psychological development (Lock, 2004). The Maudsley approach does not endorse the
traditional notion that the family unit is pathological or is to blame for the etiological
development of the eating disorder. Rather the Maudsley approach finds the parents to
be the biggest ally in the adolescent’s recovery and an imperative aspect of treatment.

The Maudsley treatment approach is a family-based, outpatient treatment
modality in which parents play an active and participatory supportive role. The parents
take sole charge of the re-feeding and weight restoration processes (Lock & Le Grange,
2005). After health has returned and the adolescent is able to function effectively, the
parents eventually return the control regarding food choices, intake amount, and other
behavioral decisions to the adolescent as continued progress and normal adolescent
development are encouraged (Lock & Le Grange, 2005).

The role of the Maudsley family therapist is to provide weekly support for parents
as they become empowered to take control of their child’s recovery process (Lock, 2004).
The therapeutic goal of the Maudsley approach within Maudsley family therapy eating
disorder treatment is two-fold: to prevent in-patient hospitalization by supporting parents
as they work towards helping their child’s recovery from an eating disorder, and to
ultimately return the adolescent to normal and functional facilities, unfettered by the
eating disorder.

Little literature exists explaining to parents the expectations and goals of the
Maudsley treatment approach. Collin’s book (2005), *Eating with Your Anorexic*, has
become the hallmark of supportive literature for the parents of adolescents with eating
disorders within the Maudsley approach. *Help Your Teenager Beat an Eating Disorder*
(Lock & Le Grange, 2005a) also explains the seriousness of the eating disorder as well as
ways in which the family unit can work towards establishing an allied front against the eating disorder. One website (www.maudsleyparents.com) is an online resource and supportive community for both parents of adolescents with eating disorders and those within the Maudsley treatment community. The *Treatment Manual for Anorexia Nervosa* (Lock et al., 2001) provides clinicians with an overview and theoretical direction within the Maudsley treatment approach. Literature for parents of adolescents with eating disorders is imperative as a method for educating parents and decreasing levels of parental distress, particularly feelings of guilt and shame (Le Grange, Lock, Loeb, & Nicholls, 2010). Results from one study suggest many eating disorder websites do not adequately address diagnostic criteria or treatment availability and options, which indicates parents should be judicious in accessing and utilizing internet information (Smith, Kelly-Weeder, Engel, McGowan, Anderson, & Wolfe, 2011). Scholarly literature holds little knowledge as to how to best support parents of adolescents with eating disorders throughout a Maudsley-based treatment approach.

**Phases of the Maudsley Approach**

The Maudsley approach identifies three distinct phases of treatment: (Phase I) refeeding the client, (Phase II) negotiations for a new pattern of relationships, and (Phase III) adolescent issues and termination (Lock, 2004). These three phases are designed to be implemented over the course of one year, with greater intensity of treatment initially and tapering sessions as the adolescent moves throughout the three phases (Lock et al., 2001).
**Phase I.** In Phase I, *refeeding the client*, the primary goal of the treatment focuses on the importance of weight restoration secondary to the imminent dangers of malnutrition, primary hypothermia, cardiac dysfunction, psychological and cognitive deficits, and growth and hormonal changes, such as loss of bone density and menses in women (Lock et al., 2001). The goal of the Maudsley family therapist is to assist the parents in the re-feeding process and restoration of the adolescent’s healthy weight. At times, a family meal with the therapist can serve to help the therapist best identify aspects of the family system surrounding food and eating, as well as overtly supporting the parents as they encourage their child to consume food (Lock & Le Grange, 2001).

The therapeutic alliance between the Maudsley family therapist and family, particularly the parents, is an essential aspect of Phase I, particularly as levels of distress and discord within the family may emerge as parents assume control of the re-feeding process (Ellison et al., 2012; Lock et al., 2001). Literature also suggests that therapeutic alliance with the parents may result in a more effective treatment process (Ellison et al., 2012; Pereira, Lock, & Oggins, 2006).

One of the most important aspects of Phase I of treatment is the therapist coaching the parents to continue with the re-feeding process, despite difficulties, negotiations, or arguments the adolescent may present (Eisler et al., 1997). An example may be the therapist coaching the parents to provide foods the adolescents is fearful of, and supporting the family system as the adolescent has difficulty eating the food. The therapist takes a non-judgmental stance regarding the family system, all the while encouraging the parents and adolescent to externalize the illness, rather than viewing it as
a result of familial pathology or systemic maladjustment (Le Grange, 1993). The goal of externalizing the eating disorder is to differentiate and separate the adolescent from the eating disorder. The therapist may model this via statements such as “the eating disorder is causing your child to fight against your expectations for how much dinner is to be completed.” Externalization of the eating disorder may cause parents to have more ability to work and collaborate with the therapist regarding goals and tasks of the therapeutic process (Pereira et al., 2006). The therapist is careful to continue to focus on the refeeding process, supporting the parents in difficult times and weight gain, and avoiding exerting too much therapeutic time to other adolescent issues (such as school, social life, and outside activities).

**Phase II.** Phase II of the Maudsley approach to treatment, *negotiations for a new pattern of relationships*, can be identified by the adolescent accepting the parents providing amplified food intake resulting in stable weight gain and decreased turmoil within the family system regarding food, treatment, and expectations for recovery (Lock et al., 2001). The hallmark of this phase of treatment is parents slowly allowing their adolescent to assume increased control over eating (Lock & Le Grange, 2001). The therapist and parents work towards establishing criterion necessary for the continued parental relinquishment of control concerning eating. The therapist and family continue to focus on eating disorder symptomology. However, conflicts surrounding weight gain are not as pervasive as within Phase I (Lock, 2004). Issues regarding day-to-day adolescent struggles postponed within Phase I of treatment may enter the therapeutic conversation (Le Grange, 1993). An example of Phase II may be allowing other
conversations, such as school or social issues, to enter the therapeutic process if the adolescent is maintaining a healthy weight trend and is compliant with parental expectations. However, these conversations only occur within the context of continued weight gain and decreased eating disordered behaviors, such as restricting, bingeing, or purging, for the adolescent (Eisler et al., 1997).

**Phase III.** Phase III, *adolescent issues and termination*, works towards the adolescent establishing a healthy adolescent identity after the adolescent has established and maintained a weight above 85% of ideal body weight, and restriction or other eating disordered behaviors have diminished completely (Lock, 2004). The therapist and family work towards identifying interpersonal autonomy and development, and maintenance of appropriate parent/adolescent relational boundaries (Eisler et al., 1997). The adolescent begins to establish an identity, which is able to largely function free of eating disorder pathology and appropriate as per developmental state and age (Le Grange, 1993). Upon the maintenance of Phase III goals, the adolescent may eventually move towards a more individualized treatment approach, such as weekly individual therapy, if the eating disorder behaviors continue to abate and weight stays within acceptable ranges (Le Grange, Eisler, Dare, & Russell, 1992). A way in which Phase III may occur is the adolescent, who is maintaining a healthy weight, is able to focus, quite independently, on other manifestations of adolescence (such as school, social life, and activities), without the focus of treatment being solely upon the eating disorder recovery process.
Efficacy of the Maudsley Approach

Within a family-based treatment approach, dropout rates of adolescents with eating disorders are “more acceptable and statistically manageable” than those of adults with eating disorders (Lock, Couturier, Bryson, & Agras, 2006, p. 640). One consideration for the lower dropout rates is levels of parental involvement and parents’ abilities to compel the adolescent with an eating disorder into treatment. Lock et al. found the only statistically significant predictor of dropout, as well as lower remission rate, within a Maudsley-based treatment approach was the presence of comorbid disorders, such as depression or anxiety.

Studies have noted efficacy within the Maudsley approach to treatment (Eisler et al., 2000; Eisler, Simic, Russell, & Dare, 2007; Russell et al., 1987). In one study, approximately 60% of adolescent clients were weight restored at the end of the year-long family based treatment intervention, and 75-90% of those were at their full weight in a 5-year follow-up (Eisler et al., 1997; Lock et al., 2001). Similarly, a case series utilizing a Maudsley-based treatment approach suggested efficacy in weight gain as well as other symptoms of anorexia nervosa such as depressed mood and decreased levels of functioning (Chen, Le Grange, Doyle, Zaitsoff, Doyle, Roehrig, & Washington, 2010). Research has also noted psychological improvements for the adolescents with eating disorders as well (Le Grange, 1999).

A very recent comparison of Maudsley treatment versus traditional individual therapy indicated Maudsley treatment is the more effective treatment for adolescents with eating disorders. More than 50% of clients engaged in Maudsley treatment achieved full
remission after a one year treatment process, and after a one year follow-up, only 10% relapsed. Comparatively, 23% of adolescents who engaged in solely individual therapy achieved remission, and 40% relapsed upon a one year follow-up (Lock et al., 2010). Also, during the one year treatment process, 15% of adolescents who were engaged in Maudsley treatment were hospitalized, compared with 37% of those in individual therapy.

Within one recent study, several key components of a Maudsley-based treatment approach were purported to be significantly related to more effective outcome as defined by weight gain (Ellison et al., 2012). Specifically, higher parental control of the eating disordered behavior, greater unity between parents, decreased expressed criticism of the adolescent by the parents, therapeutic alliance between parents and the counselor, and increased externalization of the eating disorder were high predictors of successful outcome of a Maudsley-based treatment approach. High levels of parental control over the disordered eating behaviors may be an “essential part of treatment,” as parental control was most correlated with successful outcome of treatment as well as significantly predicted lower dropout rates (Ellison et al., 2012).

Rhodes, Baillee, Brown, and Madden (2008) explored whether parent-to-parent consultation improved the effectiveness of a Maudsley-based treatment approach. One finding from the study, which paired parents of adolescents who had completed a Maudsley-based treatment approach (consultants) with parents of adolescents beginning treatment for one 60-minute session, purported parent-to-parent consultation may have the propensity to augment the treatment process. Specifically, parents of adolescent
beginning the treatment process developed an immediate and powerful bond with the consultants, which also caused the parents to experience decreased feelings of isolation, as well as felt encouraged and hopeful in regards to their ability to manage the eating disorder.

Whereas there are several studies that examine the efficacy of the Maudsley treatment approach for adolescents with eating disorders, this researcher has not located any research that studies the subjective experiences of parents within the Maudsley treatment approach, which can often be a long and intensive treatment modality. At this point, this researcher has solely located quantitative, efficacy-based research concerning the Maudsley treatment approach for adolescents with eating disorders.

**Maudsley Family Treatment in the United States**

The Maudsley treatment for eating disorders has slowly spread throughout parts of the United States, including facilities at Columbia University and Mt. Sinai School of Medicine in New York, Stanford University in California, Duke University in North Carolina, The Cleveland Center for Eating Disorders in Ohio, and the University of Chicago in Illinois (Maudsley Parents, n.d.). Other practitioners throughout the United States are becoming increasingly familiar with this unique, family-based approach to the treatment of eating disorders. However, the integration of comprehensive Maudsley family treatment programming is primarily centered at the aforementioned treatment facilities.
The Cleveland Center for Eating Disorders

The Cleveland Center for Eating Disorders (CCED), located in Beachwood, Ohio, was established in 2006 and provides day treatment (DTP), intensive outpatient treatment (IOP), individual, and Maudsley family therapy for adolescents and adult individuals with eating disorders (Cleveland Center for Eating Disorders, n.d.). The adolescent program works solely within the Maudsley family treatment approach and provides treatment for adolescents who hold diagnoses of anorexia nervosa, bulimia nervosa, and eating disorder not otherwise specified (see Appendix D). Maudsley family therapy is the integral aspect of the adolescent programming, which includes the DTP and IOP levels of care. The DTP is a 30-hour a week program that is considered to be a partial-hospitalization level of care for adolescents with severe eating disorders. The IOP program is traditionally a “step-down” level of care from the DTP program, although occasionally, adolescents can be directly admitted into the IOP level of care if their eating disorder severity does not warrant DTP level of care.

Initiating Treatment at Cleveland Center for Eating Disorders

Often, referrals to CCED are made from various mental health professionals, physicians, and hospitals throughout Northeast Ohio. At times, adolescents may begin the programming at CCED immediately upon discharge from a hospital setting where the adolescent was medically stabilized. Also, families locate CCED via word-of-mouth, as well as through Internet searches. Upon contacting CCED, an assessment is put in place with an eating disorder clinician as soon as possible in order to facilitate the assessment and subsequent commencement of the treatment course.
To initiate the treatment process at CCED, adolescents and their parents attend an assessment session with a qualified clinician in order to ascertain the proper level of care for the adolescent with the eating disorder and the family. Recommendations, based upon the level of seriousness of the eating disorder, are then made and the adolescent may begin the DTP, IOP, or “pure” out-patient Maudsley family therapy programming. After the recommendation is made, the family makes an initial appointment with a Maudsley family therapist and beings the treatment.

**Modified Maudsley Treatment at CCED**

If the adolescents are participants in the day treatment (DTP) or intensive out-patient programming (IOP), their families are considered to be participating in a modified Maudsley approach because the adolescents participate in group therapy programming via the DTP and IOP structure. The original Maudsley family therapy (“pure Maudsley”), developed by Dare and Eisler in the late 1970’s and early 1980’s, solely includes out-patient once a week family therapy (Lock & Le Grange, 2005b). However, CCED provides families of adolescents with eating disorders with a more structured treatment approach as the adolescents participate in both Maudsley family therapy as well as group therapy with other adolescents with eating disorders (see Appendix E).

There are several main differences between the modified Maudsley treatment approach and the “pure” Maudsley treatment approach: (a) within modified Maudsley treatment, the adolescent with an eating disorder is in group programming (DTP or IOP), whereas within the “pure” Maudsley approach, the adolescent is not in group
programming; (b) within modified Maudsley treatment, parents of the adolescent have
the support and guidance of their Maudsley family therapist, family group meetings, and
parent support groups, whereas within “pure” Maudsley treatment, the parents solely
utilize their Maudsley family therapist for support and guidance; and (c) within modified
Maudsley treatment, the parents are thought to be the head of their adolescent’s treatment
team, but have the support of the Maudsley family therapist and the entire adolescent
treatment team at CCED (such as group leaders, psychiatrists, and clinical directors),
whereas within “pure” Maudsley treatment, the parents are the head of their adolescent’s
treatment team with support primarily from their Maudsley family therapist.

**Modified Maudsley Family Therapy Sessions at CCED**

Modified Maudsley family therapy sessions for adolescents participating in the
day treatment or intensive out-patient programming are held once a week for the
adolescent with the eating disorder and parents. The Maudsley family therapist works
towards establishing a therapeutic alliance as well as supporting the parents as they
initiate the Maudsley process and navigate the three phases of the Maudsley treatment.

The parents of adolescents participating in the day treatment (DTP) and intensive
out-patient (IOP) programming also participate in thrice-weekly family group meetings at
the conclusion of the treatment day. The number of families participating in the family
group meetings can vary, averaging approximately 6-10 families. During these meetings,
all of the adolescents in the DTP and IOP programming meet with all of the parents, as
well as a qualified clinician, as a source of support for all participating in treatment.
Twice a week, the parents and adolescents participate in a dialectical behavioral skills
group, and once a week, a parent support group is led by a qualified clinician as well. These groups are a way in which parents can unite with one another and utilize support and information from other parents participating in the modified Maudsley treatment approach.

**Group Therapy Within the Modified Maudsley Approach**

The adolescent DTP and IOP programs offer therapeutic groups such as Art Therapy, Creative Expressions, Adolescent Developmental Issues, Mindful Movement, Cognitive Behavioral Therapy, Dialectical Behavioral Therapy skills groups, and Behavior Chain Group. Creative expressions allows for the adolescents to creatively explore avenues of expression, while Art Therapy is a time in which the adolescents express themselves artistically through various mediums. The Adolescent Developmental Issues group is a time in which the clients process ways in which their eating disorder affects their being engaged in typical adolescent activities, such as school, sports, and social engagements. Mindful Movement groups are times in which the clients engage in breathing, yoga, and other meditative acts in order to relieve stress and allow the adolescents to work towards understanding their bodies in movement. Cognitive Behavioral groups provide structured integration of the foundations of CBT, such as catastrophizing and personalization, as pertaining to the eating disorder. The Dialectical Behavioral Therapy skills group is a didactic group, which teaches various skills (distress tolerance, emotion regulation, interpersonal effectiveness, and mindfulness). Finally, Behavior Chain Group is a group in which clients utilize behavior chains within the DBT therapeutic approach to understand and process various behaviors.
Statement of the Problem

Eating disorder prevalence within the adolescent population continues to be widespread and holds the highest rates of mortality of any psychiatric disorder, specifically for young females ages 15 to 24 (Pomeroy, 2004; Sullivan, 1995). Despite this fact, few clinical trials have been conducted to understand the most effective treatment modalities for adolescent eating disorders (Lock & Le Grange, 2005).

Historically, therapeutic interventions for adolescents with eating disorders were primarily individual cognitive-behavioral treatment as well as traditional family therapy (Fairburn, 1997a, 1997b). As previously discussed, these modalities do not access family involvement as an integral aspect of the treatment (Lock & Le Grange, 2001). Ultimately, these traditional therapeutic approaches have outcomes considered less than satisfactory (Fairburn & Brownell, 2002).

The Maudsley approach to the treatment of adolescent eating disorders, developed within the past several decades, has a distinctly different approach than traditional modalities (Lock, 2004). The Maudsley approach directly involves the parents in the eating disorder treatment, ultimately giving parents control of their child’s food intake and eating disorder behaviors (Lock & Le Grange, 2001). Scholarly literature has suggested the Maudsley treatment to have a recovery rate for adolescents with eating disorders that is higher than traditional approaches (Eisler et al., 1997; Le Grange et al., 1992; Lock et al., 2010; Lock & Le Grange, 2001; Russell et al., 1987). Approximately 60% of adolescent clients have weight restoration at the end of the family based treatment intervention, with 75-90% of those at their full weight in a 5-year follow-up (Eisler et al.,
2000; Lock & Le Grange, 2001). Although several studies have looked at efficacy rates and outcomes, this researcher has found no study that has examined the experiences of the family system and parents as they engage in this long, often intensive, treatment modality.

Because the parents within Maudsley family therapy are utilized as allies within the recovery process, playing a critical role, the experiences of parents may elicit further understanding of the Maudsley family therapy approach and therefore provide clinicians and researchers with a more comprehensive lens through which the Maudsley treatment approach may be developed and utilized. Furthermore, conceptualizing the parent experiences of the Maudsley treatment approach may lead to further research regarding the Maudsley treatment approach as well as provide clinicians with a framework through which to best support the parents as they initiate the Maudsley treatment process. As eating disorders often result in dire medical, psychological, and interpersonal consequences for the adolescent with an eating disorder, developing a complete depiction of the Maudsley treatment process may spur further research and increase treatment options for families, which may improve the quality of, or save, the lives of those with eating disorders.

This researcher wanted to focus on the initiation of Phase I of a modified Maudsley treatment approach because it is often the earliest, and most crucial, time within the treatment process. Because the adolescent is often medically compromised and the eating disorder is at its most severe, understanding the experiences of parents of
adolescents with eating disorders within Phase I will provide insight for both clinicians and researchers as the parents are supported in this treatment process.

**Research Question**

The main research question of this study was: What are the experiences of parents of adolescents with eating disorders who initiate and participate in Phase I of the modified Maudsley treatment approach?

**Summary**

This researcher wished to study the experiences of parents of adolescents with eating disorders within the modified Maudsley approach to treatment. Because the modified Maudsley approach is a relatively new approach to treatment of eating disorders, no research study that this researcher found explored the experiences of parents utilizing the modified Maudsley approach. This researcher is largely interested in examining the ways in which parents navigate the treatment and subsequent recovery process of their adolescent within a modified Maudsley treatment approach.
CHAPTER II

METHODOLOGY

The previous chapter summarized literature pertaining to eating disorders in adolescents, with specific focus on the Maudsley treatment approach. Research suggests that the Maudsley treatment approach for adolescents with eating disorders is considered to be effective, yet largely understudied within scholarly literature (Lock & Le Grange, 2001). The intent of this study was to better understand the subjective experiences of parents of adolescents with eating disorders initiating Phase I of a modified Maudsley treatment approach. The guiding research question was: What are the experiences of parents of adolescents with eating disorders who initiate and participate in Phase I of the modified Maudsley treatment approach? This chapter provides an overview of the methodology utilized in this study.

Phenomenological Qualitative Research Design

A qualitative, phenomenological research design was used to study the experience of parents within the modified Maudsley treatment approach. Qualitative research utilizes a largely holistic approach to understand and analyze the human condition (Creswell, 1998). The data collected within a qualitative approach are rich in description of people, places, and situations and do not use many mathematical or statistical measures (Bogdan & Biklen, 2007). This researcher wanted to work towards best understanding the experiences of the parents of adolescents with eating disorders within a modified Maudsley treatment approach by studying their subjective stories.
Most research about eating disorder treatment lies within the quantitative realm via outcome studies, medical descriptions, and survey research. Pertaining to the Maudsley treatment approach for adolescents, research, qualitative or quantitative, is limited within scholarly literature. Although the aforementioned research findings regarding eating disorder treatments are useful, they do not provide information on the experiences of those who have the eating disorder. Even less prevalent within eating disorder research is the study and understanding of the experiences of family members, parents, and siblings. Therefore, this research study used a phenomenological approach to examine the experiences of parents of adolescents with eating disorders within a modified Maudsley treatment approach.

The purpose and goal of phenomenological research design is to describe the meaning for participants of events and interactions; the researcher does not assume to understand what things mean to those they are studying (Bogdan & Biklen, 2007). The phenomenological researcher emphasizes the personal experiences of a situation through accessing the conceptual world of the participants. To do so, the researcher examines the situation by asking participants the following questions: (a) how they perceive the experience, (b) how they describe the experience, (c) how they feel about the experience, (d) how they remember the experience, (e) how they formulate a sense of the experience, (f) how they evaluate the experience, and (g) how they dialogue about the experience (Patton, 2002).

This researcher ultimately chose to utilize a phenomenological approach as it best suited the purpose and goal of this study: to understand the experiences of parents of
adolescents with eating disorders within a modified Maudsley treatment approach. Because research surrounding eating disorder experiences is limited, particularly that of parents of children with eating disorders, a phenomenological approach was a useful foundation through which understanding the subjective experience of parents of adolescents with eating disorders within a modified Maudsley treatment approach could emerge.

Qualitative research, by definition, is also influenced by the subjective experiences of the researcher throughout the research process. The researcher brings her own experiences, thoughts, and assumptions into the research scenario. The phenomenological qualitative researcher strives to begin the inquiry with silence (Psathas, 1973). This “silence” allows the researcher to work towards understanding the participants’ stories as subjective truth. The researcher acknowledges she does not know what the subjective experiences of the participants mean and strives towards studying the experiences in an attempt to fully understand. Phenomenological researchers purport there are numerous ways through which understanding and interpreting a situation may take place. It is the meaning of an experience or interaction, therefore, that ultimately constructs the reality of the world around us (Bogdan & Biklen, 2007).

**Description of the Participants**

The participants in this study were parents of adolescents with eating disorders who had completed the assessment process at the Cleveland Center for Eating Disorders, and had participated in the Adolescent Day Treatment Program (DTP), which works within a modified Maudsley treatment approach, within the calendar year before the
recruitment for this study. The parents were willing to participate in two interviews, one 60-90 minute interview to review the expectations and experiences of the modified Maudsley treatment approach and one brief 20-30 minute interview to validate themes and perceptions of the participants. The researcher did not utilize parents of adolescents with eating disorders who had either been in the day treatment program outside of the past calendar year, or who had never been treated in the day treatment program. Also, the researcher wanted to ensure the experiences of the parents with adolescents with eating disorders as they navigated the treatment process were as uniform as possible.

**Description of the Adolescents**

In order for the parents of the adolescent with an eating disorder to participate in this research study, the adolescents needed to meet certain criteria. The adolescents with eating disorders needed to (a) have participated in the day treatment program within the year prior to recruitment initiation; (b) not have had any prior Maudsley family therapy within Day Treatment or Intensive Out-Patient Programming for the eating disorder treatment, other than that experienced at CCED; (c) be between 12-18 years old; and (d) have parents willing to participate in two interviews. If the adolescent had prior “pure” Maudsley family therapy, but had not participated in the Day Treatment programming, the child’s parents were not eligible to participate in the study.

This researcher chose to include the parents of both adolescent males and females as possible participants within the study, as many of the maladaptive behaviors and diagnostic criterion surrounding eating disorders are universal across gender lines, with the exception of amenorrhea (absence of menses) in females (Nicholls, 2004). Also, the
Maudsley treatment approach does not differentiate between male and female adolescents in the implementation of the treatment modality, as medical and therapeutic aspects of treatment for adolescent females and males are largely the same.

**Description of the Parents**

The parents of adolescents with eating disorders were chosen within the following criteria: (a) their child must meet all criteria listed above, (b) their child must not have had any prior Maudsley family treatment other than that received at CCED, (c) the parent actively participated in their child’s treatment process, and (d) the parent must be willing to participate in one 60-90 minute interview, with a second 20-30 minute interview to validate findings. Criterion for active participation in their child’s recovery for this study included parents planning to regularly prepare, eat, and enforce meal and behavioral compliance with their children, which is the crux of the modified Maudsley therapy approach.

In the case of divorced parents of an adolescent with an eating disorder, this researcher chose to include both parents in the study if two parents (either biological or step-parent) were participants in their child’s eating disorder recovery process (attending modified Maudsley family therapy and participating in meals and behavioral compliance). In the case of a single-parent household, or if one parent from a two-parent household chose to participate in the study, the researcher chose to include these solo participants as well.

The participants were recruited by fliers hung around CCED (see Appendix F). The flier included contact information for this researcher. The researcher was either
contacted via telephone, email or in person, at which point the information contact form was completed with the parents (see Appendix G). Upon assessing participation criterion eligibility via the screening form (see Appendix H) the researcher contacted the parents either via postal mail or email to give the parents the First Interview Topics Schedule (see Appendix I) as well as the Recruitment Letter (see Appendix J), and to schedule the first interview. This letter clearly defined the purpose of the study and criteria for participation in the study. The letter also included contact information of the researcher, including telephone and email address.

No participant was excluded from the study based on gender, religion, ethnicity, race, or sexual orientation. Each parent gave his or her consent to be part of this study and have interviews audio-taped. Participants were also aware that they could discontinue their participation in the study at any point. To ensure confidentiality, the families were assigned family surname aliases. Only information such as age of the adolescent, the specific eating disorder diagnosis of the adolescent, whether the adolescent had any prior psychological treatment, and when treatment at CCD began was presented in the data and results sections. The researcher also presented the marital status, racial/ethnic identity, and age of the participants within the data and results section. This study was reviewed and approved by the Institutional Review Board of Kent State University (see Appendix K). The final sample size was 11 parents from 8 families.
The final sample size of the participants in this study was determined through saturation of information and data. Saturation occurred when the researcher determined that information and data became excessive or redundant (Glaser & Strauss, 1967).

**Description of the Researcher**

The researcher conducted the interviews for this study. She is a Caucasian female who was a doctoral candidate in the Counseling and Human Development Services program at Kent State University in Kent, Ohio. She is a Licensed Professional Clinical Counselor with Supervisor status (LPCC-S) in the state of Ohio as well as a National Certified Counselor (NCC). She was a full-time employee at the Cleveland Center for Eating Disorders until June 2011, where she saw both adolescent and adult individual patients and led some adolescent and adult groups. The researcher has never been and is not currently a Maudsley family therapist. The adolescent groups in which the researcher participated were within the DTP and IOP programming, but she did not have any direct Maudsley therapeutic interaction with the parents of the adolescents.

This researcher acknowledges she entered the research process with several assumptions about eating disorders, adolescents, and eating disorder treatment modalities for adolescents. This researcher also assumed that she held personal views regarding body weight, shape, and size. This researcher acknowledges having had prior struggles with self-acceptance of shape and size. She worked within the adolescent treatment team at the Cleveland Center for Eating Disorders, which solely utilized a modified Maudsley family treatment approach. Therefore, this researcher acknowledges she held assumptions regarding the modified Maudsley treatment approach and its efficacy within
eating disorder treatment of adolescents. The researcher acknowledged she feels the
Maudsley treatment approach is a positive development within the treatment of
adolescent eating disorders. She also assumed that the participants in this study would be
positively affected by having the opportunity to explore and verbalize their experiences,
via self-reflection, of initiating Phase I within a modified Maudsley family treatment
approach.

Sampling
This researcher chose to utilize convenience sampling, as the prevalence of eating
disorder treatment centers utilizing the Maudsley treatment approach in the United States
is currently very small, as discussed in Chapter 1. Weiss (1994) argued there are certain
situations within qualitative research where convenience sampling may be the only way
to access a small population. Therefore, utilizing a convenience sample applied to this
research endeavor, because there were limited populations of parents and treatment
facilities utilizing the Maudsley treatment approach within the United States from which
to choose. Only a few locations within the United States utilize a program of Maudsley
family treatment for adolescents with eating disorders, some being: Stanford University,
the University of Chicago, Yale University, Duke University, and the Cleveland Center
for Eating Disorders (Maudsley Parents, n.d.).

Purposive sampling was also utilized in that the researcher was careful to ensure
participants represented varying demographic criterion, such as sex, age and diagnosis of
the adolescent, or whether the homes had step-parents or biological parents present. If
the researcher noticed an accumulation of one demographic, the researcher was then
careful to recruit differing demographics to ensure a range of participants were included in this study.

If two parents within the home elected to participate in the study, both parents were interviewed simultaneously in order to provide an arena through which the experiences of the couples could be explored together, as well as provide multiple perspectives of the treatment process. Conversely, if one parent in a two-parent home was not active in the treatment process, the inactive parent was not interviewed, as the research question focused on the experiences of parents actively involved in their adolescent’s treatment process. Although the inactive parent could have offered another perspective of the treatment process, this perspective was beyond the scope of the current study.

**Procedure**

Prior to initiating the recruitment process, the researcher received approval via the agency consent form (see Appendix L) from the directors of the Cleveland Center for Eating Disorders to conduct this research project. Potential participants were ultimately gleaned from the recruitment flier. The researcher hoped to have at least eight sets of parents agree to participate in the study. During analysis of the data, the researcher had the option of re-engaging in the recruitment process in order to find more participants for the study if the data did not seem adequately saturated.

Potential participants contacted this researcher via telephone, email, or in person to express interest in participating in the interview. When discussing possible participation with the participants, the researcher completed the information contact form
and reviewed the screening form to determine whether the participants met criteria for participation. If a potential participant did not meet criteria for participation, the researcher thanked the potential participant for his or her interest in the study, but did not utilize the potential participant within the study. If the potential participant did meet criteria for participation, the researcher provided the participant with the Recruitment Letter as well as the First Interview Topics Schedule and set up a time for the interview that worked best for the participant.

Upon contacting the parents who met criterion for participation in the research study, the researcher further explained aspects and details of the study and the screening procedure. The researcher also reviewed the participants’ contact and personal information, such as mailing address, phone number, email address, preferred method of contact, and documented this information in a Microsoft® Word document. The potential participating families were also given a family surname alias noted on the Screening Form, which was used to ensure continued confidentiality throughout the research process.

The researcher aimed to interview a total of eight sets of parents during the first round of interviews while analyzing the data and consider saturation. Therefore, after eight sets of parents agreed to participate in the study, the researcher discontinued the recruitment process. The researcher ensured saturation was present within the data analysis of the eight sets of parents’ interviews through careful analysis, reflection, and consultation.
All of the interviews were held at CCED. During the initial interview with the participants, the participants had an opportunity to review and complete the Consent Form (see Appendix M), which described the research process as well as included pertinent information for participants, such as the researcher may utilize additional intake information held by CCED within the data gathering and subsequent analysis portions of this study. Participants also reviewed and completed the Demographic Questionnaire (see Appendix N), and the Audiotape Consent Form (see Appendix O). The researcher answered any questions and addressed any concerns the participants had at this point. Upon review, signature collection, and addressing any questions the participants had, the researcher began the audiotape recording and interview. At the conclusion of the first interview, the participants were given a $25 gift certificate to Target as thanks for participating in the interviews.

The initial semi-structured interview with the parents lasted approximately 60-90 minutes and used questions to glean information from the parents regarding their expectations and experiences of initiating Phase I of the modified Maudsley treatment approach. After the completion of the first interview, the researcher recorded thoughts and initial reactions in a reflexive journal to reflect on possible emerging themes, overall processes, and personal reactions. The researcher ensured careful reflection and subsequent documentation was done in a timely manner to promote continued close proximity to the data.

The researcher utilized the support of an outside transcriptionist. At the completion of the first interviews, the audio-taped interviews were transcribed within one
to two weeks of the interviews. The researcher was careful to ensure the transcriptions were accurate by comparing the audio-taped interviews with the transcriptions. In order to further ensure close proximity with the interviews, the researcher listened to the interviews at least two times. Once the transcription was complete, the researcher mailed a transcription of the interview to the participants either via postal mail or email. This provided an opportunity for the participants to also read, review, and verify the transcript reflected their thoughts before participation in the second interview. The researcher also mailed the Second Interview Topics Schedule with the first interview transcription (see Appendix P). The researcher then began introductory data analysis prior to the second interview by beginning to code the data and formulate possible emerging themes.

After the completion, transcription, and review of the initial interview, the researcher scheduled a second interview with the participants. One of the purposes of the second interview was to review the transcripts of the initial interviews with the participants for accuracy, known as participant validation (Bogdan & Biklen, 2007). The second interview served as a chance for the participants and researcher to review the findings of the study and discuss themes that had emerged. The participants did not receive any additional compensation for participation in the second interview.

The second interview with the participants was also audio-taped and transcribed by an outside transcriptionist. Once the transcriptions from the second interviews were completed, the researcher built upon the initial data analysis from the first interviews through the utilization of reflexive journals and peer debriefing in order to authenticate themes and respect data analysis procedures (see Section “Trustworthiness”).
As the participants discussed potentially sensitive topics and experiences regarding their child’s eating disorder and expectations and experiences of the modified Maudsley treatment approach, the researcher also ensured at the close of all of the interviews the participants were not in a distressed state via debriefing. Debriefing was utilized in order to assess the level of distress regarding the interview and subsequent emotional reactions the participants may have had. If the researcher had felt a participant experienced significant distress, she would have provided the participant with recommendations for further support via individual or family therapy through therapists at CCED or in the community at large; however, the researcher did not feel any participant needed any additional support after the interview process was completed.

Instrumentation

Five instruments were utilized in this research project: the Information Contact Form, the Screening Form, the Demographic Form, the First Interview Topics Schedule, and the Second Interview Topics Schedule. The following sections examine each form and discuss the process utilized within the interviews.

Information Contact Form

The Information Contact Form was completed by this researcher when contacting the potential participants who had expressed interest in participating in the study. It served as a way for the researcher to contact possible participants in order to provide information and answer questions, and possibly set up a time for the first interview.
Screening Form

The Screening Form was utilized to gather preliminary information about possible participating parents, as well as to assess the criteria set forth by the researcher for participation in the study. The form was completed at the same time as the Information Contact Form with the potential participants who had expressed interest in participating in the study. The form asked the researcher to answer all questions by checkmark or filling in the blank. The researcher ensured all answers reported on the form were confidential in nature. The researcher also urged the possible participants to contact the researcher by phone or email to discuss any questions or concerns that might emerge.

The potential participating parents were asked to provide the following information: (a) when the participants had initiated treatment at CCED (must have been within the past calendar year of recruitment), (b) if their child participated in the day treatment program within the past calendar year, (c) whether their family had any previous experience within a Maudsley treatment process for their adolescent with an eating disorder other than that at CCED, and (d) whether they would be willing to participate in a total of 2 interviews. Participants were also asked to delineate days of the week and times that were most convenient for the scheduling of the first interview.

Demographic Questionnaire

The participants completed the Demographic Questionnaire during the initial part of the interview process, prior to recording. During the initial part of the first interview, the researcher reviewed the Demographic Questionnaire with each participant. The researcher reviewed the questions in order to provide an opportunity for increased rapport
with the participants. The answers from the Demographic Questionnaire provided
categories for data analysis and increased the information the researcher had about the
participants. Participants were asked to report information regarding the following
demographic information: (a) age of the mother/father, (b) occupation of the
mother/father, (c) marital status of the parents, (d) ethnic/racial identity of the
mother/father, (e) whether the family had worked within any other eating disorder
treatment approach other than Maudsley, (f) whether the adolescent had \any other
psychological treatment other than within the Maudsley treatment approach, and (g) the
number of children in the home.

**First Interview Topics Schedules**

The fourth instrument was the First Interview Topics Schedule. The First
Interview Topics Schedule included open-ended questions and probing questions to
encourage participants to elaborate on details surrounding their expectations and ultimate
experiences of implementing the modified Maudsley treatment approach. The questions
within the first interview were intended to allow the parents to describe their experience
surrounding their understanding of their child’s eating disorder and subsequent
expectations and experiences of the modified Maudsley treatment approach for their child
with an eating disorder. The questions were formulated and guided by the research
questions for the study in an effort to allow participants to describe their expectations and
experiences regarding their adolescent, the eating disorder, and the implementation of
Phase I of the modified Maudsley treatment approach for their adolescent with an eating
disorder.
A phenomenological, qualitative interview invites a conversation during which the researcher and participant explore a particular phenomenon. The researcher utilized responsive interviewing techniques and probes to further understand the participants’ responses, particularly through further questions or reflecting statements (Rubin & Rubin, 2005). Responsive interviewing consists of both the researcher and participant exchanging ideas via a two-way conversation. The researcher was careful not to impose viewpoints on the participants while developing a rapport with the participants that was changeable and adaptive (Rubin & Rubin, 2005). Probes, such as “what do you mean” or “give me an example of that,” were also used (Bogdan & Biklen, 2007).

The participants were all asked the same questions within the First Interview Topics Schedule in order to ensure all topics were broached within the interview. The First Interview Topics Schedule, developed within the context of the research questions, was as follows:

1. The situation surrounding the identification and diagnosis of your child’s eating disorder, and your reaction to the identification of your child’s eating disorder.
2. The process through which you found and ultimately chose the Maudsley treatment approach at CCED.
3. Any prior eating disorder or psychological treatment your child has received.
5. Your expectations and hopes at the onset of implementing the Maudsley treatment approach.
6. Your experiences of ultimately implementing the Maudsley treatment approach.

7. The way in which you and your parenting partner expected to participate in your child’s treatment (Levels of involvement).

8. The way in which you and your parenting partner ultimately participated in your child’s treatment (Levels of involvement).

9. Any difficulties or relevant issues that you expected or (did not expect) to arise throughout the Maudsley treatment approach (managing eating disorder behaviors, choosing foods, etc.).

10. How you feel the Maudsley treatment approach has supported you throughout your adolescent’s treatment process.

11. How you as the parents experienced the various issues and processes that arose throughout the Maudsley treatment approach.

**Second Interview**

The second interview was conducted after the initial data analysis of the first interview was completed and served several purposes. The second interview served as a respondent validation opportunity. The participants had been provided with a transcript of the first interview via postal mail and were encouraged to review the transcript prior to the second interview. Upon review with the participants of their perceptions regarding the first interview transcripts, the researcher provided and discussed with the parents a brief narrative summary of the first interview. The researcher also reviewed with the parents the purpose of the research project and preliminary findings and themes emerging
throughout the data analysis. As each emerging theme was introduced, the researcher utilized member checking by asking the participants to reflect carefully on the themes as well as to expand upon their perspectives of the themes through narrative examples, memories, and responses to probing questions. The researcher provided each parent with a Second Interview Topic Schedule via postal mail or email following the first interview to promote reflection prior to the interview. The researcher asked the following questions to all participants in the second interview:

1. I will provide you with a brief summary of our last interview. I will then ask you the following questions:
   a. How do these ideas compare with your experience?
   b. Have any aspects of your experience been omitted?

2. What additional comments would you like to make surrounding your expectations and subsequent experiences of the Maudsley treatment approach?

Other specific questions for the second interview varied across the participating parents. The questions were developed for each parenting unit after transcription and preliminary analysis of the first interview with the parents. The second interview provided an opportunity for the researcher to (a) clarify content of the first interview, (b) follow-up on particular emerging themes, (c) allow the participants to corroborate themes, (d) allow for new or additional information to emerge, and (e) provide a format through which the participants comment upon their subjective experiences of the Maudsley treatment approach.
If at any point throughout the research process the participants wanted to discontinue their participation in the research study, or were unable to participate for any reason, the researcher would have been careful to document the discontinuation of participation in the study within the data analysis.

**Analysis**

The researcher utilized an inductive analysis approach to best understand and discover themes regarding the parental experiences of implementing Phase I of the modified Maudsley treatment approach that emerged throughout data analysis. Within phenomenological research, data analysis is an integral juncture at which the researcher develops a narrative description and understanding of the experiences of the participants. Three steps within phenomenological data analysis are: (a) separating the original transcript into specific units, (b) transforming these meaning units into psychological concepts, and (c) connecting the transformations into a general description of the phenomenon (Polkinghorne, 1989).

The data analysis for this study included the following steps: (a) transcription of the audio-taped interviews, (b) organization of the data, and (c) investigation into the experiences of parents initiating Phase I within the modified Maudsley treatment approach. The outside transcriptionist transcribed the interviews in as timely a fashion as possible in order to keep the material in close proximity to the researcher. After the transcription of the first interviews, the researcher read all transcripts to formulate a sense of the entirety of the first interviews. The researcher read the interview transcripts and listened to the audio-tape recordings at least two times in order to be familiar with the
material, initiate the data analysis aspect of the research project, and be able to ask the participants about the first interviews.

The researcher then revisited the transcripts and gleaning key phrases or sentences (as judged to be so via the research questions) that were straightforwardly related to the experiences of parents implementation of Phase I within the modified Maudsley treatment approach for their adolescent with an eating disorder. The researcher determined statements were noteworthy if the statements related to the research question and offered information on the experience of parents within the Maudsley treatment approach.

These statements were initially highlighted in the transcription document and then coded in a document using a table in Microsoft® Word. Also, the researcher utilized NVIVO, a data analysis tool, to code responses. Coding, the process of building towards a narrative via systematically sorting, grouping, ranking, and comparing information gleaned from interviews, allowed the researcher to search for patterns and linkages within the data (Rubin & Rubin, 2005). Sorting and grouping the data allowed the researcher to categorize various sets of data, whereas the ranking and comparing allowed for the emergence of theoretical concepts pertaining to the research questions. Color coding the printed data within Microsoft® Word, as well as NVIVO, allowed the researcher to best group the various data sets. Examples of codes included “hell,” “books and websites,” and “day treatment program relief.”

The researcher utilized coding in order to organize the data and facilitate comparisons between the data in order to develop various theoretical concepts regarding
the parent experiences of the modified Maudsley treatment process (for example of coding via NVIVO, reference Appendix Q). Via the coding process, the researcher formulated a brief summary of the first interview to share with the parents at the beginning of the second interview. This process was guided by utilizing scholarly literature regarding qualitative research such as Bogdan and Biklen (2007) and Maxwell (2005).

In order to ensure accurate understanding of the first interview, the researcher reviewed the final summary of the first interview with the participants at the beginning of the second interview. At this time, the researcher asked the following questions: (a) How do these ideas compare with your experience? and (b) Have any aspects of your experience been omitted? (Colaizzi, 1978, p. 62). The researcher utilized these follow-up questions to pursue concepts and themes that emerged in the first interview to arrive at new interpretations and attain a meaningful understanding and subsequent richer narrative (Rubin & Rubin, 2005). Any new or varying information from this review of the initial summary was included in further data analysis. The researcher also asked the participants to provide reactions and comments surrounding the emerging themes.

Upon the conclusion of the second interview, the researcher hired a transcriptionist to transcribe the second interview and then coded responses in the same manner as the initial interview. Ultimately, the researcher combined summaries of the first and second interviews to formulate a comprehensive and rich narrative description of the parenting experiences within the Maudsley treatment approach.
Upon developing a narrative description of each participant, the researcher organized and condensed these summaries into clusters of themes through utilizing newsprint and color-coded highlighters, as well as NVIVO, to categorize and picture similarities and differences between the participants. The researcher was able to identify themes via this process relating to the experiences of parents initiating Phase I within the modified Maudsley treatment approach for their adolescent with an eating disorder. The researcher revisited the transcripts of the interviews to verify the themes identified and did not dismiss any data that contradicted these themes.

The emerging themes were then incorporated into a comprehensive description of the experience of parents of adolescent children with eating disorders within the initiation of Phase I of the modified Maudsley treatment approach. Ultimately, the researcher reduced this description into a narrative account of the overall basic fundamental experiences of these parents.

**Trustworthiness**

Qualitative, phenomenological research is often validated by the extent to which the project presents trustworthiness of the data and subsequent analysis of the research in question. Lincoln and Guba (1985) asserted that several factors increase trustworthiness: (a) credibility, (b) transferability, (c) dependability, and (d) confirmability. The way in which the researcher utilized these factors in this study is described as follows.

**Credibility**

Credibility is the researcher’s capability to represent the views and experiences expressed by the participants in a study. In order to increase credibility within this study,
this researcher utilized the following procedures: (a) respondent validation (member checks) and (b) peer debriefing.

Respondent validation is an opportunity for the researcher to solicit specific feedback about data and themes from the participants in a research study (Lincoln & Guba, 1985; Maxwell, 2005). Respondent validation for this study included an opportunity for the researcher to review the transcribed first interviews with the participants. The researcher also reviewed emerging themes from data analysis during the second interview and elicited responses and feedback from participants. Respondent validation is the most important way in which the researcher can rule out any misinterpretation of the meaning behind participants’ responses and perceptions of the particular experience in question. Respondent validations also aid the researcher to identify any biases or assumptions of the experience being studied (Maxwell, 2005). The second interview served as a participant validation session during which the researcher shared research findings. The participating parents were encouraged to discuss their thoughts, feelings, and responses to the research findings.

Peer debriefing is a process through which the researcher consults with a peer regarding the data analysis procedure (Lincoln & Guba, 1985). Peer debriefing serves as a catalyst through which the researcher collaborates with a colleague of neither junior nor senior status. The peer should have an understanding of the research project at hand and utilize the devil’s advocate position to challenge the findings within the data analysis (Lincoln & Guba, 1985). The peer debriefer used in this study reviewed a sample of the data. The researcher met with the peer debriefer after the second interviews and
subsequent transcription had been completed. The peer debriefer was a colleague within the Kent State University Counselor Education and Supervision program who had the academic standing of doctoral candidate. The meeting served to do the following: (a) converse about and scrutinize the data, (b) discuss the researcher’s interpretations of the data, (c) and review the next steps within the research project (Lincoln & Guba, 1985).

**Transferability, Dependability, and Confirmability**

Qualitative research is an ongoing process, which surrounds the continual assessment of goals, theories, research questions, methodology, and threats to validity (Maxwell, 2005). Subsequently, the aim of this research project was to provide a working conceptualization through which this researcher provided a rich narrative of the experiences of parents of adolescent children with eating disorders initiating Phase I within the modified Maudsley treatment approach. It is through this rich description that future readers and scholars may be able to weigh the transferability of this study to other similar contexts of parents utilizing a Maudsley treatment approach for their child with an eating disorder (Lincoln & Guba, 1985).

Dependability relies upon the level of reliability of the research results, and confirmability gauges and assesses the level of researcher objectivity (Lincoln & Guba, 1985). This researcher utilized her dissertation committee members as auditors in order to increase the levels of dependability and confirmability. The committee serving as auditor differed from the peer debriefer as the members reviewed the data analysis subsequent to the data analysis procedure. The members examined the research process as well as the final product and findings of the project.
This researcher also worked to establish trustworthiness through reflective field notes, through which the more personal account of the research process for the researcher was recorded. The reflective field notes included the following categorizations of thought: (a) reflections on analysis, (b) reflections on method, (c) reflections on ethical dilemmas and conflicts, and (d) reflections on the observer’s frame of mind (Bogdan & Biklen, 2007).

Through analysis and reflection on the reflective notes, the researcher developed second interview questions and summaries of the research process, that were used within peer debriefing and with dissertation committee members. Consequently, these various procedures elicited an increased level of trustworthiness and dependability for the study.

**Summary of Chapter 2**

This research study was an opportunity to gather data and information concerning the experiences of parents of adolescents with eating disorders within the modified Maudsley treatment approach. The guiding research question for this qualitative, phenomenological research study was as follows:

- What are the experiences of parents of adolescents with eating disorders who initiate and participate in Phase I of the modified Maudsley treatment approach?

Via the utilization of interviews, parents of adolescents with eating disorders depicted their experiences initiating and implementing the modified Maudsley treatment approach for their child’s eating disorder recovery process. The researcher used a phenomenological approach to procure an understanding of the parental experiences
within a modified Maudsley treatment approach. The following chapter presents the findings of this research investigation.
CHAPTER III

RESULTS

This chapter presents the research findings of this phenomenological investigation on the subjective experiences of parents within Phase I of a Maudsley treatment approach for their adolescent with an eating disorder. The first section introduces the eight families to the reader, including demographic information and an overview of each parents’ experiences of their child’s eating disorder treatment within the Maudsley approach. Once each family is introduced, the second section provides a description of the research findings on the subjective experiences of parents within Phase I of the Maudsley treatment approach for their adolescent with an eating disorder.

Participants

The sample included eight parenting units who met criteria for participation in the study, with three interviews including both parents, and five interviews with a solo parent. This section introduces the reader to each of the parenting units. All of the participants had engaged in a modified Maudsley treatment approach for their child with an eating disorder. Table 1 provides an overview of the participants, including demographic information such as gender, age, occupation, and marital status. Tables 2 and 3 provide information regarding the adolescent with an eating disorder, such as age, sex, eating disorder diagnosis, and rough date of initiation of treatment at the Cleveland Center for Eating Disorders.
### Table 1

*Demographic Data (1)*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms. Winters</td>
<td>46</td>
<td>Divorced</td>
</tr>
<tr>
<td>Ms. Gold</td>
<td>52</td>
<td>Married</td>
</tr>
<tr>
<td>Mr. Gold</td>
<td>51</td>
<td>Married</td>
</tr>
<tr>
<td>Ms. Alton</td>
<td>51</td>
<td>Married</td>
</tr>
<tr>
<td>Mr. Kinston</td>
<td>53</td>
<td>Married</td>
</tr>
<tr>
<td>Ms. Kinston</td>
<td>49</td>
<td>Married</td>
</tr>
<tr>
<td>Ms. Masey</td>
<td>53</td>
<td>Married</td>
</tr>
<tr>
<td>Mr. Masey</td>
<td>52</td>
<td>Married</td>
</tr>
<tr>
<td>Ms. Potts</td>
<td>50</td>
<td>Married</td>
</tr>
<tr>
<td>Ms. Rose</td>
<td>46</td>
<td>Married</td>
</tr>
<tr>
<td>Mr. Burns</td>
<td>52</td>
<td>Married</td>
</tr>
</tbody>
</table>
Table 2

*Demographic Data of Adolescent With Eating Disorder (1)*

<table>
<thead>
<tr>
<th>Adolescent</th>
<th>Age</th>
<th>Sex</th>
<th>Eating Disorder Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winters</td>
<td>13</td>
<td>Female</td>
<td>307.50 (Eating Disorder, NOS)</td>
</tr>
<tr>
<td>Gold</td>
<td>15</td>
<td>Female</td>
<td>307.50 (Eating Disorder, NOS)</td>
</tr>
<tr>
<td>Alton</td>
<td>15</td>
<td>Female</td>
<td>307.1 (Anorexia Nervosa)</td>
</tr>
<tr>
<td>Kinston</td>
<td>14</td>
<td>Female</td>
<td>307.1 (Anorexia Nervosa)</td>
</tr>
<tr>
<td>Masey</td>
<td>16</td>
<td>Female</td>
<td>307.1 (Anorexia Nervosa)</td>
</tr>
<tr>
<td>Potts</td>
<td>16</td>
<td>Female</td>
<td>307.1 (Anorexia Nervosa)</td>
</tr>
<tr>
<td>Rose</td>
<td>14</td>
<td>Male</td>
<td>307.5 (Eating Disorder, NOS)</td>
</tr>
<tr>
<td>Burns</td>
<td>16</td>
<td>Female</td>
<td>307.1 (Anorexia Nervosa)</td>
</tr>
</tbody>
</table>

Table 3

*Demographic Data of Adolescent With Eating Disorder (2)*

<table>
<thead>
<tr>
<th>Name</th>
<th>Initiation of Treatment</th>
<th>Prior Psychological Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Winters</td>
<td>January 2009</td>
<td>Yes – Outpatient Counseling</td>
</tr>
<tr>
<td>Gold</td>
<td>September 2009</td>
<td>Yes – Outpatient Counseling</td>
</tr>
<tr>
<td>Alton</td>
<td>August 2009</td>
<td>No</td>
</tr>
<tr>
<td>Kinston</td>
<td>November 2009</td>
<td>Yes – Outpatient Counseling</td>
</tr>
<tr>
<td>Masey</td>
<td>July 2009</td>
<td>No</td>
</tr>
<tr>
<td>Potts</td>
<td>November 2009</td>
<td>Yes – Outpatient Counseling</td>
</tr>
<tr>
<td>Rose</td>
<td>April 2009</td>
<td>No</td>
</tr>
<tr>
<td>Burns</td>
<td>October 2009</td>
<td>Yes – Outpatient Counseling</td>
</tr>
</tbody>
</table>
The Winters Family

Ms. Winters is a 46-year-old Caucasian woman. She is the mother of two, a 13-year-old daughter and a younger son. She is divorced and not remarried. Her ex-husband lives a few hours away from her and her children and she has had recent financial difficulty. Mrs. Winters initiated treatment at CCED in January of 2009 for her 13-year-old daughter, who was diagnosed with Eating Disorder, Not Otherwise Specified. Her daughter had participated in outpatient individual therapy prior to CCED pertaining to her parent’s divorce. Throughout the treatment process, her daughter was hospitalized several times due to cardiac concerns, primarily orthostasis and prolonged QTC intervals.

Ms. Winters was the first participant interviewed. The interview with Ms. Winters took place in the researcher’s counseling office at CCED during her daughter’s individual therapy appointment. Ms. Winters appeared friendly, as she smiled often, initiated conversation, and had taken notes on the First Interview Topics schedule prior to the first interview in order to provide the most accurate information. Throughout the interview, she became slightly tearful and demonstrative of emotionality, particularly when discussing her memories of worry over her daughter’s health. She also discussed feeling enthusiastic about the interview and research, even stating she had told other parents she knew about the study.

Her daughter had prior counseling in order to address stressors that arose within her parents’ divorce. She had never had any eating disorder treatment prior to initiating treatment at CCED in January 2009. The family continued to participate in outpatient
Maudsley Family Therapy, and the daughter also was engaged in individual cognitive behavioral and dialectical therapy at the time of the first interview.

The Gold Family

Ms. Gold is a 52-year-old Caucasian, and her husband is a 51-year-old nurse. The Golds are married, with a son who attends a local university, and a 15-year-old daughter, who attends a private all-girls school. The Golds initiated treatment at CCED in September 2009 and their daughter was diagnosed with Eating Disorder, Not Otherwise Specified. Their daughter participated in the Day Treatment Program for approximately nine weeks at the time of the interview. At one point, she initiated a lower level of care (outpatient therapy), but did not fare well, thus she re-engaged in the Day Treatment Programming for further treatment.

The Golds participated in the interview at the end of a day of day treatment for their daughter. Mr. Gold had attended the family group within the DTP programming, and Ms. Gold arrived a few minutes late to the interview, as she was coming straight from her nursing work. Both were actively engaged in the interview and contributed equally to the conversation. They were very verbose in their explanation and provided specific examples throughout the interview of their experiences within the modified Maudsley treatment process. Ms. Gold became tearful when disclosing her fears for her daughter’s health secondary to eating disorder concerns, particularly when discussing prior knowledge of adolescents who had died due to eating disorders. The Golds seemed to hold similar opinions of their experiences as evidenced by their responses to the questions and probes, and appeared extremely forthcoming in their answers.
Their daughter had prior psychological treatment since the age of five for an anxiety disorder, but had not had prior eating disorder specific treatment before initiating treatment at CCED in September of 2009. Their daughter had engaged in several levels of care at CCED and had begun individual dialectical and cognitive behavioral therapy at the time of the first interview.

The Alton Family

Ms. Alton is a 51-year-old Caucasian, and her husband is also a 51-year-old Caucasian. She participated in the interview alone. Her only daughter is 15 years old and began treatment at CCED in August of 2009, and she was diagnosed with Anorexia Nervosa. She participated in the Day Treatment Program for approximately four weeks and in the Intensive Outpatient Program for three weeks.

Ms. Alton was very verbal throughout the interview; however she also was quite self-deprecating in her initial approach to the interview. She made several statements to me doubting that she would “be able to provide much” within the interview. Her approach to describing her experiences within the modified Maudsley treatment approach was very matter-of-fact in nature, particularly when discussing reactions to the development of her daughter’s eating disorder.

Her daughter had never had any prior psychological or eating disorder treatment before initiating treatment at CCED. At the time of the first interview, the family continued to engage in outpatient Maudsley Family Therapy and their daughter participated in individual therapy, based within cognitive-behavioral and dialectical
behavioral therapy approaches. She also has participated in the Adolescent Body Image Group, which has a cognitive-behavioral therapy approach.

The Kinston Family

Ms. Kinston is a 49-year-old Caucasian, and Mr. Kinston is a 53-year-old Caucasian. They are married, and have an older son who lives out of state and a 14-year-old daughter, who initiated treatment at CCED in November 2009 and was diagnosed with Anorexia Nervosa, Purging Type. She was in the Day Treatment Program for approximately six weeks, during which time the family lived at a local hotel due to their home being approximately two hours from the Cleveland Center for Eating Disorders.

Both parents participated in the interview and arrived for the interview in the evening. They live several hours away and were in town for an outpatient Maudsley family therapy session as well as a follow-up medical appointment for their daughter. Ms. Kinston had taken notes on the First Interview Topics Schedule prior to the first interview and appeared motivated to participate within the interview process. At times throughout the interview, they expressed overt anger with prior treatments they had received for their daughter’s eating disorder that they felt were ineffective, specifically surrounding the medical and behavioral monitoring of their daughter. Ms. Kinston also became tearful when discussing her concern about her daughter’s medical well-being. They both participated equally within the interview and corroborated each other’s experiences. They were also very animated in speech and demeanor, particularly when discussing behavioral aspects of their daughter’s eating disorder.
Their daughter had outpatient individual therapy prior to CCED for management of “adolescent issues.” She also had engaged in eating disorder treatment prior to CCED in another city, which the parents felt was largely ineffective. At the time of the first interview, the Kinstons continued to participate in weekly outpatient Maudsley Family Therapy.

The Masey Family

Ms. Masey is a 53-year-old Caucasian, and Mr. Masey is a 52-year-old Caucasian. They are married, and have an older daughter who is a student at a university in northeast Ohio. Their younger daughter is a 16-year-old junior at a high school approximately 45 minutes away from CCED. She began treatment at CCED in July of 2009 and was diagnosed with Anorexia Nervosa. She participated within the Day Treatment Program approximately six weeks and in the Intensive Outpatient Program for five weeks.

The Maseys participated in the interview preceding a Maudsley Family Therapy appointment. They arrived promptly and had reviewed the First Interview Topics Schedule en route to the interview. They were both interested in participating in the study and expressed enthusiasm in regards to the outcome of this study. The Masey parents seemed very much in synch with each other and expressed a great deal of admiration and love for each other and their children. Mr. Masey became somewhat tearful when discussing a sense of alienation from his daughter due to the eating disorder and its subsequent treatment. They also discussed their Christian faith as an important aspect of their lives.
The Maseys continued to engage in outpatient Maudsley Family Therapy and their daughter also participated in outpatient cognitive-behavioral individual therapy at the time of the first interview. She also participated in approximately half of the Adolescent Body Image Group, but due to scheduling conflicts did not complete the group. Prior to CCED, she had never engaged in any psychological treatment.

**The Potts Family**

Ms. Potts is a 50-year-old Caucasian, and she participated in the interview alone. Mr. Potts is a 49-year-old self-employed Caucasian carpenter. They have an older son who is in the home, who has a diagnosis of Bipolar Disorder. Their 16-year-old daughter initiated treatment at CCED in November of 2009 and was diagnosed with Anorexia Nervosa, Purging Type. She also has a prior diagnosis of Bipolar Disorder and has a history of self-harm as reported by Ms. Potts. She participated in the Day Treatment Program for approximately six weeks.

Ms. Potts participated in the interview after a psychiatry appointment. She was on time and appeared somewhat shy during the initial part of the interview. The researcher had to ask her to raise her voice several times throughout the interview. Throughout the interview, and in reviewing of the transcripts, this researcher found herself feeling as if Ms. Potts had a sense of loneliness and sadness about her, particularly when discussing her difficulties surrounding the psychiatric disorders of both of her children. At several points throughout the interview, she became somewhat tearful such as when discussing levels of severity of her daughter’s eating disorder and depressive symptomology.
The Potts continued to engage in intermittent outpatient Maudsley Family Therapy at the time of the first interview. Prior to CCED, their daughter had engaged in multiple outpatient therapies, primarily for the management of her mood disorder. She also continued to address mood disorder management in outpatient therapy, not at CCED.

The Rose Family

Ms. Rose is a 46-year-old Caucasian, and Mr. Rose is a 47-year-old Caucasian. Ms. Rose participated solo in the interview. The Rose family has an older daughter in the home who is an upper-classman at a local public school. Their 14-year-old son initiated treatment at CCED in April of 2009, with a diagnosis of Eating Disorder, Not Otherwise Specified. He had never had any psychological treatment or diagnoses prior to CCED. He participated in the Day Treatment Program for approximately five weeks and in the Intensive Outpatient Program for three weeks.

Ms. Rose arrived at the interview on an early morning on which she did not have work. She was thoughtful throughout the interview, taking time to answer questions purposefully, and at times became tearful, particularly when discussing the process of discovering, and subsequently accepting, her son had an eating disorder.

The Rose family had discontinued outpatient Maudsley Family Therapy at the time of the first interview, but their son continued to engage in outpatient individual cognitive-behavioral therapy. Prior to CCED, their son had never engaged in any psychological treatment.
The Burns Family

Mr. Burns is a 52-year-old Caucasian who participated in the interview without his wife. Ms. Burns is a 50-year-old Caucasian. They have two daughters in the home, the oldest of which is a 16-year-old female who was diagnosed with Anorexia Nervosa. She initiated treatment at CCED in October of 2009. She participated in the Day Treatment Program for three weeks.

Mr. Burns arrived on time for the interview prior to a Maudsley Family Therapy session for his daughter. He was animated and interested in the study, stating he wanted to contribute to the literature surrounding Maudsley therapy. He also stated his motivation for participation is due to his master’s work in which he had to recruit participants. He stated he understood the stress of finding participants for studies. He was fairly matter-of-fact throughout the interview; however, towards the end when discussing his views of Maudsley therapy, he appeared somewhat disgruntled and concerned for his daughter’s continued mental health stability, stating the “jury is still out” regarding his final thoughts on Maudsley and the continued treatment she was needing.

His daughter had had prior individual outpatient therapy to address an anxiety disorder. They continued to engage in outpatient Maudsley Family Therapy at the time of the first interview. They also disengaged from the Day Treatment Program against the advice of CCED due to wanting their daughter to return to school. The CCED treatment team felt it was not appropriate to return to school given her emotional and physical volatility.
Parental Experiences of Phase I of a Modified Maudsley Treatment Approach for Their Adolescent With an Eating Disorder

The guiding research question for this study was: What are the experiences of parents of adolescents with eating disorders who initiate and participate in Phase I of the modified Maudsley treatment approach? A phenomenological qualitative approach was utilized in this study to understand the aforementioned research questions. Participants were parents of adolescents with eating disorders who had participated in the Day Treatment Program at the Cleveland Center for Eating Disorders who were willing to participate within this study. These parents participated in two interviews as to their experiences of a modified Maudsley treatment approach for their adolescents with eating disorders.

Themes derived from the phenomenological data analysis suggested there are some similarities in the experiences of parents who participated in this study in implementing Phase I of a modified Maudsley treatment approach. Three major themes emerged from the data: (a) Empowerment, (b) All-Consuming, and (c) Community. The theme of empowerment was the process through which participants gradually assumed a sense of control over the behavioral and emotional aspects of their child’s eating disorder within a modified Maudsley treatment process through increased awareness and psycho-education as well as decreased levels of parental guilt and fear. The theme of all-consuming was the manifestation of the enormous task the participants assumed within the treatment process, which required an overt, life-altering commitment on behalf of the participants and family systems to initiate and follow-through with the treatment process.
The theme of community highlighted the participants’ experiences of “not being alone” within the treatment process, through interactions with other parents, the CCED staff, and the day treatment program. This section of the chapter represents each of these categories and corresponding subcategories. Additionally, this section incorporates findings from the second interviews within discussion of the themes, as well as additional findings from the second interview.

**Empowerment**

Empowerment was the process through which participants assumed increased control over the eating disorder through psycho-education, support, and feedback from others, despite guilt and fear. As participants began to initiate and learn more about their child’s eating disorder, they reported initially experiencing a great amount of guilt and fear, particularly as details of their child’s physical and emotional instability came to light. However, as participants were provided psycho-education and support from their Maudsley family therapist, CCED, and outside sources, the participants reported gradually experiencing a sense of empowerment over their child’s eating disorder. Via determination and reliance upon the treatment process, participants began to feel as if their child’s eating disorder, over which previously they had no control, was something that could and would be manageable. Six distinct categories for empowerment emerged as participants began to exhibit a sense of empowerment within the modified Maudsley treatment approach: (a) guilt, (b) fear, (c) resourcefulness, (d) externalization of the eating disorder, (e) request for guidance, and (f) determination.
Guilt. Participants discussed a great amount of initial guilt upon discovering their child’s eating disorder. Participants reported feeling guilty because they had missed signs of the development of the eating disorder, as well as guilt due to not pursuing treatment earlier. Some participants also felt guilty because they had inadvertently initially encouraged or applauded their child for his or her seemingly healthier habits. Participants also discussed at length their sense of guilt and questioned themselves as to whether they had done anything to cause the eating disorder.

Mr. Burns initially commended his daughter for her ostensibly healthier lifestyle choices. He stated:

We were complimenting her because she had a little muffin top and with the exercise, which just started out with going on walks. We were complimenting her on that. She started looking good. You know, like a nice shape to her and all that. And then, she’d do weights in the basement, and she never really had a real anorexic look. So, we were never really concerned.

Mr. and Mrs. Gold also had a similar experience in that they initially applauded their daughter’s change in behavior. Mr. Gold described their thoughts about their daughter’s transformation. “She was eating sugary stuff . . . when we really started to notice that that started to change and initially thought it was a good thing.” Mrs. Gold continued: “At first it was very healthy things that she stopped doing. No Coke, I was like, that’s fine. No fast food, I’m like that’s good too. I was very satisfied with what she was eating, turkey sandwiches.” Mr. and Mrs. Gold continued to applaud their daughter, as did other family members and friends. They described telling her she “was
looking great” and “everyone in the family was telling [her], oh you look great, oh you look excellent.”

Mr. and Mrs. Kinston had a similar experience in that they initially applauded their daughter’s weight loss. Mrs. Kinston described their reaction to their daughter’s change in exercise amount and weight loss:

We’re thinking wow, boy, she’s really taking [exercise] seriously, because [Mr. Kinston] is really physical and works out and everything else . . . so we were all like this is really great, you know, the weight’s coming off and she’s looking good and she’s feeling better.

Ultimately, the Kinstons realized their daughter’s exercise and weight loss was out of control and she had developed a severe eating disorder.

Mr. Burns expressed guilt that he and his wife had not recognized some of their daughter’s behaviors as being pathological earlier. “Well, just look back, like well gee, you know, maybe we should have caught some of these things sooner.” He also discussed levels of guilt at not engaging in treatment earlier and more forcefully:

Yeah, had maybe been a little more forceful in addressing some of these issues and just being a little lazy, you know, busy with work . . . who wants to spend free time trying to take her to doctor’s appointments and therapy appointments?

Even as their pediatrician began to become concerned for their daughter’s health, Mr. and Mrs. Gold had a difficult time accepting and understanding the seriousness of their daughter’s eating disorder. When their pediatrician stated that if their daughter lost any more weight after she had dropped from 145 pounds to 120, she would be at risk
medically, Mrs. Gold, who is a nurse, continued to have difficulty understanding the physiological manifestations of the eating disorder. Mrs. Gold said:

I must admit I worked on a nutrition support team, I know about BMI, I know what the calculation is . . . She’s 5’4”, she weighed 120 [pounds] and I was like, what’s this? What’s the concern? But it was more that she was dehydrated, malnourished.

Mr. and Mrs. Masey expressed guilt in that they had an intuition their daughter had an eating disorder but were reluctant to address it. Mrs. Masey described her feelings of her daughter possibly having an eating disorder, stating, “we have an eating disorder problem here, and I can’t speak for [my husband], but I think within my heart I knew that was happening but I didn’t want to address it.” Mr. Masey, a pastoral counselor, also expressed regret and guilt due to his profession, as he was reluctant to accept the possibility of his daughter having an eating disorder. “I think also there was a part of me that resisted seeing [the eating disorder] because of my background . . . and so there was probably a period of time of denying it because of that.” Mr. and Mrs. Masey, though they both had the intuition their daughter had an eating disorder, both reported having difficulty accepting their daughter’s illness.

Mrs. Potts had a very different experience of discovering the eating disorder in that she felt guilty she did not recognize the eating disorder sooner. When asked as to how she discovered her daughter was purging, she stated:

I had no idea at that point. I don’t know why I didn’t . . . I look back at it now and I think how could I not know that? . . . She told [the clinician who assessed
her at CCED] that she was purging like five times a day. I had no idea. That makes me feel like such an idiot. But I really had no idea that she was doing it that much . . . I just felt like an idiot that I didn’t follow her around more or whatever, be more suspicious . . . I would just kind of . . . she’s okay, she knows what she’s doing.

Mrs. Potts held herself very responsible for not recognizing her daughter was engaging in eating disorder behaviors. When discussing this during the interview, her body language suggested she continued to hold a great amount of guilt and anger towards herself for not recognizing the eating disorder behaviors in her daughter sooner. She became tearful and crossed her arms while hanging her head as if she held a great amount of shame.

Several participants, when discussing discovering their child’s eating disorder, questioned whether they had done something to cause the development of their child’s eating disorder, which contributed to their feelings of guilt. The participants questioned whether their own behaviors towards food and exercise, or their parenting style, had contributed to their child’s eating disorder. Mrs. Alton questioned whether her daughter had developed her eating disorder as a result of her behaviors.

I thought, oh God, did she get this from me? Is this my fault? Because I’ve always tended to be on the thin side of normal and I somewhat watch, I care about what I eat because I have high cholesterol, I’ve always sort of been cautious about what I ate and I’m sure like you know, every woman occasionally will say, “Do I look good in this?” you know, “Does this make my behind look big?”
Mrs. Alton, who has a thin physique, was very alarmed at the thought that she had in some way been a cause of her daughter’s eating disorder.

Similarly, Mrs. Masey questioned whether her food choices had influenced her daughter:

And she would be irritable and yet I was not picking up the signs because I think I didn’t want to think that there was something that maybe I had done that had caused [my daughter] to have an eating disorder.

Mr. and Mrs. Masey expressed they had always attempted to teach their two daughters healthy lifestyle choices, such as a moderate dietary intake and healthy approach to exercise. Mrs. Masey continued:

I always wanted to teach the girls to eat well and, with [my husband] and my cholesterol, we were low fat and we were trying to incorporate into our lifestyle and I thought, oh I shouldn’t have done it and I’ve aggressively gone too far.

When this researcher probed Mrs. Masey to discuss her questioning herself, she became more open in discussing her discovering her daughter’s eating disorder and bluntly stated, “Well if I’m going to be totally truthful, which I want to be, uhm, I thought, first of all what have I done? What did I do to cause this?”

Mrs. Potts also experienced several levels of questioning how and if she had caused her daughter’s eating disorder. One of her concerns was whether she or her husband had caused the eating disorder inadvertently. When asked to describe her immediate reaction to her daughter’s eating disorder diagnosis, she stated:
I had a lot of mixed things and I was starting to blame myself thinking how did I contribute to this? Is it her father? Because he’s really kind of like a strict kind of guy, did he contribute to this? How could I have prevented it? I should have never let her be a vegan . . . Because I was blaming, it is my husband being strict, it is because we’ve lived under renovation, is it because, you know, we kind of wanted her to be in something like 4-H, so she chose [vegetarianism]. Did we contribute to it? So I was doing the, oh my God, it’s my fault and everybody thinks, everybody thinks . . .

Mrs. Potts also discussed guilt in that both her and her husband’s family history has various psychological diagnoses. She was worried her and/or her husband’s genetics had contributed towards her daughter’s vulnerability to an eating disorder or other psychological disorder. “Or is it a genetic thing because my husband’s family and my family suffers from depression and anxiety.”

Many participants discussed various levels and manifestations of guilt surrounding the development of their child’s eating disorder. Whether questioning their possible causation of the eating disorder, or guilt at not having had addressed the eating disorder earlier, participants seemed to hold themselves highly responsible in many circumstances surrounding their child’s eating disorder.

**Fear.** All of the participants interviewed expressed various levels of fear upon the discovery of their child’s eating disorder. The fear had various causations, such as fear for their child’s health, fear for their child’s future, and fear for the effect of the eating disorder on the family unit as a whole. When discussing their fear of the eating
disorder, many participants became quite emotional and sometimes tearful, particularly when discussing feeling terrified at the prognosis of the eating disorder and the possibility their child’s health was in serious jeopardy. Also, participants found themselves becoming increasingly scared as they were provided psycho-education about eating disorders both from physicians and the treatment team at CCED.

Mrs. Alton experienced a sense of helplessness. “I just felt like completely helpless. I thought, is this something that we are going to be able to fix? . . . When we first started, I thought she was going to die.” As Mr. and Mrs. Gold began to be educated about eating disorders and their seriousness, they became increasingly alarmed. Mr. Gold described, “it was a slow process of realizing that this is really . . . this is a disease and that she really is into it.” Mrs. Gold continued:

I mean, [the eating disorder] will kill you . . . and you know, I think why I was so sad, and afraid, afraid because I never felt in a million years we would ever have to deal with this in our family.

Mr. and Mrs. Kinston also experienced a great amount of fear due to their daughter’s eating disorder. As they watched her weight fall from approximately 170 pounds to a staggering low below 100 pounds, their point of overt discovery of their child’s eating disorder was after she excused herself to go to the bathroom after a meal. Mrs. Kinston followed her daughter and found her daughter purging. She poignantly described the moment:
I went running upstairs just in time to hear her puking in the toilet, and I just screamed for [my husband], and I’m just like, “Oh my God,” and that day, is when I knew . . . I was like, “Oh my God.” I thought she was bulimic.

As this researcher asked Mr. and Mrs. Kinston to describe their emotional reaction to their daughter purging and the obvious development of the eating disorder, Mrs. Kinston stated, “No anger . . . it was more like, complete fear, scared . . . I mean, ‘Oh my God!’” Mr. Kinston continued, “It was fear and desire for action . . . it was like okay, we’ve got a problem, we can fix it.”

Mrs. Rose, being a school nurse, had an awareness of the seriousness of eating disorders. As she discovered her son’s eating disorder, she recalled:

It was a shock. It was like, I don’t know, something that I never would have thought that he would have. It was upsetting emotionally because I knew how serious it was and how serious it could be, and how dangerous medically it was.

Mrs. Winters, in describing her emotional reaction to her daughter’s eating disorder, became quite tearful and sad during the interview. Her daughter was hospitalized several times due to cardiac concerns (a prolonged QTC), leading her to feel increasingly concerned and fearful for her daughter. She described her experience as:

I was just so worried. I mean, I was scared to death. And I thought, please no, don’t let this be because you know . . . it’s just not a good thing. You know, I just knew and it’s psychological so there’s so much more on the physical side of it. She’s such a beautiful girl and she’s always been so proud that she was the tallest, the biggest, had the biggest size shoes, you know . . . and for her to have a body
image problem, it just – it was devastating . . . you know, to me just because of who she was.

As her daughter’s medical complications came to light and her daughter was hospitalized, Ms. Winters continued to feel terrified: “Then, I realized the heart implications, and all . . . I mean, I slept on the floor outside her room to listen to her breathe and stuff, it was very scary.”

Mrs. Potts, after reading Amy Liu’s (2007) book Gaining, became more knowledgeable, and subsequently fearful, of her daughter’s eating disorder. Amy Liu discussed her life-long struggle with her eating disorder and recovery, which caused Mrs. Potts to feel very concerned about her daughter’s future:

I just realized . . . it just settled in that this is a lifetime thing even though I kind of already knew, but listening to [Amy Liu’s] stories of her going through this her whole life, and was just oh God, here we go. Is she ever going to be able to get out of this?

Several participants discussed feeling particularly fearful due to prior associations with individuals with eating disorders. Two participants discussed remembering the death of Karen Carpenter, a popular singer, who died from complications of anorexia nervosa in 1983. Mrs. Alston said, “I’m sure there is not a person in the United States who is my ageish who doesn’t know that Karen Carpenter died of anorexia.” Mrs. Gold also mentioned Karen Carpenter’s death.
I mean, we all know Karen Carpenter and when this illness really started to come to be . . . people were more aware of it . . . but I just always thought, well this is something that should not kill you and it does.

Karen Carpenter, who famously made headlines when the “emaciated picture of the famous and talented singer haunted the public from the cover of People magazine” (Costin, 1999, p. 1), was a reminder to several participants of the seriousness of, and possible fatal consequences that can arise from an eating disorder.

Mr. Burns, who has a counseling degree, was fearful due to both his educational knowledge of eating disorders as well as interactions with a fellow student from his classes who experienced an eating disorder herself. He described his experience:

I’ve happened to through my educational background, become friends . . . with a fellow student, who suffered with an eating disorder her whole life and in her 30’s, she still has that emaciated look . . . She’s been in and out of hospitals, you know, inpatient, outpatient, she had actually been [at CCED] at one point in time – so I had a background in what eating disorders are and how very difficult they are. So it was kind of like, I looked at my DSM and just remembered how serious of an issue it is. So I was kind of in shock.

Several other participants discussed having personal connections to other individuals who have had eating disorders. Mrs. Gold described a young girl her family knew through social connections who was approximately the same age as her son. This young girl had an extensive history of an eating disorder, and had engaged in various levels of eating
disorder treatment. According to Mrs. Gold, the young girl died several years ago due to medical complications caused by her eating disorder. Mrs. Gold stated:

[The young girl’s death] made it more real to me that this was a fatal problem and it could turn into a fatal problem and that it is something that clearly . . . I mean [the young girl’s] mom is a nurse and she’s very attentive and I just couldn’t believe that it could go to that point.

Mr. and Mrs. Gold also described the recent sudden death of a young woman who attended the same school and was in the same academic year as their daughter. Mr. and Mrs. Gold held some suspicion that the death was caused by an eating disorder. This also contributed to their level of fear caused by the development of their daughter’s eating disorder.

Mrs. Potts had a college roommate who had a severe eating disorder. She noticed her daughter had some of the same behaviors as her college roommate:

I said [to my daughter], you’re reminding me of my college roommate, because my college roommate was bulimic. And I said it was very frightening and you can’t do this . . . You have to be careful . . . I told her about my roommate a long time ago, but then I kept thinking about my roommate . . . I’m like oh my gosh, she’s reminding me of [my roommate].

As Mrs. Potts continued to discover the severity of her daughter’s eating disorder, she became increasingly alarmed. “I thought of [my roommate] and I was like oh my God, she was really very sick and she was really . . . I never knew what happened to her . . . and I was like, oh my god, I was devastated.”
Resourcefulness. Many participants discussed websites, books, and articles as being useful in both providing psycho-education about eating disorders as well as serving as a means through which participants decided upon the Maudsley treatment approach. Mrs. Rose received the local magazine, *Your Teen*, in the mail, in which there was an article about eating disorders and adolescents that discussed the Maudsley treatment approach and quoted clinicians at CCED. She said, “I actually had gotten that ‘Your Teen’ thing in the mail that talked about CCED and it described eating disorders and I started thinking, hmm . . . maybe this is what’s going on.” She then began to more closely pay attention to her son’s behaviors, resulting in her discovering her son was purging after dinner. After contacting CCED, Mrs. Rose was encouraged to visit a few websites that discussed the Maudsley treatment approach. After visiting the website for parents who are utilizing a Maudsley treatment approach, she was encouraged that the Maudsley treatment approach does not blame parents:

After I read about what caused an eating disorder, that it was partly genetics, it was a trigger, and you know, it just didn’t seem to fit that it was the parent’s fault, so I thought that the Maudsley treatment approach would be the best thing.

Several participants utilized literature as a means of gaining information about eating disorders, which also served as a means to motivate participants to choose the Maudsley treatment approach. Mr. and Mrs. Masey, at the time of their daughter’s assessment, were encouraged to read Laura Collin’s (2005) book *Eating With Your Anorexic*. Mr. Masey described “devouring” the book and subsequently recognizing the numerous similarities between the adolescent with an eating disorder in the book and his
daughter. “We went home and devoured that and it was . . . that’s my daughter!” The Maseys also read Help Your Teenager Beat an Eating Disorder by Lock and Le Grange (2005) and found it to help “tremendously” in that the book provided “groundwork” information as to what the Masey family was going to encounter within the Maudsley treatment approach. Mrs. Masey described her experience with the literature. “We understood what we were getting into, where before it wasn’t crystal clear. When we read the book, ‘Oh my daughter does that’ . . . very helpful . . . it really got us in the correct mindset.” Mrs. Masey found the literature she read to be helpful in describing eating disorders, stating “again, my inability to understand the eating disorder and to have adequate reading material to gain the knowledge to be able to fight this” was very informative.

Mrs. Alton also found herself immersed in eating disorder literature recommended to her:

I’m a big reader, so I ran to Barnes and Noble and the first book I put my hands on was that book by Lock and Le Grange, Help Your Teenager Beat an Eating Disorder and I started reading through that. I mean, I sat down that day and I think I finished, like I read until 3 in the morning and then I got up the next morning and finished reading it.

Mrs. Alton also found reading the literature provided her with a sense that she “was doing something.” She stated, “until that, I had thought, I don’t know what to do. I really don’t know anything about eating disorders.” The books she read, which also included Gaining by Amy Liu (2007), Eating With Your Anorexic by Laura Collins (2005), and
Next to Nothing by Carrie Arnold (2007), confirmed her preliminary thoughts that until her daughter had weight restoration, doing individual therapy would not make sense. “And once I started reading those books, I thought, I’m so smart! I thought, it just kind of makes sense.” This confirmation, thus, propelled her towards the Maudsley treatment approach.

As previously discussed, the Kinstons both discovered the Maudsley treatment approach and CCED via their searches on the Internet. Mrs. Potts, herself an English teacher, found the literature to instill in her that her daughter was unable to control her eating disorder behaviors. She read Gaining (Liu, 2007) and Eating With Your Anorexic (Collins, 2005) and was encouraged that the Maudsley treatment approach:

Didn’t blame the parents . . . I don’t know, I felt like I can use that as a source. It helped. I just think learning more. I think it made me – that “One Spoonful at a Time” made me realize too, I have to take control of her.

The literature ultimately proved to be very helpful for participants in both a psycho-educational manner as well as a confirmation of the Maudsley treatment approach.

**Externalization of the eating disorder.** An aspect of participants’ understanding and subsequent conceptualization of their child’s eating disorder emerged within the externalization of the eating disorder. The Maudsley treatment approach encourages both parents and treatment teams to approach the eating disorder as a separate entity from the adolescent. Through perceiving the eating disorder as being something that “has taken
over” their child, the participants developed increasing patience and resolve to eradicate the eating disorder from their lives.

Mr. Burns compared his daughter’s experience of developing an eating disorder to that of being “taken over like a monster.” He was able to separate his daughter from the “monster,” which aided his responses towards his daughter’s emotional and behavioral outbursts throughout the treatment process. “When she acts like that and she apologizes and she feels guilty about her behavior afterwards . . . I say no, that’s okay, that’s the eating disorder monster that has taken over.” Mr. Burns seemed to find solace in separating the eating disorder’s disturbing outbursts from the calm and sweet daughter he knew and loved prior to the eating disorder. Similarly, Mr. and Mrs. Kinston depicted their daughter’s eating disorder as being a “devil that had come out in [their child] . . . there’s a nasty person in there.” They found themselves wanting to ask their daughter, “Who are you, and where did my daughter go?”

Similarly, Mrs. Alton found patience with her daughter’s behavioral bursts throughout the process, stating “I had . . . patience because I knew, I kept saying, she’s sick, she’s not in control. If she had cancer or she was diabetic you wouldn’t yell at her. I kept saying, she can’t eat!” Comparing the eating disorder to a medical disease provided a metaphor for participants to utilize when frustrated with their child’s behavior or the process of the modified Maudsley treatment approach. Ms. Winters’ Maudsley family therapist was helpful in assisting her to understand and respond to her daughter’s experience of the eating disorder.
And [the Maudsley family therapist] kept telling me what to do because you want
to get so angry, you want to scream, you want to say, what the heck are you
thinking? But you can’t because they are in a different place.

When preparing to go on an outing with his daughter, Mr. Masey decided to approach his
daughter clearly in that he told his daughter that “you and I are going, and ED (the eating
disorder) is not invited. And she said, ‘okay, I’ll do the best I can.’”

Request for guidance. As participants began the modified Maudsley treatment
approach for their child with an eating disorder, many remembered experiencing a strong
sense of wanting clear direction in management of their child’s eating disorder behaviors,
behavioral outbursts, and food intake requirements. Participants, having a sense of being
overwhelmed with the process, welcomed the interventions of both their Maudsley family
therapist as well as the entire CCED staff. Participants sought concrete feedback and
found relief in having a team which provided direction.

Mr. and Mrs. Kinston came to CCED after several other treatment stints which
were largely unsuccessful. Mrs. Kinston reflected upon her decision to come to CCED:

We came here with the desperation to save my daughter’s life instead of sending
her to residential treatment. It was just help us . . . because that’s the one thing
that was missing [in prior treatments] was there was no guidance on how to get
her to eat, how to . . . none at all.

As the Kinstons engaged in the modified Maudsley treatment approach, they found
solace in having direction on how to recognize and subsequently address eating disorder
behaviors in their daughter. Mr. Kinston stated he appreciated the absence of
“psychobabble,” and found a direct behavioral approach that taught “tools” for parents to use to be extremely beneficial. Mrs. Kinston concurred, “Having the family counselor go, okay family, this is a family problem. This is not a ‘how are you feeling today honey?’”

Mr. and Mrs. Masey also found help in receiving a “stamp of approval” to assume control of their daughter’s eating and behaviors. In discussing their understanding of the modified Maudsley treatment approach, they were particularly struck by an analogy utilized by their Maudsley family therapist. Mrs. Masey remembered:

> What I found that was very helpful is when [the Maudsley family therapist] said if your child is supposed to be in at 10 o’clock and she didn’t get in until 11, you would discipline your child and take care of that event. Where if my child isn’t eating correctly, why don’t I take control of that? And so, I looked at it as, here are my boundaries and this is what I need to do and this is what I wanted to do all along, but for some reason, I was pulling back. Questioning myself. So, I got kind of affirmation that maybe what we were doing was right.

**Questioning one’s self.** Because participants questioned themselves often throughout the process, they often found themselves asking overtly for guidance from the treatment team. Participants described a great deal of questioning their decisions within the modified Maudsley treatment process, particularly in regards to the amount of food intake they were expecting of their children. As participants had not witnessed their children eating in a normal fashion in quite some time, assuming control of their children’s food, particularly in light of the necessity for adequate weight gain, was
difficult for many participants. Mrs. Alton had always had an awareness of calories and nutritional information; however, she found herself having to start to “read things and try to put together the most caloric things I could.” She described assuming an overt knowledge of various foods, such as which ice cream had the most calories per serving. Mr. and Mrs. Gold also had a difficult experience choosing the amount of food their child needed, as well as setting boundaries around social activities their daughter wanted to do. For example, when their daughter’s weight would decrease over a weekend, they felt guilt in that they had allowed their daughter to baby-sit or go to the mall with friends. Similarly, they also “analyzed whether we’re doing [the re-feeding] right, are we giving her enough food?”

Mrs. Potts had difficulty assuming complete control of her daughter’s intake, as she was concerned about whether she was giving her daughter “too much” or whether she had the “perfect portion.” Mrs. Rose seemed to feel as if she were constantly questioning herself in regards to her son’s intake. She described going to bed at night thinking, “Okay, what am I going to give him for breakfast tomorrow? What am I going to . . . where’s this, is that enough calories?”

Some participants also questioned themselves feeling guilt secondary to having to “force” their children to eat amounts of food that seemed extremely high. In particular, if their child was experiencing physical discomfort with the re-feeding process, which is quite common, parents experienced high levels of guilt. Mr. Burns described his discomfort with the food amounts his daughter required to facilitate weight gain:
[My daughter] has gone hypermetabolic, shoving more food in her, you always feel bad, you know, you’re giving her a big muffin and a yogurt for breakfast, which is more than I would care to eat . . . you kind of feel guilty as a parent by putting this enormous or this big amount of food in front of a kid and knowing that she’s got to eat it. And I don’t think we were prepared for the guilt.

Mrs. Potts also had difficulty with questioning herself, particularly surrounding the amount of food her daughter required for weight gain. She also questioned herself as to whether she was causing increased distress for her daughter in light of the caloric intake she needed.

I wondered if I’m giving her too much. I wondered if I’m overfeeding her . . . how much is the perfect portion for her . . . But then I was like, well, I’m not even hungry right now, so how can I make her eat that?

Similarly, when Mrs. Masey was urged to increase her daughter’s caloric intake, she questioned the amount of food required.

At the beginning there was some comparison on my part in wanting to make sure that I was meeting the expectations that [CCED] was saying. We upped the food, so I would look around to see what other kids were eating because my daughter was always telling me she had the most.

Mrs. Masey also described relief in ultimately having their Maudsley family therapist be a “second person saying, yes, what you’re doing is correct.”

**Wanting more.** Some participants found themselves wanting more support and structure within the modified Maudsley Treatment approach for their child within the
Day Treatment Programming (DTP). Of particular import was some participants’ hopes for increased instruction as to how to manage the daily behavioral aspects of their child’s eating disorder. Within DTP, participants attended two Dialectical Behavioral Therapy (DBT) skills groups per week, and one parent support group. Despite finding the skills group helpful, some participants would have liked more support group interaction with other parents of adolescents with eating disorders. Mr. Burns described wanting to have more knowledge of how to manage the “noise” from his child, particularly as she was highly inquisitive.

Mr. and Mrs. Kinston were the most vocal in expressing a desire to have had more parental support time. Mr. Kinston stated, “the only other thing here that would have been helpful is some more time either in the group with the other parents and a counselor there to go through some of the things.” Mrs. Kinston agreed with her husband as she found interactions with other parents invaluable.

I just think that the parents need that hour of, you know what? Tell us what to do in this situation . . . I think having like one night for the parents to be able to be like, oh my God, this is what she did or whatever . . . how do I do this without having to deal with what she says about it?

Participants readily discussed relying on other parents throughout the process both for support as well as for learning specific tactics in managing their child’s behavioral aspects of the eating disorder. Mrs. Potts stated having the “contact with the parents” was helpful, particularly in discussing “what tricks have you found lately?”
**Determination.** When participants first discovered their child’s eating disorder, many experienced feelings of guilt and fear. However, through information from books and websites, as well as interventions by the treatment team at CCED, participants began to develop a sense of empowerment to treat the eating disorder. Of particular import was determination on the part of the participants to take proper action in the treatment of the eating disorder.

As Mrs. Potts began to become increasingly informed about the Maudsley treatment approach, she realized the necessity of assuming control of her daughter’s nutritional intake and subsequent eating disorder behaviors.

The Day Treatment Program was when I really started learning more about it . . . and I’m like, okay, here we go. This is serious. This is what she needs even though she was bucking us the whole time.

Having had a college roommate with a serious eating disorder, Mrs. Potts was particularly concerned about saving her daughter’s life.

Mrs. Rose also found herself gravitating towards the modified Maudsley treatment approach, as she wanted to be overtly involved in her son’s treatment for his eating disorder.

I couldn’t not be involved . . . I guess I’m one of those parents that is totally involved with my children and I think if we had done some other type of treatment, I would have felt like totally stymied.

As she began to assume control of her son’s eating, she remembered that she did not question herself or the modified Maudsley treatment approach:
I knew that I had to keep doing what I was doing and I knew that this was probably . . . that I was the one that he trusted, so he knew no matter what he said or did to me, there was going to be unconditional love. If that’s what it took, then that’s what it took.

Mr. and Mrs. Masey found relief in feeling as if they had been given a “stamp of approval to be united” in the face of treating their daughter’s eating disorder. Similar to Mrs. Rose, they gravitated toward a modified Maudsley treatment approach because they wanted to overtly be involved in her treatment process. Mr. Masey remembered:

I don’t think anyone would label us as controlling parents, but we are involved parents and it never felt right [within treatment of his daughter’s eating disorder] to be out of the loop. We’ve been given the responsibility of raising our daughter, not someone else and to just to hand her over [to someone else would have been difficult].

Mrs. Masey found assurance from the treatment team at CCED to be affirming of her initial hesitancy to assume control of her daughter’s eating, particularly when she began to question herself or her decisions. Ms. Winters, a divorced mother of two, was initially overwhelmed at the prospect of assuming control of her daughter’s eating. Having to take a leave of absence from work, she soon became quite determined to treat her daughter’s eating disorder.

I remember, [acquaintances] said, you’re a single mom and you’re going to do this on your own? And I’m like, do I have a choice? And so, I’m still on a medical leave from my job, it’s been tortuous, and financially it’s been, you know
. . . but I thought, I need to focus on her and her getting well and I’m all she’s got right now and I don’t want her life to be about this forever.

She remembered explaining her determined stance towards the eating disorder to her daughter.

It was just like, you know what honey? We have a problem and we’re going to fix this, and I’m going to take care of it and you just sit here and you get better. I don’t care what it takes, you get better. I’m going to give you what you need, you have to trust me.

Participants experienced an over-all sense of empowerment as they initiated a modified Maudsley treatment approach for their adolescent with an eating disorder. Initially feeling guilt and fear, participants, though psycho-education were able to feel empowered to assume complete control of their adolescent’s intake and eating disorder behaviors.

**Dialogue regarding empowerment theme within the second interview.** The second interviews served as a member check opportunity to discuss the themes which emerged within the first interview. Within the second interviews, often the themes of the first interviews were validated and clarified. When reviewing the themes of interview one, many participants discussed the guilt and fear which they experienced during the initial aspect of Phase I of a modified treatment approach for their adolescent with an eating disorder during the second interview. Of note was the emotionality which continued to be expressed throughout the second interview as participants recalled the levels of fear they experienced, particularly as they came to understand the dire
consequences, both physically and psychologically, of the eating disorder. Mr. Gold recalled:

We did know of a girl who died of an eating disorder, so that was terrifying for us and when we started to get our daughter involved here we became aware of the consequences and all of the ramifications were intense. We jumped on [the treatment of] her eating disorder pretty quickly.

Mrs. Winters also expressed concern about her daughter’s medical stability, “to me the fear was, the immediate fear was, just getting her to a safe place again health-wise.”

Participants also continued to place importance upon the psychoeducation they received regarding the Maudsley treatment approach, particularly as this motivated them to engage in the treatment process. When recalling the initiation of treatment, Mrs. Alton had interviewed one counselor who did not utilize the Maudsley treatment approach: “I did check out one other therapist, and five minutes into it, I just thought this is the biggest waste of time. She’s going to sit there for 60 minutes every week saying ‘you need to eat.’” Because she felt individual therapy without family involvement would not be useful, when she came to CCED and became knowledgeable of the Maudsley treatment approach, she found herself feeling “pretty determined from the beginning. I felt lucky in that I didn’t flounder around looking for help.” Mr. Gold also described feeling motivated to initiate Maudsley treatment for his daughter, particularly as he became aware of the consequences of the eating disorder. “When we started to get [our daughter] involved here, we became aware of the consequences and all of the ramifications, which was intense. We jumped on [her] eating disorder pretty quickly.” Mrs. Gold also stated
that her “eyes were open” due to having had prior experiences and increased knowledge of the consequences of eating disorders.

During the second interview, participants discussed the importance of the externalization of the eating disorder from their child as well as continued externalization of the eating disorder within conversation. Externalization of the eating disorder, defined as actively separating and delineating the illness from the adolescent, continued to permeate the participants’ discussions. When asked her thoughts on externalization of the eating disorder, Mrs. Winters stated, “it was really hard and important to do, separate the behavior [from my child]. Mrs. Gold gravitated to the externalization of her daughter’s eating disorder, particularly as it allowed her to accept her daughter’s behavior:

I started realizing at that point that this is an illness, it really is an illness. And so, then that made me feel better because I think at that point I realized that it wasn’t just willful acting out because I felt so hurt by the way she was sometimes. But that this is an illness that we’re dealing with and that empowered me, the sudden realization that she’s sick.

Within the second interview, participants also discussed their overt determination to engage in the Maudsley treatment process, despite fear and concern. Mrs. Masey found herself increasingly determined to challenge the eating disorder, particularly as time passed and she learned more about the Maudsley treatment process. Her daughter engaged in DTP twice, and in the second interview, Mrs. Masey was able to review her perceptions of returning to DPT. Within her daughter’s first DTP treatment, Mrs. Masey
was at times unable to participate in the treatment process due to her breast cancer treatment. However, within the second DTP process:

I had the sense, the second time that I’ve come back, more of, “we’re gonna beat this thing.” This is what we’re going to do. Like if [my daughter] will say “mom do I really have to have that snack today?” “Yes. You do.” In the past it was, not that every time I would give in, but I would question myself. It was much more authoritative for me.

When asked her perception of determination within the Maudsley treatment process for her son, Mrs. Rose recalled:

And then, we started the treatment and I felt a little bit more like, okay, I can do this no matter what it takes. I’m going to do it because it’s the best way for my child and even though he hates me at this point, he doesn’t want to do what I’m telling him to do, I’m going to stick with it until we beat this thing no matter what it takes.

When recalling her thoughts concerning levels of determination, Mrs. Rose’s voice became stronger and more firm and her eyes watered, leading this researcher to believe Mrs. Rose felt a great amount of conviction about the necessary actions she had to take to treat the eating disorder.

Mrs. Winters, a single mother, also found herself quite determined to treat the eating disorder, despite her daughter’s “stubborn and strong-willed” attitude, stating “those characteristics didn’t kick me.”
Some participants, when asked about their levels of determination in the treatment process, reflected upon their relationships with other parents of adolescents with eating disorders who were engaged in DTP as motivational and validating of their determination. Mrs. Masey and another mother became friends and provided encouragement for each other within the treatment process. “The nicest thing that came out of this experience was my friendship with her and sharing what we’ve learned and just being real good friends.” Mrs. Rose also appreciated the validation of her relationships with other mothers:

After we would set up breakfast, we’d go out. I would go out for coffee with some of the other moms and that was really reassuring for me and reaffirming that I was doing the right thing and that he was at the right place and that he was going to get better.

Mrs. Winters also continued to utilize the relationships she developed with other mothers as a source of encouragement, months after her daughter was discharged from DTP. “Still two of the parents I talk to all of the time, even though they’re no longer here because, yeah, it’s a difficult situation and any little pep talk you can give each other is helpful.”

**All-Consuming**

The theme of all-consuming illustrates the completely encompassing nature of a modified Maudsley treatment process as experienced by the participants, which required high levels of involvement and determination in the face of “hellish” behavioral outbursts by the adolescents. In describing experiences of implementing a modified
Maudsley treatment approach for their adolescents with eating disorders, participants discussed the all-consuming nature of the treatment process. Participants found themselves completely devoted to the treatment of their child’s eating disorder, often at the expense of self-care, particularly as the treatment process became difficult. Three overarching categories emerged within the all-consuming nature of a modified Maudsley treatment approach: (a) wanting involvement, (b) family changes, and (c) experiencing “hell” throughout the treatment process. To define the “hell” in which participants found themselves within the process, parents discussed having an extremely difficult time that surpassed expectation, both personally and with their adolescent with an eating disorder. When discussing the all-consuming nature of the modified Maudsley treatment process, this researcher found the participants to be quite emotional, particularly as the participants descriptively disclosed the “hell” they experienced as the modified Maudsley treatment process was implemented. This researcher also found herself feeling an overwhelming sense of sadness when the participants discussed their child’s illness, which this researcher attributes to the levels of emotionality that were presented by the participants and a sense of compassion that arose from this researcher due to the all-consuming, tumultuous experiences the participants disclosed. This researcher postulates her emotionality arose due to having had personal interactions with some of the participants within the Day Treatment Program.

**Wanting involvement.** Participants often discussed wanting to be involved in their child’s care; however, this involvement at times became all-consuming due to the expectations of Phase I of a modified Maudsley treatment approach. A contributing factor
towards participants deciding to engage in the Maudsley treatment approach was a desire to be involved in their child’s eating disorder treatment. As parents are conceptualized as being the head of their child’s treatment team within the Maudsley approach, parents are fully involved in their child’s treatment. This approach was appealing to participants, as several participants did not feel comfortable with being excluded from the treatment process, which is how non-Maudsley treatment approaches traditionally operate.

Mrs. Rose had previously read about traditional eating disorder treatments that do not include the parents in the treatment process, and she said:

I knew that that was not an approach that I could take. I couldn’t just not be involved at all because that’s not the kind of parent I am. I need to be there and I want to know, I want to know what’s best and [the Maudsley approach] sounded like the best approach.

She went on to describe her parenting style as one that is “totally involved” with her children’s lives and felt she “couldn’t” not be involved with her son’s treatment.

Mr. Masey discussed similar sentiments in that he had initially expected not to be involved with their daughter’s treatment and expected to be told “you’re part of the problem.” Mr. Masey described his family system as quite close in nature and he was not comfortable with being uninvolved in his daughter’s treatment. Being a pastoral counselor also contributed to Mr. Masey’s decision to be involved in his daughter’s treatment as he included parents of adolescents that he counsels and desired the same for himself. Mr. Masey stated, “I expected my daughter to pretty much be isolated from us in the treatment process and that rubs totally against our philosophy as parents.” He
described the solitary reason he was receptive to the Maudsley treatment approach was because of the family involvement:

> And the sole change, the reason why I was open and receptive to it [Maudsley-based treatment at CCED] was because of the family involvement and the empowering of parents. One of the things [the assessing clinician at CCED] said to us was that as we work with her, we will continue to involve you and give you feedback . . . . And because that was the approach here, that made me more willing. Otherwise, I’m not going to stick my child in a situation where I don’t know what’s going on.

Mr. and Mrs. Masey ultimately found relief in that they were given access to their daughter’s treatment and had a full investment in her treatment process. They both described feeling “relieved” that they were included within the process.

> Mrs. Potts found being included in the process of her daughter’s treatment “freeing” in that she was given the “strength” to take over her daughter’s eating and disordered behaviors. She stated:

> Like, OK, I can do this. I am just going to do it and I don’t care if she hates [me]. I wrote her a letter, you’re going to CCED, I don’t care, you can hate me for the rest of my life, but this is what you’re doing and as your mother, I have made this decision, and I don’t care at this point what you think of me.

Having realized her daughter was unable to manage her food intake and eating disorder behaviors, the Maudsley approach provided Mrs. Potts with a sense of empowerment in
wanting to manage her daughter’s eating disorder. She concluded, “I’m going to come in and do the best I can while I have the opportunity before you’re 18 to save your life.”

Mrs. Alton also felt her daughter would not improve without her involvement in the treatment process. She noticed her daughter had lost the ability to control her behavior and therefore, found it necessary to ensure the cessation of weight loss and ultimately initiate weight gain. The Kinstons had attempted unsuccessful outpatient treatment during which they had limited access to their daughter’s eating disorder treatment. Living about 90 minutes from CCED, they decided to utilize the modified Maudsley treatment approach at CCED in an attempt to avoid having to go to a residential facility. Having witnessed their daughter continue to succumb to her eating disorder, and continue to lose weight while in treatment in another city, the Kinstons knew they needed to assume control of their daughter’s food intake and eating disorder behaviors.

**Family changes.** As participants began to initiate a modified Maudsley treatment process for their children with eating disorders, family changes began to emerge. Total involvement in the treatment process proved to be challenging and all-encompassing, causing variations within the traditional structure of the families’ schedules, interpersonal interactions, and expectations of living with an adolescent. Concern about the results of the changes also arose for the participants. As Mr. Burns expressed, “Because what’s [the eating disorder treatment process] going to do to her sister, what is it going to do to the marriage, because these things are always very trying on families.”
A major change within the family dynamics was expectations surrounding meal times. Mrs. Alton recalled that as they initiated the modified Maudsley treatment approach, her husband was home for dinner “for the first time in forever . . . that my husband has been home earlier than 10 o’clock.” Also, participants found their families shifting from a less structured approach to meal times to a much more structured, sit-down meal. Mr. Burns recalled:

When you get older and you have kids . . . with different schedules, the family dinner becomes more like self-serve. So I knew it would be hard to coordinate in our house, it’s very hard for mom to come up with one dinner that satisfies everybody.

Participants also found the structuring of meal times and management of other chores to be difficult. Ms. Winters had difficulty engaging in a regular schedule:

I’d run down to get laundry, I’d get on the phone and then I’m oh my gosh, it’s time for her 10 ounce smoothie and a granola bar and I need to sit and watch her. It was time consuming and harder to put in place than to hear what I had to do.

Mrs. Rose described a similar circumstance, in which she was unable to “run out to the store” because of having to monitor her son constantly within the initial parts of his treatment. She found herself feeling as if her family unit was taking “steps backwards . . . because once [children] get to be teenagers, you kind of start letting go and then we had to kind of pull back again.” Mrs. Gold similarly described her experience with her daughter; “we can’t leave the house, we feel like we cannot leave her alone. It’s almost like keeping a young child.” The parents expressed regret at having to monitor their
children so closely, particularly as this constant monitoring is incongruent with the developmental processes of adolescence, in which adolescents begin to assume increasing autonomy within the family system.

Other changes that emerged within the treatment process were that traditional family activities and outings were very much affected. The Burns family would engage in leisure activities prior to the eating disorder; however, once the eating disorder treatment process began these activities were much less leisurely and more stressful. “We used to go to the movies as a family, but that usually involves food and so, whether it’s popcorn or whatever, there’s always noise [fighting about the eating disorder]. You can’t just go to the movie and get popcorn.” Participants described their families as having to change their expectations surrounding activities, interactions, and family meals throughout the treatment process.

Participants also found themselves having difficulties surrounding their approach towards their child’s treatment within the modified Maudsley treatment approach. Primarily, some participants found themselves disagreeing with their partner about how to implement total control of their child’s eating disorder treatment and subsequent behaviors. An example was when one parent had a more lenient approach towards their child, while another parent was stricter. Mrs. Alton described her situation as “I just think that if we were tougher with her, she would probably be making more progress and [my husband’s] thing is, you know, life is bearable, let’s not rock the boat.” Similarly, Mr. Burns described his approach to his child’s treatment as being “we’ve got to take this
really seriously, and be real strict with this.” Conversely, he described his wife as being “let’s not make her too anxious, let’s try to be a little more ‘go with the flow.’”

Some participants utilized each other as a moderating force when making decisions regarding their child. By utilizing each other to balance expectations of their adolescent with an eating disorder, participants were able to find common ground. For example, Mr. Gold described himself as being “easier to play . . . I have a much longer fuse before I get upset. I can be pushed around easily.” He utilized his wife’s ability to “set better limits” when he found himself acquiescing to his daughter’s eating disordered demands. Mr. and Mrs. Masey described the way in which they were able to support each other when feeling “worn down” by their child’s questions and negotiating regarding food and exercise. Mr. Masey described their united front:

And some of the negotiating was wearing [Mrs. Masey] down and that’s when I would step in and say, no, we’re not negotiating, it’s not up for discussion. And then, when I would wear down, she would end up stepping up. So we seemed to work through [the negotiating] for the most part.

Participants found their child was able to utilize differences in parents’ approaches advantageously. Participants described their children as being able to easily manipulate any difference of opinion between parents. Mr. Burns described his daughter as a “16 year old who can be very clever learning how to drive a bigger wedge in there.” Mr. Gold also stated his daughter was particularly clever in “knowing how to play” her parents’ differences of opinion. In regards to the decisions made by Mr. and Mrs. Kinston, they found when they were not a completely unified front towards their
daughter, stating “she would find a crack. If she found a crack of being able to separate us in some way, that was not a question.”

Participants also offered unsolicited advice to other parents as they began to institute a modified Maudsley treatment approach for their child. Mrs. Alson stated, “I think it’s important for you to be on the same page with your spouse.” Mrs. Kinston agreed with Mrs. Alton, as she stated, “The one thing I have to say, you have to be a united front.” All of the parents interviewed agreed with the importance of parents holding the same limits and being similar in their expectations of their child.

**Hell.** As participants described their experiences of implementing a modified Maudsley treatment approach for their adolescents with eating disorders, many depicted a process in which they experienced a great amount of distress, particularly as their child’s behavior and attitude became almost unrecognizable. The “hell” of assuming responsibility for the management of their child’s eating disorder was apparent, particularly as participants exhibited a great amount of displayed emotionality when recounting the process. The “hell” discussed by participants became quite clear as parents had difficulty with the emotional outbursts of their children, as well as the impact upon the parents and the family dynamics in general.

Mrs. Alton’s expectations and experiences of the modified Maudsley treatment approach for her daughter were aligned. She stated, “[my daughter] doesn’t care and has been really difficult—I expected it to be hell and it was hell.” She described her child as being strong-willed and very difficult to control. In particular, participants described the “hell” experience of their children’s response to their interventions, stating their
children’s responses were very difficult for the participants to endure. Mrs. Kinston recalled her daughter’s response towards her parents as being unbearable: “It’s pure hell. Pure hell. What they’re going through. What they are doing to themselves . . . and what comes back at the parent [the adolescent’s anger].”

Mrs. Kinston discussed having had prior experience with her daughter’s emotional volatility and anger, but was impressed by the overt nature of her daughter’s fury. She stated:

I was kind of used to her being tough like that with me. So, I was like, bring it on . . . I’m used to it . . . I mean, I imagine as a parent of a child that’s always been sweet and compliant, it would be a nightmare, but I have some experience with her anger issues.

The Kinstons also expressed a desire to provide support for other parents who would be engaging in a modified Maudsley treatment process, almost in a protective manner. Mrs. Kinston continued:

I don’t think that anyone can prepare you on how hard it can become. No one can prepare you unless you probably talk to somebody . . . like if I talk to somebody that was heading into this program now, I would almost want to sit them down and be going, you know what? You are about to go on the most hellish ride you have ever been on because the anger, the devil that comes out in your child.

The Gold family was told initially by their Maudsley family therapist their family would possibly have an explosive response as their daughter began the Maudsley treatment process. Although their Maudsley family therapist had foretold of the
difficulty they would experience, the Golds were still unprepared for the way in which they would experience the initiation of the treatment process. Mrs. Gold described her experience:

Well, no, it’s funny, because [our Maudsley family therapist] told us in our first session—she said, you know what? I see that your family is gonna “explode” and I remember thinking in that session, well, I don’t want my family to explode. I want it to be quiet at home. And it did, though—you know, things got tense, tempers got out and it really did.

The Golds described both their daughter’s temper exploding as well as their own as they became exasperated as they implemented the process.

As participants engaged in a modified Maudsley treatment approach for their child, they found themselves feeling as if their child was no longer the child they knew and loved. Describing the eating disorder as an entity that had taken over their child, participants found themselves aghast in the ways in which their child was responding to themselves and the treatment process. Mr. Burns stated:

You know, where she was screaming and swearing at me, using words that she normally doesn’t hear—it’s just being taken over like a monster, like a Sci-Fi movie and some monster had crawled inside and taken her over.

Mrs. Kinston similarly described her daughter as having been taken over by “the devil,” as Mr. Kinston stated, “There’s a nasty person in there.”

**Dialogue regarding all-consuming theme within the second interview.** When asked about their perceptions as to the theme of all-consuming, many participants had an
overt, agreeing, response. Mrs. Alton stated, “I couldn’t talk about anything else. So I
would say it was all-consuming of my thoughts and probably 95% of our time.” Mrs.
Gold responded, “110% correct, all-consuming couldn’t be more correct.” Mr. Gold also
endorsed the theme of all-consuming: “It was all-consuming. I kind of look at this as our
eating disorder year because we missed out on a lot of things that we normally do
because of the eating disorder.”

Mrs. Winters elaborated on her perceptions of all-consuming:

I felt [our life] was about our life and the rigidness, checking this and checking
that. It was all-consuming. And then being a single-parent and having another
child that needed attention as well, it was all-consuming.

Despite feeling as if the Maudsley treatment process was all-consuming,
participants continued to feel as if their involvement in their adolescent’s treatment
process was of upmost importance. Reflecting on her experience, Mrs. Rose stated:

I think if I wasn’t included it would be harder. I mean, having it be all-consuming
was a horrendous experience just because, you know, like you said, it’s
all-consuming. It was my life until things got back on track. But the flip side, I
don’t think, it would have been terrible because I wouldn’t have known what was
going on and I want to be involved and I think [involvement] helps the [treatment]
process.

When the results of “hell” was introduced to the participants, many responded with a
quick laugh, in that they agreed that their experience of the Maudsley treatment process
was quite a hellish experience. Within the second interview, participants were much less
emotional than within the first interview when discussing the hellish experience of the
treatment process. For example, Mrs. Rose agreed:

> It’s funny you’re saying that because the other night we had an incident with [my
son] where he was out way past curfew, so my husband and I were sitting in the
living room and I was like, doesn’t he know he’s taken us to hell and back
already? I can’t deal with this. So yeah, absolutely. You hit the nail right on the
head.

Mr. Gold also remembered how difficult his experience was of his daughter’s
reactions during the treatment process:

> We were amazed that, you know, [our daughter], I mean, the time and money and
effort we were putting towards [her] and she was lashing out at us . . . she really
was. She was really lashing out at us and it was hard.

Particularly when responding to the hellish experience of her daughter’s reaction,
Mrs. Alton recalled feeling as if her daughter “became possessed.” She also discussed
the ways in which her daughter’s personality manifested throughout the process,
particularly the improvement she noticed over the months her daughter has been engaged
in the Maudsley treatment process:

> She is generally sweet tempered. She has always been stubborn, but this was just
like off the charts stubborn and just, I mean, foul language and just bitchy beyond
belief, especially in the beginning when she was malnourished. As she started
weighing more, her personality got back, I mean her temperament got better, and
now, I would say she has some eating disordered behaviors but her personality is back.

Mr. Gold also stated that “once we recognized the eating disorder and got [our daughter] involved in treatment, things got worse before they got better.”

Within the second interviews, despite endorsing the theme of all-consuming, some participants described their attempts at setting boundaries and limits on the level to which the eating disorder overtook their lives. Mrs. Alton stated, “we did try to make an effort to not let it be just the only thing [in our lives].” When Mrs. Masey’s daughter returned to DTP, Mr. and Mrs. Masey attempted to set clearer limits on the manifestation of the all-consuming nature of the treatment process:

Because it was all-consuming. Again, coming back [to DTP] this time, I have boundaries on this that I did not have last time. And that has really made a difference in our family. And that has really made a difference in our family and our relating to each other. All-consuming – am I allowing it to happen? . . . This is not a quick process but we’re not going to stop life while we’re moving along.

**Community**

Although participants tended to experience a sense of isolation at the onset of the treatment process, through interactions with other parents, the CCED staff, and treatment programming within the modified Maudsley treatment process, they developed a sense of belonging, support, and community. A sense of community within the Day Treatment Program at the Cleveland Center for Eating Disorders was also an aspect of participants’ experiences within their child’s modified Maudsley treatment process. As their children
engaged in DTP, participants found themselves having a sense of relief that their children’s eating disorder behaviors were being closely monitored by a staff that the parents trusted. Also, participants found a sense of camaraderie with other parents of children with eating disorders. The community the parents established amongst themselves, as well as a trust in the staff and treatment process at CCED, proved to be an important aspect of the modified Maudsley treatment process. Four themes surrounding community emerged: (a) isolation, (b) DTP relief, (c) community of parents, and (d) trusting CCED.

**Isolation.** Within the diagnosis and initiation of a modified Maudsley treatment approach for their children, participants often found themselves feeling isolated from their extended families, friends, and communities. Particularly, participants felt as if no one could understand their circumstance “unless they have been through it.” Mrs. Alton described her experience as if “feeling like you’re the only person in the world.” As she reached out to a psychiatrist for support, she found herself:

> Just wanting someone to talk to . . . and most of my friends actually don’t have children, so even though they were sympathetic, you know, they can’t even imagine what it’s like. And my husband had his own thing. I only stayed in touch with the friends that I could talk to about it. Because if I couldn’t talk to you about it, I wouldn’t talk to you.

Mr. and Mrs. Kinston had a similar experience in wanting to reach out to others for support, however, feeling as if their friends and family were largely unable to understand their experiences with the treatment of their daughter’s eating disorder. Mr.
Kinston recalled wanting “to reach out sometimes, but on the other hand, the folks that are family and friends, and unless they have been through it, they don’t understand.”

Mrs. Rose, a school nurse, was able to discuss aspects of her son’s eating disorder with colleagues, but found supportive understanding at times difficult to access. Initially, her husband did not want to discuss their son’s eating disorder with “anyone.” Also, Mrs. Rose did not know any other parents who had children with eating disorders. However, after a few days of treatment, Mrs. Rose insisted upon telling some family and friends in an attempt to access support, both physically and emotionally. It was through these contacts, as well as parental support at CCED, that Mrs. Rose was able to feel increasingly supported and less isolated from her community and family.

Mrs. Potts, who lived approximately an hour from CCED, felt “very, very isolated in the community.” Her daughter did not want her mother to discuss with anyone her eating disorder, which was difficult as Mrs. Potts ultimately took time off of her job as a high school teacher. Also, Mrs. Potts was primarily responsible for taking the helm of her daughter’s treatment, as her husband worked full-time and was not very involved with the treatment process. Both because Mrs. Potts felt others in her community blamed her for causing her daughter’s eating disorder, as well as her husband not being very involved in the treatment process, Mrs. Potts experienced a crushing sense of isolation.

**Day Treatment Program relief.** Within the modified Maudsley treatment approach at the Cleveland Center for Eating Disorders (CCED), adolescents with eating disorders participate in the Day Treatment Program (DTP) which is five days a week, Monday through Friday, for five or six hours a day. During DTP, the adolescents with
eating disorders have therapeutic meals and various group therapies. When discussing their experiences within DTP at CCED, participants expressed a sense of relief that their child was in a safe environment, and that DTP provided participants a respite from the continuous supervision required of parents within the Maudsley treatment approach. Mr. Burns stated, “[DTP] gave us a break. It’s six hours where she is being supervised, you know she’s eating, she’s being occupied.”

Participants discussed a sense of relief in that their child’s meals were being supervised in DTP, which also allowed the participants not to engage in arguments with their children about their food. Mr. Kinston, whose daughter was quite argumentative while at home, found a respite in that his daughter’s meals were supervised. “And what was a great experience . . . the fact that here, she would have a breakfast or lunch or both here and what would end up happening is she’d eat it all . . . no matter what.” Mrs. Kinston, who held primary responsibility for ensuring her daughter was eating all she was given, agreed with Mr. Kinston:

To be honest for me personally, oh my God! It was a relief that someone else was making her eat today. And I got a break. To be bluntly honest, because it was so much on me that there were days where I was just like, I don’t know if I can do this anymore. So for that alone—I knew, because you can’t just leave her with anybody.

Mrs. Rose, who had primary responsibility for monitoring her son’s food intake, found similar respite.
Even though I had to prepare [the meals], there was still relief in the fact that I didn’t have to sit and watch him eat every meal. And I knew that he’d be watched and they’d make sure that he would eat everything that I gave him.

The parent who had primary responsibility for his or her child’s eating disorder treatment continuously discussed solace in having meals and days when they were not continuously responsible for monitoring their child’s eating habits. Ms. Winters concurred, “You’re doing all this with a lot of worry and then when you’re not there, you’re happy that someone is taking over the refeeding.”

Participants also discussed a sense of trust in the staff of CCED who were ensuring their child was adequately completing meals. Mrs. Gold described her experience as parallel to having a toddler who was in “good hands.” Similarly, Ms. Winters stated, “[DTP] was almost like she was in daycare, you know, like how you feel when you find a good daycare.” Mrs. Potts concluded, “Well, I felt like okay, she’s in the right place. So, I felt comforted in that way.”

**Community of parents.** All of the participants in this study discussed the positive experiences of the community of parents that was found within the Day Treatment Program. Because participants had such a sense of isolation from family and friends, they found relief in meeting other parents who were experiencing similar circumstances. Also, through the interactions with other parents, participants were able to see various stages of the treatment process, which provided motivation and solace for those beginning the overwhelming modified Maudsley treatment process.
Mr. and Mrs. Gold agreed that hearing other parents’ experiences was very helpful, particularly in making decisions about their child’s schooling and social interactions. Mrs. Alton was surprised to find herself looking forward to the parent support groups:

I definitely found [the parent support groups] helpful. I mean, the first few sessions, I kind of felt, oh God, what are we going to hear? I don’t want to hear all these other people’s problems. I just want to deal with my own. But as you listen more, you do learn things from what other people are saying. And I thought the sessions were great. I mean, I started—instead of thinking, oh God, I have to leave work early to go to them, I started to look forward to them.

She also met parents with whom she continued to stay in touch, because these parents have been “in the same boat.”

Mrs. Kinston described the community of parents as a “sorority”:

I think for us, knowing that we felt like there was this feeling of safety net here, everyone here understood what we were going through. We felt like we were in this like, sorority of . . . It was like oh my God!

Mr. and Mrs. Kinston used the contacts they made at CCED, both with other parents and staff, for support in initiating control over their daughter’s intake and eating disorder behaviors. Some participants described their friendships with other parents as being helpful, both in the formal groups as well as informal interactions. Mrs. Potts articulated:

Just talking to the parents in the morning when you’d see each other, you know, how are you doing . . . everybody is in the same boat. Some of the best times I
had were just standing in the elevator or afterwards, because we just seemed to get down to the nitty gritty . . . I almost wish that we had the numbers of some of the parents.

Mrs. Rose also found it beneficial to discuss specific behavioral interventions concerning her sons’ eating disorder with other parents:

Just listening to other parents was really helpful to see how they did it and how their kids reacted so I could say, okay this is normal that he’s acting this way. And this is normal that, you know, I feel like my whole life is revolving around feeding my child . . . I wasn’t alone in this endeavor. We were all kind of in this together and supporting each other.

Mr. Burns found a sense of relief in meeting other parents who “had the same exasperated look that we felt.” Also, Mr. and Mrs. Masey found the parental interactions “helpful,” particularly in assessing their progress through the treatment process, as Mrs. Masey stated:

[The parent groups] were especially helpful. It allowed us to see what we had ahead of us. I can remember sitting there initially pretty quiet and hearing parents and then later saying, okay, we are finally at that stage. And so that was very helpful.

**Trusting CCED.** As participants discovered their children’s eating disorders, they were often overwhelmed at the diagnosis as well as the prospect of treatment (as previously discussed). Finding and choosing a treatment approach, as well as treatment providers was often a daunting process, particularly if participants encountered
misinformed treatment providers or pediatricians. Mrs. Alton recalled having concerns about the Day Treatment Program, particularly as she worried her daughter would learn eating disorder behaviors from other participants in the group. Through interviews with CCED’s psychiatrist, she and her husband began to trust the treatment recommendations for their daughter:

Dr. Warren assured me that [my daughter learning eating disorder behaviors] wouldn’t happen and I just said to my husband, we have to trust him. I mean, they wouldn’t be in business, there wouldn’t be a packed waiting room if they were making kids sicker or you know, anything . . . so we just had to trust [CCED].

Ultimately, Mrs. Alton “completely trusted” her treatment team, “because nothing else made sense to me,” particularly upon recommendations for the Day Treatment Programming, psychiatric consultation, and weight and medical management.

Mr. and Mrs. Gold also found themselves finding a sense of trust within the recommended modified Maudsley treatment approach. Mr. Gold described their process:

I think we both agree with the Maudsley approach though. It sounds reasonable and workable and it sounds like the way to go and we’ve heard that it is from all of the therapists here and we’ve felt that it sounds like it’s the time-tested method. Mrs. Gold furthered her husband’s assessment of trust in the modified Maudsley treatment approach:

We’ve been kind of guided by this team and just . . . we haven’t gotten to be experts on really what Maudsley is, what’s the other approaches to eating
disorders? What other options are there? If you don’t like Maudsley what is there? I don’t know, I just have to believe that this is the treatment that works.

Mr. and Mrs. Kinston’s daughter had had several unsuccessful treatments for her eating disorder prior to engaging in treatment at CCED. As her parents watched her weight dramatically fall from over 170 pounds to below 90 pounds, they were desperate to find a treatment modality in which they could have a sense of confidence. Mrs. Kinston described finding CCED:

We came here with the desperation to save my daughter’s life . . . save our daughter’s life, instead of sending her to residential treatment. It was just help us! Because that’s the one thing that was missing [in prior treatments] was there was no guidance on how to get her to eat, how to . . . none at all . . . By the time we came here, she was down to 89 pounds at 5’5” and we were like, oh my God! We felt she was water through our fingers, and all [other treatment facilities] wanted to send her away. I think it was here it was more like, we just felt like, okay, the Day Treatment Program, okay, she’s going to be in a place where she is being monitored by someone else.

Mr. and Mrs. Masey found themselves trusting the entirety of the CCED staff, particularly in the consistent message delivered by all involved in their daughter’s treatment. Mrs. Masey described her relationships with staff. “More positive for us I think, even the relationships we built, even with the ladies at the front desk . . . it was wonderful. I wasn’t expecting it to that extent.” Mr. Masey concurred, “The integration of the team is just great. Consistency. There was a constant message.”
Mrs. Potts, who held the primary responsibility for her daughter’s eating disorder treatment, found herself trusting the treatment team’s recommendations, particularly as she questioned herself. She also appreciated the consistent message from the entirety of the treatment team.

I realized that I couldn’t do it on my own . . . so I realized I’m not alone. And then [the treatment team] giving me feedback and the group therapy I thought was really good. So, all of that was very kind of comforting along the way . . . I felt like, okay, she’s at the right place. So I felt comforted in that way.

Mrs. Rose also remembered experiencing a sense of trust and relief within the treatment process of her son’s eating disorder. Initially, her husband questioned the need for the Maudsley treatment approach; however, after speaking with their son’s pediatrician, he concurred with the modified Maudsley treatment approach. Mrs. Rose summarized her experience within the modified Maudsley treatment approach:

I would say, for my experience with it was very positive and it was very, very devastating . . . finding out that my son had an eating disorder was very hard, but the way that it was treated I think really made things a lot easier. Because you had family therapy, you had individual, the Day Treatment Program, which supported him and got him through and then the evening sessions with just the parents . . . I think the whole process of the treatment of the eating disorder was phenomenal.

Mrs. Winters also found herself trusting the consistent messages from the treatment team, particularly since her daughter was also receiving the same messages. “I think doing the
Maudsley alone without the support from a team of people would be a lot more difficult because she was hearing the same thing from them that she was hearing from me.” She continued, “How do I think the Maudsley approach supported me? It was very helpful that the team at CCED handled and coached the food issues consistently and that we were all on the same page.”

**Dialogue regarding community theme within second interview.** As the theme of community was introduced to parents, they had several reactions. Participants endorsed the results of isolation within the modified Maudsley based treatment course for their adolescents with eating disorders, particularly within the initial aspects of the process. Mrs. Rose and her husband had differing perspectives on disclosing their son’s eating disorder and subsequent treatment, recalling, “I’m pretty close to my family and I’m the kind of person that likes to talk about things, but at first my husband didn’t want to tell our family.” Mrs. Winters had a similar experience in that:

I absolutely agree with [the finding of isolation] and the hardest part of that is having other parts of your family not understand. I told [my ex-husband], it’s you and me against this thing. You know, you got a lot of [funny looks from others], like what are you doing?

Another aspect of isolation discussed by participants was that of feeling as if they were not able to communicate with others unless they also had a child who had an eating disorder and was able to “understand” their experience. “I could only see people that I could talk to about [the eating disorder], because I couldn’t talk about anything else” remembered Mrs. Alton. She continued:
But I think [the community of parents] is important because otherwise you feel like you’re the only one going through it and no one can understand. I mean, as sympathetic as all of my friends are, most of them don’t even have kids much less kids with eating disorders. So it was hard.

Within the second interview, participants continued to be very appreciative of the support they received from the treatment team at CCED. They found the Day Treatment Program (DTP) very helpful in the modified Maudsley treatment process, particularly within the initial throes of treatment. Mrs. Winters described the aspects of DTP that were most helpful:

I think you can kind of equate [the treatment process] to having, like, a toddler again. And I think the safety net of CCED was like it is all-consuming but I knew when she was here, you guys were on it. I would know if she was doing good behaviors. So it’s almost like taking her to a day care and making sure she was okay and then [DTP] eased up what I had to do at home.

When asked of her thoughts regarding DTP being beneficial, Mrs. Alton responded:

Yes, I don’t know what we would have done if we hadn’t done day treatment, we would have had to do something. I didn’t feel really equipped for a while to be able to deal with her behavior. [My daughter] could sit for hours on end [at home] and just not eat. So it was really good to know that she was here and she had no options and also I felt like it would make it easier for me because she would know that we weren’t going to let her fall through the cracks.
The community of parents during the second interviews continued to permeate the experiences of the participants. Several stated they continued to communicate with other parents they met during their child’s treatment in DTP after their child’s discharge from programming. Mrs. Masey, when asked of her thoughts of the community of parents, stated:

Yes, [it is] very helpful. In fact there is one lady that we e-mail probably five times a week. One thing I said to her the other day was that the nicest thing that came out of this experience was my friendship with her and sharing what we’ve learned and being just good friends.

During the second interview with Mrs. Masey, her daughter had been discharged from DTP several months prior; however, she continued to engage in relationships with other parents she met during DTP. Similarly, Mrs. Winters, in the second interview when asked to describe her perceptions of the community of parents at CCED, responded:

Right. There’s somebody else that really understands even though each kid is unique. And, I mean, still two of the parents I talk to all the time even though they are no longer here, because, yeah, it’s a difficult situation and any little pep talk you can give each other is helpful.

Mrs. Alton described having met a “life-long friend.” Initially, she had thought that the parents-only support group “was going to be a huge waste of time, the last thing I wanted to do was hear someone else talk about what their kid is doing.” However, she came to find it “definitely something [my husband and I] found beneficial.”
Mrs. Rose found the community of parents validating in that she received feedback that what she was doing in terms of the treatment for her son was correct, in both informal and formal interactions with other parents within DTP:

I’d go out for coffee with some of the other moms and stuff and that was really reassuring for me and reaffirming that I was doing the right things and that [my son] was at the right place and that he was going to get better.

She also commented on the helpfulness of the parents-only support group when asked about the theme of community:

Yeah, I found the group sessions to be really helpful and especially the parent-only sessions where we could just really say how we felt and what we were going through and realize everybody else was going through the same thing. And troubleshoot things that we were having problems with, and yeah, that was really great.

Some participants within the second interviews expressed a great amount of appreciation and thanks for the support they received from the treatment team at CCED. Mr. Gold, when asked of his perceptions of trusting and appreciating the treatment team at CCED, stated, “We feel a sense of definitely comfort and relief just having this place here. We’re so thankful it’s so close.” Mrs. Gold continued, “But I can understand that we would have traveled to continue this because it really, yeah, the team seemed our only answer for getting this thing treated.”

Mrs. Masey, when recalling her experiences of the treatment team at CCED, became somewhat tearful, as she described:
And CCED has, you know, I was walking this morning and thinking what an impact this whole place has made on our lives. You know, I really don’t know where we would be without this place, from Dr. Warren down to these ladies, sweet ladies, at the reception area. It’s just a wonderful place. You know, I can drop [my daughter] off and I know she’s going to be safe, she’s going to be fine. [The treatment team members] are amazing . . . inspiring. I mean to do this with [their] lives and to give so much of [themselves]. It’s not just a job. It isn’t. It’s just, [the team has] impacted us in so many ways.

She also appreciated the consistent messages she received from the treatment team, stating, “I knew you were teamed with me and I knew you guys were all on the same page.”

Mrs. Winters also found the consistent messages of the treatment team extremely helpful:

[The treatment team] was really, really important, especially because [Maudsley treatment] is not very well known and there wasn’t really anywhere else we could go. So as she improved, and it was really helpful to hear from the counselors and Dr. Warren, “okay, I have seen this before, and this has happened before, this is typical, this will change, this will get better,” the whole group really helped.

**Discussion and Additional Findings of Second Interview Member Checking**

After the data from the initial interview with parents were analyzed and organized, six participants participated in a second interview, lasting approximately 30 minutes, in which the researcher discussed the results of the first interview via member
checking. The other two participants who participated in the initial interview both had informal contact with the researcher, which validated the themes which emerged within this study, but did not participate in the formal, recorded, second interview. Mrs. Potts was unable to come to CCED due to distance concerns; also her daughter was engaged in mood disorder treatment at another facility. However, she spoke with this researcher informally and received a written summary of the themes, which she validated. Mr. and Mrs. Kinston’s daughter, after the initial interview, attended a residential treatment facility in another state. Although they received a written summary of the themes, they were unable to attend the second interview due to distance and their daughter being treated in another state. They informally endorsed the themes discovered in this study via telephone conversation.

**Burns’ Second Interview Results**

This section discusses the second interview with Mr. Burns, during which new information and experiences were shared, and he expressed strongly differing opinions of a modified Maudsley treatment process as presented in his first interview. When Mr. Burns attended the second interview, his perceptions of Maudsley family therapy had greatly changed from the first interview, and he discussed very different feelings about the Maudsley treatment process. Throughout the second interview, he also appeared agitated and angry as evidenced by his facial expression, choice of words, and his tone of voice. Primarily, he felt strongly that his daughter never had an eating disorder, and was subsequently misdiagnosed by the treatment team at CCED as well as her primary care physician. He stated:
We found that our daughter did not have an eating disorder, was misdiagnosed. The whole time she was being treated we came to realize this was a medical problem and it was being automatically referred into eating disorder [treatment] because she missed her period.

He discussed his opinion that his daughter had a “hormone imbalance” which caused physical manifestations such as amenorrhea and weight loss. He encouraged the treatment team to thoroughly review assessment of eating disorders, as he felt Maudsley family therapy resulted in undue distress for both his daughter and the family system.

When this researcher discussed the results of the first interview, Mr. Burns agreed with aspects of the findings, however, was hesitant to entirely endorse the findings due to his opinion that his daughter never had had an eating disorder. He stated:

All girls, all people count calories, and you’re put into [Maudsley family therapy] and it’s just hell for the kid, hell for the parents, and hell for the sister. I’m not sure how that fits into your study but . . .

He found he experienced a great amount of stress within his marriage, as he assumed a majority of the responsibility for his daughter’s care, in that “I [felt] like I’m doing more than my fair share, and it’s not fair to me.” He also expressed guilt in that his other daughter was “forgotten” while focus was shifted upon his daughter who was in Maudsley family therapy.

He also felt that the psychoeducation given to him by the treatment team at CCED regarding the seriousness of eating disorders invoked undue fear in him and his family.
Fear was used toward us to get the child into the eating disorder program, and so we were kind of bullied into coming into the eating disorder program. The treatment tends to use a lot of fear that you’re going to end up like Karen Carpenter.

However, he found the structure of Maudsley family therapy helpful, particularly as the treatment process was very difficult for his family:

[Maudsley family therapy] was extremely difficult. It was nice to have like, a structure, it was something hopeful that this will get better. At first it was hopeful that this would get her better. Simple enough. But after we complied with [Maudsley family therapy] the weight was up and things pretty much stayed the same or maybe in some cases got worse. Some things got better, they stayed better.

Mr. Burns also experienced the community of parents to be helpful during the initial aspects of the treatment. “At first it was nice to have some kind of association, someone who could talk with us about it, but it grew old real fast.”

Ultimately, the Burns family developed the belief that their daughter did not have an eating disorder, rather a “hormone imbalance.” His final thought in the interview was: That before someone’s referred to hospitalization or a treatment center to treat an eating disorder, that there should be a full workup to be sure there is not an underlying medical condition that might be the cause of either the behavior or losing weight, whatever the case is. I know that is not always the case with
psychiatric illnesses, but that should be extremely important. That would be my advice.

Additional Findings From the Second Interview

During the first interviews, DTP programming had one weekly parents-only support group. However, during the time frame of the second interviews, DTP had begun twice-weekly parents-only support groups. Mrs. Masey’s and Mr. and Mrs. Gold’s adolescents with eating disorders were engaged in DTP during both of the aforementioned schedules. Both sets of parents found the additional parents-only support group very helpful. Mrs. Masey stated:

I hope it’s okay to reference coming back [to DTP] a second time. When you guys changed your approach, which was you put the parents to talk amongst each other with a facilitator rather than teaching us a concept . . . and then as we got to know one another and the process of parenting conversation, they warmed up and I warmed up and things got much, much better.

Mrs. Gold also commented on the schedule change:

And it was so helpful to add the group for the parents, you know, which had changed from the initial schedule, and I felt that we did, it was so helpful to just hear from other parents, it was very supportive for us.

Ultimately, these participants expressed a strong appreciation for the additional parents support group.
Summary of Chapter 3

This chapter presented the research findings from this phenomenological investigation on the experiences of parents of adolescents with eating disorders initiating a modified Maudsley treatment approach. Various themes gleaned from data analysis suggest there are parallels within participants’ experiences. This structure consisted of three major themes: (a) all-consuming, (b) empowerment, and (c) community. The next chapter examines these themes within relationship to previously researched literature about the treatments of adolescents with eating disorders, particularly within a modified Maudsley treatment approach. Limitations to this study are also presented, and the researcher then provides recommendations for future conversations on parental experiences of a modified Maudsley treatment for their adolescent with an eating disorder.
CHAPTER IV
DISCUSSION

The research question for this study asked: What are the experiences of parents of adolescents with eating disorders who engage in Phase I of a modified Maudsley treatment process? The perspective of parents has been absent from prior investigations on experiences of parents initiating a Maudsley treatment approach. Prior investigations relied primarily on quantitative methodology or narrative descriptions of the Maudsley treatment approach for both professionals and parents. In this chapter, the data are summarized, interpreted, and conceptualized with current scholarly literature. Implications for the counseling field and the eating disorder treatment community, as well as limitations of the study, are discussed. Direction for future research is also suggested.

Main Findings

The results of this research project suggest there are three major themes supported by the data from many of the participants: (a) empowerment, (b) all-consuming, and (c) community. Empowerment was the process through which participants assumed increased control over the eating disorder through psycho-education, support, and feedback from others, despite guilt and fear. The theme of all-consuming illustrates the completely encompassing nature of a modified Maudsley treatment process as experienced by the participants, which required high levels of involvement and determination in the face of “hellish” behavioral outbursts by the adolescents. The theme of community illustrated participants’ experiences of isolation at the onset of the
treatment process, however, through interactions with other parents, the CCED staff, and the day treatment program within the modified Maudsley treatment process, they developed a sense of belonging, support, and community.

The participants’ discussions regarding their experiences of Phase I of a modified Maudsley treatment process for their adolescent with an eating disorder support the aforementioned themes, as well as provide impetus for further research and subsequent scholarly dialogue regarding the subjective experiences of parents within Phase I of a modified Maudsley treatment process.

Empowerment

Results of this study suggested participants went through a process during which they experienced initial guilt and fear; however psycho-education and support from clinicians empowered participants to manage and facilitate recovery for their adolescent child within Phase I of a modified Maudsley treatment process. Participants within this study disclosed various avenues, such as books and websites, through which they ultimately found themselves holding a sense of empowerment via resourcefulness within the process of combating the eating disorder within a modified Maudsley treatment process.

Guilt and fear. Data from this study suggested that participants experienced a great amount of guilt and fear upon discovering that their adolescent had an eating disorder. This experience may have stemmed from feeling as if they themselves may have caused the eating disorder. Participants also expressed guilt and fear due to not being aware of the development of the eating disorder and subsequently not “catching the
eating disorder” in a more timely fashion. This experience aligns with scholarly literature (Lock & Le Grange, 2001; Wertheim et al., 2002) as well as books for and by parents of adolescents with eating disorders (Brown, 2010; Collins, 2005) that described how parents may react upon discovering the eating disorder. Recognition of the presence of an eating disorder can be a slow process, particularly as parents may not fully understand the ways to identify aspects that may suggest development of an eating disorder (Cottee-Lane et al., 2004; Lask & Bryant-Waugh, 1993).

Scholarly literature describes the development of an eating disorder as having numerous influencing risk factors, such as biological predisposition and environmental cues (Fairburn et al., 1999; Keel & Klump, 2003; Polivy & Herman, 2002). With the advent of Maudsley family therapy, levels of pathology regarding the causation of eating disorders are not placed upon the family system (Lock et al., 2001). Maudsley family therapists may consider normalizing parental guilt and fear, as well as providing education for parents regarding the causation of eating disorders in an attempt to decrease these feelings of guilt and fear and motivate parents towards action. Because participants described guilt and fear as overwhelming, future research may examine any possible relation between parental guilt and fear, and parents’ abilities to assume the necessary control over the adolescent’s eating disorder behavior.

Discussion points from the participants in this study also highlighted their appreciation for the non-pathologizing stance of the modified Maudsley treatment approach, as it served as an arena to relieve the fear and guilt associated with the eating disorder. This stance also motivated participants towards empowerment to take control
of the eating disorder treatment process. The non-pathologizing stance of the Maudsley treatment process is a capstone aspect of the initial aspects of Phase I of the treatment process, particularly as the Maudsley therapist works towards providing support to the family system to treat the eating disorder (Dare & Eisler, 2002; Lock, 2004; Lock & Le Grange, 2001). Additionally, the therapeutic alliance between parents and the Maudsley-based therapist has been purported to be statistically significantly related to positive outcome for the adolescent with an eating disorder as defined by weight gain (Ellison et al., 2012). Therefore, it may be important for the Maudsley family therapist to continuously highlight and model a non-pathologizing stance towards the family system throughout the treatment process.

**Resourcefulness.** When asked to describe ways in which participants came to learn of the Maudsley treatment approach, the majority of participants found books and websites helpful in both learning about and subsequently initiating Phase I of a modified Maudsley treatment process. At the time of the interviews, two books for parents of adolescents with eating disorders within a Maudsley treatment approach were mentioned by participants, Laura Collin’s *Eating With Your Anorexic* (2005), and Lock and Le Grange’s *Help Your Teenager Beat an Eating Disorder* (2005a). Maudsleyparents.org was also perceived as helpful by parents.

One conclusion regarding the importance of books and websites may surround data which suggested parents experience isolation during the initiation of treatment for their adolescent with an eating disorder. Therefore, parents may find an initial sense of community in books and websites prior to the community experienced in various avenues
within the treatment process. This finding regarding the importance of psycho-education and online support also aligns with caregivers of family members with a mental illness perceptions of the helpfulness of Internet support, particularly regarding advice and information (Perron, 2002). Specifically in regards to eating disorders, caregivers have expressed high needs for pragmatic interventions, treatment information, and coping strategies (Haigh & Treasure, 2003). Because participants seemed to place such emphasis on the importance of psycho-education and literature, more writing and literature for parents regarding the Maudsley treatment approach is needed. Specifically, as many eating disorder websites do not adequately address diagnostic criteria or treatment options for eating disorders (Smith et al., 2011), websites and public information that includes accurate and effective information and interventions is warranted.

**Externalization of the eating disorder.** When participants in this study talked about their experiences within a modified Maudsley treatment approach, they discussed their adolescent’s eating disorder as being separate from their adolescent. This seemed to be an important element in the parents’ process, as it provided an avenue through which to conceptualize their adolescent and the eating disorder, particularly as the participants described having difficulty understanding the drastic changes they experienced in their adolescent’s behaviors. An example of this may be the parents differentiating the eating disorder-driven outbursts of the adolescent from the true personality constructs of the adolescent.
This finding aligns with the literature surrounding implementation of Phase I of a Maudsley treatment process in that the Maudsley family therapist’s responsibility is to support the parents as they externalize the eating disorder from the adolescent (Lock & Le Grange, 2001). Phase I indicates the necessity for the therapist and parents to externalize the illness and not regard it as a result of familial pathology or systemic maladjustment (Le Grange, 1993). Externalization of the eating disorder has also been purported to be a significant predictor of effective outcome for those utilizing a Maudsley-based treatment approach (Ellison et al., 2012). Research also suggested the use of externalization of the eating disorder may allow parents to align with the steps necessary to assume control of behavioral aspects of the eating disorder (Pereira et al., 2006). For example, establishing the eating disorder as a separate entity from the adolescent may propel parents to be more willing to engage in the treatment process and subsequent requests of the Maudsley family therapist for parents to completely assume control of the adolescent’s eating disorder behaviors. Suggestions for further research may highlight ways in which Maudsley family therapists and parents conceptualize various manifestations of externalizing the eating disorder.

**Determination.** Within the interviews, participants often discussed experiencing a sense of determination to eliminate the eating disorder, despite difficulties that may have risen with their child, such as behavioral outbursts or arguments. These findings suggest participants, as they came to understand that their adolescent was unable to control eating disorder behaviors, became committed to assume behavioral control over
their adolescent, and relied heavily on support and direction from their Maudsley therapist.

Literature states one of the most important aspects of Phase I is the therapist support for the parents to continue to engage in the re-feeding process, despite any difficulties, negotiations, or arguments from the adolescent (Eisler et al., 1997). The therapist’s role is to provide support for parents as they become empowered to assume control of the eating disorder management (Lock, 2004). Additionally, high levels of parental control over the eating disorder behaviors was shown to be a significant predictor of effective outcomes, as defined by weight gain (Ellison et al., 2012).

One consideration regarding the determination expressed by participants may be the importance that community plays on the levels of parental determination during the treatment process at CCED. Participants received support within the parent support group at CCED, as well as from the treatment team. This may have influenced participants’ level of determination, or provided increased accountability of participants to the community formed throughout the treatment process. Rhodes et al. (2008) found parent-to-parent consultation via a 60-minute session between a parent of an adolescent who had completed Maudsley-based treatment and a parent just beginning the process to have the “potential to augment the Maudsley model of family-based treatment” (p. 105). Specifically, the parent-to-parent consultation served as a means through which the parent beginning the treatment process had decreased feelings of isolation as well as instilled hope in the parents’ abilities to manage the eating disorder behaviors. Future research may explore any possible connections between the importance of community
and levels of determination and follow-through with treatment expectations as parents initiate the treatment process.

**All-Consuming**

Many participants discussed wanting to have involvement in the treatment process rather than being excluded as they initiated a modified Maudsley treatment approach for their adolescent with an eating disorder. Numerous changes within the family system also were described. Results also suggested the experience of participants as being “hell,” as they witnessed numerous changes in their adolescent’s behavior.

**Wanting involvement.** Findings suggested participants wanted to have involvement in the treatment process of their adolescent, rather than be separated from involvement as with a more traditional approach to the treatment of eating disorders, such as individual therapy for the adolescent. The results of the interviews suggested many of the participants were uncomfortable with the notion of “someone else taking care of my child.”

This finding highlights the discrepancy between a traditional (Pike & Wilfley, 1996; Stierlin & Weber, 1989) versus Maudsley-based treatment modality for adolescents with eating disorders (Dare, 1985; Dare & Eisler, 2002; Lock et al., 2001). One interpretation of these results may be that as participants became knowledgeable and resourceful about the Maudsley treatment process, their motivation towards wanting overt involvement increased. Also, research may consider ways to provide education for parents to propel parents to decide to utilize a Maudsley treatment approach, as it is now the “frontline” treatment for adolescents with eating disorders (Lock et al., 2010).
A suggestion for future research is to explore the differences between parents who endorse a traditional versus Maudsley-based treatment approach for their adolescents with an eating disorder. Considerations for research and clinical application may also examine those parents who may not want involvement in the treatment of their adolescent with an eating disorder. Motivational factors related to wanting to engage in a Maudsley treatment process may be of import, particularly if a Maudsley family therapist encounters resistance towards involvement or compliance with the action needed of parents within the process.

**Family changes.** When participants in this study discussed the experiences of their families when initiating Phase I of a modified Maudsley treatment process, many described the numerous systemic and logistical changes that emerged within the family unit. Findings also suggested the importance of communication and agreement between parents regarding issues surrounding re-feeding, such as intake expectations, otherwise the adolescent with an eating disorder could find a way to come between the parents.

These results correspond with the value of engaging the family system in the treatment process (APA 2000a; Lock & Le Grange, 2001). Traditional family therapy has been utilized for the treatment of adolescents with eating disorders since the 1970s, as the individual with the eating disorder affects the entire family system (Lock, 2004; Lock et al., 2001; Russell et al., 1987). Maudsley family therapists encourage all family members to participate in therapy sessions and therapeutic meals, as the family is viewed as being the most valuable resource within the treatment process (Lock et al., 2001). All family members are viewed as integral to the treatment process, as every family member
holds pertinent information regarding the eating disorder and its effects upon both the adolescent as well as the family system at large.

This study examined the experiences of parents of adolescents within a modified Maudsley treatment approach and did not include other family members. Because a Maudsley treatment approach includes all family members, suggestions for researching, understanding, and supporting all family members may be of import. Little literature exists regarding supporting non-parental family members, such as siblings, within a Maudsley-based treatment approach; siblings of adolescents with eating disorders are often understudied and under-supported (Vandereycken, 2002b).

Another consideration for clinical application may be the distinction between the Maudsley family therapist joining the family system processes as they were prior to the treatment process, versus encouraging changes necessitated by treatment. For example, if a family rarely ate a sit-down dinner together prior to the presence of the eating disorder, the Maudsley family therapist must address family dynamics so that the parents ensure the adolescent adequately eats a dinner. Further dialogue is needed regarding the most effective ways the Maudsley family therapist can navigate the dialectic between joining family system processes versus pushing for changes necessitated by the treatment process.

**Hell.** Findings in this study suggest participants experienced “hell” within Phase I of a modified Maudsley treatment approach. As participants described their perception of the process, their experiences suggested the process was very difficult, arduous, and emotional for all involved.
Literature endorses the findings of this study in that families of individuals with eating disorders experience distress and anxiety throughout the treatment process (Graap et al., 2008; Sim et al., 2009). Subsequently, the *Treatment Manual for Anorexia Nervosa* (Lock & Le Grange, 2001) discussed the importance of the therapists’ continual encouragement of the parents to assume control of the adolescent’s behaviors, despite push-back from the adolescent or parental fatigue. However, scholarly literature does not discuss in great detail the possible emotional toll upon the parents of the re-feeding process within a Maudsley-based treatment approach. Within the interviews, participants were the most emotionally expressive when discussing aspects of “hell,” particularly when discussing the vast emotional and behavioral changes in the adolescents.

These experiences of participants are consistent with scholarly literature which depicts aspects of caregiver distress regarding both physical and mental illnesses (Stenberg et al., 2010). In literature describing the caregivers of patients with cancer, anxiety, depression, and distress are often discussed, which is similar to the data which emerged within this research. However, various psychosocial and educational interventions help caregivers of family members with cancer more effectively manage distress (Bultz et al., 2000; Nijboer et al., 2001). Similarly, Haigh and Treasure (2003) hypothesized increased support (pragmatic, emotional, and informative) for caregivers of those with eating disorders may allow for the caregiver to be increasingly effective in the management of the eating disorder. Therefore, continued investigation regarding specific ways in which Maudsley treatment providers can decrease distress is warranted. Another consideration for further research and clinical intervention strategies may be ways in
which community, resourcefulness, and trust in the treatment team may alleviate the experience of “hell” throughout the treatment process.

Some research suggested that parents, particularly mothers, experience caring for an adolescent with an eating disorder as burdensome (Perkins et al., 2004; Santonastaso et al., 1997). Also, a comparison between parents of adolescents with a physical condition that requires close monitoring and those with eating disorders suggested the parents of adolescents with eating disorders experience greater feelings of depression and anxiety than those with adolescents with medical conditions (Graap et al., 2008; Sim et al., 2009; Treasure et al., 2001). One question that arose for the researcher within this study was whether the stigma and reduced social awareness and acceptance of eating disorders may cause greater distress for the families of adolescents with eating disorders, particularly as the general public places levels of stigmatization upon individuals with mental and emotional disorders, as well as eating disorders. (Crisafulli et al., 2010; Crisp et al., 2000; Link & Phelan, 2001; Mond et al., 2006; Stewart et al., 2008). Future research should investigate various ways in which social stigma may influence the experiences of parents with adolescents with eating disorders.

Similar to the parental experiences of “hell,” within Phase I, data suggested participants also may have difficulty enduring various emotional and behavioral changes in their adolescents with eating disorders. The emotional liability of the adolescent, described by some participants as if a monster had taken over the adolescent, seemed to cause participants great distress.
Within the recognition and diagnosis process of the eating disorder, many parents reported drastic changes in personality and presentation within their adolescent with an eating disorder (Collins, 2005; Lock & Le Grange, 2005). A continued conversation as to how clinicians can best support parents regarding their own emotional and personal struggles within Phase I may be beneficial for Maudsley treatment providers. Further research may also explore the difficulties parents may experience within Phase I, lending data to conceptualize ways in which treatment teams and providers might assist parents if they experience emotional and behavioral changes in their adolescent, which may cause distress for the parents. Another clinical consideration may arise between the necessity of the Maudsley family therapist to provide support for parents experiencing distress throughout the treatment process versus the point at which a parent may need to seek his or her own therapeutic interventions. The Maudsley treatment manual (Lock & Le Grange, 2001) solely utilizes a family-based therapeutic approach, however, this researcher is aware of a few rare times in which the treatment team at CCED has recommended individual therapy for parents who presented in distress which surpassed the abilities of the Maudsley family therapist to support or manage.

**Community**

Data suggested participants placed great emphasis on the importance of community within the modified Maudsley treatment process for their adolescent with an eating disorder. This need for community was evident as some participants discussed a sense of isolation during the initial throes of the eating disorder discovery and subsequent treatment. Consequently, the relationships formed between the parents of adolescents
participating in the Day Treatment Program as well as with the treatment staff appeared to be of paramount import for many of the parents.

**Isolation.** Findings suggested participants experienced an initial sense of isolation within Phase I of a modified Maudsley treatment process. The experiences shared by some participants suggested they felt very alone, as if no one could understand their experience. Participants may have been reluctant to share with others their experience due to fear of that friends, family, and co-workers may make pathologizing assumptions regarding the family system. One consideration may also surround whether participants’ experiences of isolation is related to any feelings of guilt or fear. Ways in which treatment providers may decrease levels of isolation, fear, and guilt, and the ways in which these experiences may influence the treatment process, should be explored.

Participants’ feelings of isolation and fear of others’ assumptions aligns with the traditional approach towards the conceptualization and subsequent treatment of adolescents with eating disorders, which places levels of pathology on the family system and does not include parents within the treatment process (Bliss & Branch, 1960; Bruch, 1985; Morgan & Russell, 1975). One suggestion for future research and conversation may surround whether parents have increased hesitancy to endorse the Maudsley treatment process for fear of repercussions or disapproval from others. Within general eating disorder treatment, research suggested those with eating disorders do experience a level of stigmatization (Crip et al., 2000; Mond et al., 2006), ranging from beliefs regarding the etiology of eating disorder development to personality constructs of those with eating disorders. Another cause for conversation may be how to best help parents
access support and manage erroneous assumptions or assertions held by others, such as extended family members, teachers, and friends who are unfamiliar with the Maudsley treatment approach.

**Day Treatment Program relief.** Data from interviews suggested participants experienced a sense of relief when their adolescent with an eating disorder begins the Day Treatment Program (DTP). Participants discussed DTP as providing a respite from the constant supervision of the adolescents necessitated by the modified Maudsley treatment process. Subsequently, results also suggested participants experienced a sense of relief because their adolescent was being well-taken care of by trained professionals.

These results are not present in current literature, as a higher level of care, such as DTP within a Maudsley framework, is not an option at any other treatment facility in the nation. However, data surrounding day treatment programs within a generalized treatment approach have suggested effectiveness regarding weight gain and behavioral and attitude measures (Goldstein et al., 2011). Haigh and Treasure (2003) found caregivers of those with eating disorders expressed a strong need for pragmatic support and assistance, particularly at meal times. A suggestion for future research is the exploration of ways in which parents of adolescents within a Maudsley treatment process may find respite from the intense and constant supervision of their adolescent during the initial throes of Phase I, particularly in the absence of a higher level of care option. Researchers may also examine whether a higher level of care has any correlational influence on parental burn-out, adolescents’ recovery rates, or parents’ abilities to persevere in the face of any difficulties that may arise within the treatment process.
Community of parents. During the interview process, participants were asked to reflect upon their thoughts of the treatment process. The results strongly suggested participants placed a great deal of value on the relationships formed, both formally and informally, with the other parents of adolescents participating in the Day Treatment Program. Of particular note, participants discussed the significance of not feeling alone and having other parents with whom to share stories, problems, and triumphs.

This finding contrasts with the current literature on Maudsley treatment in that the Maudsley treatment manual (Lock & Le Grange, 2001) solely depicts the model as being weekly, out-patient treatment, without any subsequent groups such as parent support groups or higher levels of care considerations. Some participants discussed feeling as if the relationships formed with other parents were beneficial in that they provided accountability and encouragement that they were “doing the right thing” by engaging in a Maudsley treatment process. This finding aligns with one study, which utilized parent-to-parent consultation, during which time parents expressed having a strong bond with other parents of adolescents with eating disorders, which decreased feelings of isolation and provided a source of encouragement (Rhodes et al., 2008). Therefore, research regarding arenas through which parents engaging in a Maudsley treatment process might receive or access support from other parents may be of merit. Research may also explore whether levels of support has any impact upon the experiences and ability to initiate and have continued engagement within a Maudsley treatment process.

Trusting the Cleveland Center for Eating Disorders. Data suggested an integral aspect of a modified Maudsley treatment process for participants was the
supportive community found at CCED. Relationships formed with the treatment team members, as well as the importance of receiving consistent messages from the team, seemed to be very important throughout the treatment process.

These findings endorsed the significance of treatment teams as described by Lock and Le Grange (2001), particularly as the treatment of adolescents with eating disorders is multidisciplinary in nature (Guarda & Heinberg, 2004; Kaplan, 2002). Consistent messages from the treatment team regarding the treatment process were pertinent for participants in this study, such as feedback for parents, and management of the adolescent with the eating disorder. Considerations regarding ways in which treatment teams can be consistent may be useful in fostering trust among parents and the treatment team. Subsequently, examining trust as a tool through which the Maudsley treatment team elicits motivation from parents to initiate and engage in treatment may be useful.

One of the Maudsley family therapist’s most important jobs is to establish a therapeutic alliance with the family, particularly the parents, through assuming an authoritative stance while also being warm and accepting (Lock & Le Grange, 2001; Pereira et al., 2006). Additionally, therapeutic alliance between the parents and Maudsley therapist has been shown to be a statistically significant predictor of successful outcomes, as defined by weight gain, within a Maudsley-based treatment approach (Ellison et al., 2012). Future research may consider specific ways for treatment teams and parents to most effectively foster relationships and trust.
Additional Findings

The main findings were pertinent to the participants and led towards the development of several main themes. However, there were additional findings, both within the interviews as well as the process of this research study, which are noteworthy. Additional findings included the non-linear treatment process of families engaging in a modified Maudsley treatment process, the motivations of participants to participate in this study, this researcher’s experiences in the parent support group sessions after the data analysis for this research was completed, and the differing opinions of one participant. In this section, these findings are discussed and interpreted, and areas for future research are suggested.

Non-Linear Treatment Process

This research project had several different iterations of determining criteria for participation in the study. Initially the requirements were that the adolescent engaged in DTP immediately after the assessment, engaged in DTP for a minimum of four weeks, and had two parents in the home. However, this researcher discovered the treatment process for many families was non-linear, in that some families attempted outpatient Maudsley family therapy initially and utilized DTP as a “back-up” plan or means to stabilize the adolescent’s eating disorder behaviors for a short period of time. Also, many families did not have two parents in the home, or one parent may have assumed almost full responsibility for the re-feeding process.

As these data emerged, the researcher found it necessary to make the requirements for participation in this study less stringent. All changes for recruitment
and participation requirements were approved through the Internal Review Board of Kent State University. This finding is pertinent in that it provides clinicians information regarding the possible non-linear process of eating disorder treatment and varying demographics of families who engage in a Maudsley treatment process. A consideration for future research may explore the juxtaposition of “pure” Maudsley family therapy and the use of a higher level of care, particularly in light of the non-linear process of treatment.

Motivation for Participation

Participants in this study seemed very willing to engage in the interviews and also seemed hopeful their contributions would be helpful for other parents in the future who engage in a Maudsley treatment process. As this researcher concluded the interviews, and subsequently thanked the participants, many referenced their motivation for participation in this study was to help other parents as well as to find meaning or a positive outcome in their experience within the treatment process for their adolescents with an eating disorder.

Experiences in Parent Support Group Sessions After Data Analysis

An additional finding to note was this researcher’s experiences within the support group sessions after data analysis for this project was completed. This researcher observed numerous parent support groups, and began to notice how other parents of adolescents participating in the DTP at CCED unknowingly endorsed the findings of this study. For example, after discussing her experiences with her daughter’s treatment process, one mother exclaimed to the group, “It’s all-consuming!” Also, parents would
discuss other findings discovered in this study, such as the importance of externalizing the eating disorder, relationships with other parents and CCED, and assorted ways in which parents worked towards holding a sense of empowerment over the eating disorder. Harriet Brown, who chronicled her family’s experience of Maudsley treatment in *Brave Girl Eating* (2010), visited a group of parents at CCED during the spring of 2011. While addressing the parents, she overtly stated that she wished she had had a supportive group of parents when initiating Maudsley-based treatment for her daughter. She further stated she had felt quite alone during the throes of treatment and felt she would have benefited from the supportive community the parents establish at CCED. Therefore, this researcher experienced a sense of validation in the research findings.

Two sets of participants in this research project participated in the Day Treatment Program when it had both the once-weekly parent support group as well as the twice-weekly parent support group. During the second interviews, both sets of participants discussed their perceptions that the additional parent support group was helpful and informative. Ultimately, subjective experiences of both this researcher as well as participants suggested the additional parent support and community of parents was increasingly beneficial for other parents. Also, one hypothesis may be that the additional parent group allowed for increased levels of community and friendship between parents of adolescents with eating disorders.

**Differing Opinions of One Participating Parent**

During the second interview, one participant in the study, Mr. Burns, had a very different experience of Maudsley family therapy than during the first interview. He felt
his daughter was misdiagnosed as having an eating disorder by the treatment team at
CCED and her primary care physician. Upon seeking a second opinion months after
initiating Maudsley-based treatment, he came to believe his daughter solely had a
“hormone imbalance.” He strongly suggested a more thorough assessment process for
individuals with suspected eating disorders. Mr. Burns felt he and his family had
unnecessarily engaged in Maudsley family therapy, which was arduous and caused
distress for the entire family system.

Assessment for eating disorders should be thorough, including considerations for
weight, and dietary history, mental status, medical stability, social and developmental
history, self-report measures and standardized interviews (Crowther & Sherwood, 1997;
Halmi, 2002; Palmer, 2000). Suggestions for clinical application may be continuing
thorough assessments of eating disorders and managing differing opinions between
parents and treatment providers. Also, because the results of this study, as well as
scholarly literature, suggest trust between parents and the treatment team is an important
aspect of participants’ experiences of Maudsley family therapy, exploration of ways in
which the treatment team can align with the family system within a Maudsley treatment
process may be beneficial.

Implications

The findings of this study and subsequent connection to current literature
regarding parental experiences of Phase I of a modified Maudsley treatment process
contained implications for theory, research, and clinical application. Implications for
theory and research may consider various avenues, such as possible higher levels of care,
through which a Maudsley treatment approach may be most effective, as well as manifestations of supportive structures for parents. Implications for clinical application include recommendations and suggestions for the practice of counseling and Maudsley-based eating disorder treatment in general. This section reviews implications in both of these areas, as well as implications for CCED.

**Areas for Further Research, Theory, and Dialogue**

Findings of this study suggested participants experienced some of the capstone aspects of a Maudsley treatment process as important, as noted in Lock et al.’s *Treatment Manual for Anorexia* (2001). As previously stated, externalization of the eating disorder, continued support of the parents, and the therapeutic alliance with the Maudsley therapist seemed to be integral aspects of the participants’ experiences. Possible future research should focus upon the ways in which the Maudsley treatment process can expand these specific therapeutic approaches that are helpful for parents.

Findings of this study also suggested participants placed importance on a higher level of care (DTP). “Pure” Maudsley family therapy, which solely utilizes an outpatient model, does not allow for considerations of a higher level of care, such as a day treatment or intensive outpatient program. Research and scholarly dialogue should address the possible clinical efficacy of a higher level of care, both for the treatment of the eating disorder and the manifestations of a higher level of care upon the experiences of parents engaging in Phase I of a Maudsley-based treatment process.
Implications for Clinical Application

The findings of this study also have implications for the field of counseling as well as for eating disorder treatment practitioners. Participants seemed to place great emphasis on the importance of the non-pathological stance that Maudsley family therapy assumes. Counselors and the eating disorder treatment community may take note of this finding and apply it clinically, particularly as traditional eating disorder treatment places levels of pathology upon the family system and parents. This non-pathologizing stance may also serve as a way through which the therapeutic alliance is established, as the Maudsley therapist works to engage the family in the Maudsley treatment process.

Another implication for the practice of counseling emerged as participants also discussed the importance of the therapeutic alliance with both the Maudsley family therapist and the treatment team, particularly when experiencing difficulties with managing behavioral aspects of the eating disorder as well as managing parental stressors and concerns. As Phase I is initiated, the Maudsley-based treatment team may consider being vigilant in forming meaningful and supportive relationships with parents, both as an instrument for change within the family system to address the eating disorder, as well as to provide a means through which parents may access and subsequently utilize the supportive environment the treatment team may provide.

Implications for CCED

At the time of the interviews for this research project, parents of adolescents participating in the Day Treatment Program were required to participate in three, 1-hour groups per week: two Dialectical Behavioral Therapy groups, during which time DBT
skills were taught to both parents and adolescents, as well as one parents-only support group, which was facilitated by a member of the Adolescent Treatment Team at CCED. During this hour, parents had an opportunity, in the absence of their adolescents, to develop relationships with other parents and discuss various emotional, logistical, or relational difficulties they were experiencing. Throughout the interviews, this researcher found participants expressing both an overt appreciation for the one hour a week of parent support group, as well as a desire to have more interaction with other parents of adolescents with eating disorders within a therapeutic environment without their children present.

As this researcher began the data analysis aspect of this study, participants’ desire for additional parents-only support group time became increasingly evident. This researcher then began to dialogue with various members of the Adolescent Treatment Team at CCED who also felt that parents could benefit from increased support and psychoeducation about ways to increase parental supports within the Day Treatment Program. Ultimately, programmatic changes were made to the Day Treatment Schedule in order to address these issues, in part due to the findings of this study. The parents now attend two, 1-hour support groups led by various members of the Adolescent Treatment Team staff and one Dialectical Behavioral Therapy group per week. The goals of the parent support groups are two-fold: (a) to provide a safe and supportive environment for parents, and (b) to provide psycho-education to parents about eating disorders in adolescents and the modified Maudsley treatment approach in which the parents are engaged. As a result of the changes to programmatic scheduling, this researcher holds
the opinion that parents have increasingly created a sense of community for themselves, and are more educated about both eating disorders in adolescence and the modified Maudsley treatment approach utilized by CCED.

**Limitations**

The researcher’s relationships with the participants presented several limitations in this study. This researcher was a member of the Adolescent Treatment Team at the Cleveland Center for Eating Disorders during the treatment process of all children of the participants in this study. Therefore, this researcher held knowledge regarding various aspects of the participants’ experiences prior to the interviews conducted for the purpose of this study. Participants in this study held an awareness and experience of their prior relationship with this researcher. This may have several implications regarding limitations of this study. The participants may not have been as forthright about constructive feedback in regards to their experiences of treatment at CCED. Specifically, participants may have held back any negative feedback or experiences as to avoid hurting the researcher’s feelings or to be critical of the program at CCED. Conversely, the participants may have been more forthright due to the prior relationship with this researcher. Also, participants may have assumed the researcher had a prior knowledge of their experiences, lending the participants to not be as verbose in recounting their experience of a modified Maudsley treatment approach.

Another limitation was possible bias of this researcher. This researcher has been an active member of the adolescent treatment team at CCED for almost four years and endorses the modified Maudsley treatment process from both a professional and personal
bias. This researcher believes the Maudsley treatment approach is beneficial for the treatment of adolescents with eating disorders and does not believe other treatment approaches, such as solely individual therapy, are as effective or worthwhile as the Maudsley treatment approach. To limit any possible researcher bias within this study, trustworthiness was established by respondent validation, a peer debriefer, auditing from the dissertation committee members, and reflective field notes.

Another limitation of this research study was the varying degrees of involvement in treatment of families after the conclusion of Phase I of a modified Maudsley treatment approach. Some participants continued to be engaged in various levels of treatment at CCED. However, some have discontinued treatment due to distance concerns or the necessity for a higher level of care, such as residential, which was required for one participating family. Therefore, this researcher discovered a degree of difficulty with the follow-up second interviews due to the varying degrees of continued involvement in care at CCED. Additionally, although the researcher worked towards having a varied sample of participants, the sample of participants was not as diverse as considered optimal due to limitations surrounding those who chose to participate in the study as well as limited variation in demographics of those who presented for treatment at CCED throughout the recruitment process.

**Experience of the Researcher**

The researcher’s experiences within a qualitative project are vital to the research process, therefore, it is important to note the researcher’s personal reactions towards the research topic as well as the research experience in general.
The Cleveland Center for Eating Disorders has encouraged my interest in eating disorders, particularly the treatment of adolescent eating disorders via the Maudsley approach. Therefore, through personal, academic, and professional endeavors, including this research project, I have become a proponent of the Maudsley treatment approach for adolescents with eating disorders, as well as for the need for empirically based treatment.

Overall, this study was extremely meaningful for me, as it provided an opportunity to understand from both a personal and professional level the experiences of parents within a modified Maudsley treatment process. I experienced feeling increasingly empathic for the experiences of parents engaging in a Maudsley-based treatment process, as well as hold a great amount of passion for my work.

**Summarative Interpretation and Conclusion**

As severity and mortality rates for adolescents with eating disorders are quite high, clinicians within the treatment community continue to work towards establishing and implementing evidenced-based treatment options (Berkman et al., 2007; Harris & Barraclough, 1998; Klump et al., 2009; Sullivan, 1997). Data support Maudsley family therapy as being the most effective treatment modality for adolescents with eating disorders, particularly compared to a more traditional approach, which excludes parents from involvement (Eisler et al., 2001; Lock et al., 2010). A Maudsley-based approach involves parents completely in the treatment of the adolescent with an eating disorder and considers parents as the head of the treatment team (Lock et al., 2001). Research regarding the experiences and manifestations of parents within a Maudsley-based
treatment approach is sparse, however, emerging data continue to suggest Maudsley
treatment is the treatment of choice for adolescents with eating disorders.

Within this study, themes from interviews with participants included
empowerment, all-consuming, and community. These themes suggested participants
experienced avenues through which they developed an increased sense of empowerment
within the all-encompassing process, coupled with a strong sense of community and
support from other parents and treatment team providers. As research regarding
caregivers suggests high levels of anxiety, depression, and distress, coupled with results
from this study that highlight the participants’ experience of “hell,” cause for continued
conversation and research within the eating disorder treatment community is needed. This
continued exploration is warranted as parents of adolescents with eating disorders are
highly involved in a Maudsley-based treatment approach (Graap et al., 2008; Sim et al.,
2009; Treasure et al., 2001). Given the high levels of caregiver distress reported in
literature and this study, juxtaposed with data supporting Maudsley-based treatment as
being the most evidenced-based treatment for adolescents with eating disorders, further
investigation regarding the most effective ways that treatment providers can best support
parents within a possibly difficult process is warranted.

As parents within a Maudsley-based treatment approach implement and endure
aspects of the treatment regiment, ways in which the process can be experienced as
effective, or increase parental efficacy, should be explored. A strong sense of community
was experienced by the participants within this study, both through interactions with
other parents of adolescents with eating disorders as well as with the treatment team at
CCED. Appreciation for a higher level of care (such as a Day Treatment Program or Intensive Outpatient Program) was seen by the participants as helpful within the treatment process, highlighting perceived benefits of the treatment team and interactions with others parents who were “in the same boat.” Further research regarding how to best support parents within a Maudsley-based treatment approach, whether through a community of other parents, a higher level of care, or otherwise, should continue to be explored.

Because parents are the head of the treatment team, combating a potentially fatal disease, implications for future research and subsequent clinical implications surrounding avenues through which to sustain parents throughout the treatment process are warranted. Data suggest a Maudsley-based treatment is the most evidenced-based treatment for adolescents with eating disorders; however, further investigation into ways to increase effectiveness and willingness to engage in the treatment process is needed.

This final chapter examined the research findings as related to current literature pertaining to parental experiences of a modified Maudsley treatment approach. Through data analysis, this researcher discovered a particular structure of parental experiences that includes: (a) empowerment, (b) all-consuming, and (c) community. The themes and categories which emerged throughout this study, although suggestive of the experiences of parents of adolescents with eating disorders within a modified Maudsley approach, are not mutually exclusive and ultimately quite interrelated. These over-lapping themes and categories, such as how the theme of community may affect levels of parental
determination, spur cause for further research and exploration into the experiences of parents within a modified Maudsley treatment approach.

It is important to note is that despite some similarities between the participants in regards to a modified Maudsley treatment approach for their adolescent with an eating disorder, each participant had a unique experience. The personal experiences of these participants should be appreciated as richly unique, which is easily forgotten when examining the entirety of parental experiences within a modified Maudsley treatment process.

The results of this study provide avenues through which the eating disorder community can begin to better understand the experiences of parents within a modified Maudsley treatment approach. This researcher holds hope that these results will spur continued conversation and research within the clinical practice of the Maudsley approach for adolescent eating disorder treatment.
APPENDICES
APPENDIX A

*DSM-IV-TR* DIAGNOSTIC CRITERIA FOR ANOREXIA NERVOSA
Appendix A

*DSM-IV-TR* Diagnostic Criteria for Anorexia Nervosa

307.1 Anorexia Nervosa is classified by the following:
   a) Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
   b) Intense fear of gaining weight or becoming fat, even though underweight.
   c) Disturbance in the way in which one’s body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
   d) In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone, e.g., estrogen, administration.)

Specifying types:
   a) Restricting type: during the current episode of Anorexia Nervosa, the person has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).
   b) Binge-Eating/Purging type: during the current episode of Anorexia Nervosa, the person has regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics or enemas; APA, 2000).
APPENDIX B

DSM-IV-TR DIAGNOSTIC CRITERIA FOR BULIMIA NERVOSA
Appendix B

DSM-IV-TR Diagnostic Criteria for Bulimia Nervosa

307.51 Bulimia Nervosa is classified by the following:
   a) Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
      1) Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period of time and under similar circumstances.
      2) A sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).
   b) Recurrent inappropriate compensatory behavior in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, enemas, or other medications; fasting; or excessive exercise.
   c) The binge eating and inappropriate compensatory behaviors both occur, on average, at least twice a week for 3 months.
   d) Self-evaluation is unduly influenced by body shape and weight.
   e) The disturbance does not occur exclusively during episodes of Anorexia Nervosa.

Specifying types:
   a) Purging type: during the current episode of Bulimia Nervosa, the person has regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas.
   b) Nonpurging type: during the current episode of Bulimia Nervosa, the person has used other inappropriate compensatory behaviors, such as fasting or excessive exercise, but has not regularly engaged in self-induced vomiting or the misuse of laxatives, diuretics, or enemas (APA, 2000).
APPENDIX C

DSM-IV-TR DIAGNOSTIC CRITERIA FOR EATING DISORDER, NOT OTHERWISE SPECIFIED
Appendix C

DSM-IV-TR Diagnostic Criteria for Eating Disorder, Not Otherwise Specified

307.5 Eating Disorder Not Otherwise Specified is classified by the following:
   a) For females, all of the criterion for Anorexia Nervosa are met except that the individual has regular menses.
   b) All of the criterion for Anorexia Nervosa are met except that, despite significant weight loss, the individual’s current weight is in the normal range.
   c) All of the criteria for Bulimia Nervosa are met except that the binge eating and inappropriate compensatory mechanisms occur at a frequency of less than twice a week or for a duration of less than 3 months.
   d) The regular use of inappropriate compensatory behavior by an individual of normal body weight after eating small amounts of food (e.g., self-induced vomiting after the consumption of two cookies).
   e) Repeatedly chewing and spitting out, but not swallowing, large amounts of food.
   f) Binge-eating disorder: recurrent episodes of binge eating in the absence of the regular use of inappropriate compensatory behaviors characteristic of Bulimia Nervosa (APA, 2000).
APPENDIX D

PROGRAM DESCRIPTION AT CCED
Appendix D

Program Description at CCED

Introduction

The Cleveland Center for Eating Disorders (CCED) is committed to providing effective treatment for children, adolescents and adults suffering from an Eating Disorder. Our treatment center prides itself on taking the most up to date research and translating it into individualized programming for patients afflicted with Anorexia Nervosa, Bulimia Nervosa, Binge Eating Disorder, and Eating Disorder Not Otherwise Specified (EDNOS). Our treatment model allows us to provide an intensive level of care in a manner that is least interfering with day to day life, and is most cost effective.

Child and Adolescent Programming

Our Adolescent programming draws from three statistically effective treatments: the Maudsley approach for family-based therapeutic services; Dialectical Behavior Therapy (DBT) which teaches skills in effective emotion regulation; and Cognitive Behavioral Therapy (CBT), considered to be the backbone of any effective eating disorder treatment. Psychiatric evaluation and treatment are also provided by our staff Psychiatrist, Dr. Warren. All adolescent clients will be required to be medically monitored either by a physician of their choice, or one of our allied pediatric physicians who specializes in treating the medical concerns of adolescents with Eating Disorders. There are several levels of care available for adolescents suffering with and Eating Disorder, and their families. Adolescent group programming is typically open to children ages 10-18. Children younger than 10 will be treated with a ‘pure’ Maudsley format, as described below.

Day Treatment Programming (DTP)

The Adolescent DTP meets 3-5 days per week, 5-6 hours per day. The number of days in DTP each week is determined by the specific needs of the adolescent, however in most cases adolescents beginning the DTP program will start at 5 days per week. This treatment format allows our adolescent clients to have two meals and one snack on-site, participate in peer support, DBT, and CBT skills groups, and evening programming with their parents 3 nights per week. Clients and their families will have weekly family meetings, to facilitate the recovery process at home and to support the family during this difficult time. Clients will also have weekly meetings with the psychiatrist as needed. At the beginning of the DTP treatment process, parents and their adolescent will meet with our staff dietitian for advice and information on providing nutritionally and calorie appropriate meals. All meals and snacks are provided by parents.

Intensive Outpatient Programming (IOP)

The Adolescent IOP Program consists of 3 hours of group treatment, 1-3 days per week. The number of days of treatment each week is determined by the specific need of each adolescent. Specifically, treatment includes adolescent peer support, DBT and CBT skills groups, parent participation for one hour each evening, and a Maudsley oriented family therapy session each week. Weekly psychiatric visits are
provided as needed. Parents attend twice weekly groups to learn the DBT skills along with their children and thus can help support skill use at home. One evening per week, parents have their own group, led by one of our experienced professionals. During this group parents of all our adolescent clients share support and feedback.

In order to best meet the needs of individual families, a family meeting will be required one time per week to help families generalize the skills taught in group, as well as work through problems that arise while implementing the treatment at home.

“Pure” Maudsley Program:

Some families may opt to address their child’s or adolescent’s Eating Disorder using only Maudsley treatment. In its purest form, the Maudsley method of treating an Eating Disorder suggests that parents are the key to success, and the leaders of the treatment team. Parents take responsibility for planning, providing and supervising all meals and snacks, with the guidance and support of weekly family meetings. This method may be most successful for families with young children experiencing an Eating Disorder, families who are interested and committed to a higher level of care in their home setting, families who live a distance from CCED, or for children whose Eating Disorder symptoms would suggest this level of care.

Our treatment program is lead by Lucene Wisniewski, PhD and Mark Warren, MD. If you have any further comments/questions or wish to schedule an appointment, feel free to contact us at 216-765-0500, or e-mail info@edcleveland.com.

Reference: http://www.edcleveland.com/program.html
APPENDIX E

COMPARISON OF MAUDSLEY TREATMENT AND MODIFIED MAUDSLEY TREATMENT
Appendix E

Comparison of Maudsley Treatment and Modified Maudsley Treatment

<table>
<thead>
<tr>
<th>“Pure” Maudsley Treatment</th>
<th>Modified Maudsley Treatment at CCED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Once-a-week Maudsley family therapy with a Maudsley family therapist.</td>
<td>Once-a-week Maudsley family therapy with a Maudsley family therapist.</td>
</tr>
<tr>
<td>Client does not participate in therapeutic group programming (DTP or IOP).</td>
<td>Client participates in therapeutic group programming (DTP or IOP).</td>
</tr>
<tr>
<td>Traditionally utilized for the treatment of children younger than 12.</td>
<td>The average age of adolescents in the therapeutic group programming is 13-17.</td>
</tr>
<tr>
<td>Parents utilize the support of the Maudsley family therapist in order to take control of their child’s recovery and treatment.</td>
<td>Parents utilize the support of the Maudsley family therapist, family group meetings, and parent support groups within the DTP and IOP programming structure in order to take control of their child’s recovery and treatment.</td>
</tr>
<tr>
<td>The Maudsley family therapist helps the family navigate the three phases of Maudsley treatment.</td>
<td>The Maudsley family therapist helps the family navigate the three phases of Maudsley treatment.</td>
</tr>
<tr>
<td>The parents are thought to be head of the treatment team for their adolescent with an eating disorder, with the Maudsley family therapist supporting the family.</td>
<td>The parents are thought to be head of the treatment team for their adolescent with an eating disorder. The adolescent treatment team, with the Maudsley family therapist, works towards supporting the family as well.</td>
</tr>
</tbody>
</table>
APPENDIX F

RECRUITMENT FLIER
Attention Parents!!!!

Announcing a research study surrounding the experiences of parents of adolescents within the Maudsley Treatment Approach

Participation in this study includes one interview and one brief “check-in.”
*Not participating in this study will not affect your child’s treatment at CCED*

Participants will receive a $25 gift card to Target as thanks for participating.

If you are interested in participating, please contact Claire McCullough at 216.765.0500 x417 or email cmccullough@eatingdisorderscleveland.org
Appendix G

Information Contact Form

Parents’ names: __________________________________________________________

Mailing Address:
_______________________________________________________________________
_______________________________________________________________________

Phone Number:________________________________________

Alternative Phone Number(s):_____________________________

Email Address:_________________________________________

Preferred Method of Contact:______________________________

Any Further Comments or Questions:
APPENDIX H

SCREENING FORM
Appendix H

Screening Form

Screening Questions:

1. When did you initiate treatment at CCED for your child’s eating disorder (must be within the last 12 months)? __________________________________________

2. Did your child participate in the Day Treatment Programming at CCED at any point in the treatment process (must be yes)?
   _______Yes ________ No

3. How old is your child who received treatment at CCED? ____________ years old

4. Has your family participated in the Maudsley treatment approach in any prior treatment for your adolescent with an eating disorder other than that received at CCED?
   _________Yes __________ No (If yes, please explain)

5. Would you be able to participate in two audio-taped interviews (one 60-90 minute interview and one 20-30 minute check-in) to explore your experiences of your child’s treatment within the Maudsley treatment approach?
   __________ Yes ____________ No

What are times that are convenient for you to schedule the interview?

Monday:__ (Date/Time) ____________________________________________

Tuesday:__ (Date/Time) ____________________________________________

Wednesday:__ (Date/Time) ____________________________________________

Thursday:__ (Date/Time) ____________________________________________

Friday:__ (Date/Time) ____________________________________________
Appendix I

First Interview Topics Schedule

Please describe:

1. The situation surrounding the identification and diagnosis of your child’s eating disorder, and your reaction to the identification of your child’s eating disorder.
2. The process through which you found and ultimately chose the Maudsley treatment approach at CCED.
3. Any prior eating disorder or psychological treatment your child has received.
5. Your expectations and hopes at the onset of implementing the Maudsley treatment approach.
6. Your experiences of ultimately implementing the Maudsley treatment approach.
7. The way in which you and your parenting partner expected to participate in your child’s treatment. (Levels of involvement).
8. The way in which you and your parenting partner ultimately participated in your child’s treatment. (Levels of involvement).
9. Any difficulties or relevant issues that you expected or (did not expect) to arise throughout the Maudsley treatment approach (managing eating disorder behaviors, choosing foods, etc.).
10. How you feel the Maudsley treatment approach has supported you throughout your adolescent’s treatment process?

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11. How you as the parents experienced the various issues and processes that arose throughout the Maudsley treatment approach?
Appendix J

Recruitment Letter

Dear (Participant Name):

My name is Claire McCullough and I am a doctoral student at Kent State University. I am also an employee of the Cleveland Center for Eating Disorders and am a member of both the Adult and Adolescent Treatment Team.

I am currently working on my dissertation in Counselor Education and Supervision and am recruiting volunteer participants for a research study on the experiences of parents within the Maudsley treatment approach for adolescents with eating disorders. I am interested in the ways in which parents experience the Maudsley treatment approach as their adolescent navigates the path towards recovery. **Your child will not be interviewed or be involved in this research study at all.**

**I sincerely hope you may be interested in participating in this study!!!**

After I receive your information and ensure that you meet criterion for participation, I will contact you to schedule the first interview. I would like both parents to be able to attend the first interview, however, if only one parent is able to attend, that is fine. The interview will be held at a day and time most convenient for you. The location for the interview will be at CCED. This packet also includes a list of topic areas to be addressed during the interview. Please also note that all interviews may include other questions or discussions based upon your responses.

I am looking for approximately five to ten parenting couples to participate in this study. Therefore, even if you meet criteria for participation in this study, you may not be scheduled for an interview depending upon the number of responses I receive.

You will sign Consent Forms for the research study and the Audio-Taping Consent Form at the beginning of the first interview. No information will be included in the publication of these research findings which would reveal the identity of any participants.

After the first interview, we will schedule a second interview “check in” at a time convenient for you. This interview is to validate what I learned from our prior conversation. You will receive a **$25 gift certificate to Target at the end of the first interview** to express my thanks for participating in this research project.
This project holds no immediate risk for you beyond any distress experienced in every day life. If you experience any distress within the interview process, you will have the opportunity to discuss this with your Maudsley family therapist.

If you have any questions about this study or these forms, please do not hesitate to contact me at 216.246.7883, 216.765.0500 ext. 417, cmccullough@edcleveland.com. You may also contact my dissertation advisors, Dr. Jason McGlothlin or Dr. Jane Cox at 330.672.2662. This study has been approved by the Kent State Institutional Review Board. If you have any questions about the rules for research at Kent State University, you may also contact Dr. John L. West, Vice President and Dean, Division of Research and Graduate Studies at 330.672.2704. You may also contact Dr. Lucene Wisniewski, Clinical Director of the Cleveland Center for Eating Disorders at lwisniewski@eatingdisorderscleveland.org or 216.765.0500 ext. 403 if you have any questions about this study or programming at CCED.

Sincerely,

Claire B. McCullough, LPCC-S, NCC
Doctoral Candidate, Kent State University
Appendix K

IRB Approval

December 4, 2008

Cheryl Boyenga McCullough

ACHVE

Research Experiences of Phase I of a Modified Maudsley Treatment Approach for their Adolescent in an Eating Disorder: A Qualitative Approach

Dear Mrs. McCullough,

I am pleased to inform you that the Kent State University Institutional Review Board has reviewed and approved your Application for Approval to Use Human Research Participants in Level II research through the expedited review process. This was approved on December 3, 2008. Approval is effective for a twelve-month period, December 3, 2008 through December 2, 2009.

Federal regulations and Kent State University IRB policy require that research be reviewed at intervals appropriate to the degree of risk, but not less than once per year. The IRB has determined that this protocol requires an annual review and progress report. The IRB will forward an annual review reminder notice to you by email as a courtesy. Please note that it is the responsibility of the principal investigator to be aware of the study expiration date and submit the required materials. Please submit review materials (annual review form and copy of consent form) one month prior to the expiration date.

NIH regulations and Kent State University Institutional Review Board guidelines require that any changes in research methodology, protocol design, or principal investigator have the prior approval of the IRB before implementation and continuation of the protocol. The IRB must also be informed of any adverse events associated with the study. The IRB further requests a final report at the conclusion of the study.

Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); ID #WA Number 0000283.

If you have any questions or concerns, please contact me at 330-672-7704 or christine@kent.edu.

Sincerely,

Gwen Frederick
RN, BSN
Research Compliance Administrator

C: Jason McGlothlin, Ph.D.
Jane Cox, Ph.D.
APPENDIX L

AGENCY CONSENT FORM
Appendix L

Agency Consent Form

This study is being conducted at the Cleveland Center for Eating Disorders (CCED) to understand parents’ experiences of implementing Phase 1 of the Maudsley treatment approach for their adolescent with an eating disorder. As the referring agency, you are being asked to consent for your agency to participate in this study. The parents who meet criteria for participation in this study will participate in a total of two interviews, and be asked to discuss their expectations and experiences of implementing Phase 1 of the Maudsley treatment approach for their adolescent with an eating disorder. The interview questions will be scripted and will also have follow-up questions.

The interviews will be conducted much like a conversation and will be audio-taped and then transcribed. The interviews will take place in my office at CCED. The parents participating in this study will have an opportunity to withdraw from participation in this study at any time. The interviews will not include any of the adolescents being treated by CCED. The parents, at the conclusion of the first interview, will receive a $25 Target gift card to use at their discretion.

Only I will know what the parents say and do in this study. All reasonable steps will be taken to ensure their identity is protected. No one will have access to the recordings of the interviews, except me and an outside transcriptionist. The recordings will be locked throughout the study. Only my dissertation committee will have access to the interviews or other research materials. Any participants’ names will be changed in any reports.

If you have any questions or concerns, please contact Claire McCallough, Doctoral Candidate, or Dr. Jason Medlovein or Dr. Jason Cooper within the Counseling and Human Development Services Department at Kent State University at 330.672.2662. This project has been reviewed and approved by the KSU IRB Human Subjects Committee.
I have read this consent form, and any questions I asked have been answered to my satisfaction. I agree to consent for this agency, the Cleveland Center for Eating Disorders, to participate and I have the authority to consent participation. I understand the patient’s participation will include audio-recording.

[Signature]
Dr. Lucinda Wilenski, Clinical Director

[Signature]
Dr. Mark Warren Medical Director

CM McCullough, Doctoral Candidate,
Claire McCullough, Doctoral Candidate,
Appendix M

Consent Form

Parental Experiences of a Phase I of a Modified Maudsley Treatment Approach for their Adolescent Child with an Eating Disorder: A Qualitative Study

I would like to do research on parents’ experience of the Modified Maudsley treatment approach for their child with an eating disorder. I would like to do this research because I am professionally and personally interested in the experience of parents of an adolescent who has an eating disorder, particularly within the Maudsley treatment approach. I would like you to take part in this project.

If you decide to participate in this study, you will be asked to participate in one 60-90 minute interview and one brief 20-30 minute check-in. It is my hope for both parents to attend both interviews, however if only one parent is able to attend the interview, that is fine. The interviews will be audio taped and will be scheduled at a time most convenient for you. The second interview will be scheduled upon completion of the data analysis. I may also reference your intake information held by CCED to provide me with additional data for this study.

After interviews, I will transcribe the interviews and keep all findings and transcriptions confidential. I may utilize the assistance of an outside transcriptionist who will also treat all information as confidential. All audio tape recordings and transcriptions of interviews will be kept confidential in a locked space. I may also access intake information held by CCED to further supplement my data collection and understanding of your experience. No information will be included in the publication of these research findings, which would reveal the identity of any participants. The risk of participation in this study is no more than the risks encountered in every-day life.

The findings of this research project will be published in a doctoral dissertation in Counselor Education and Supervision, and may be published in a scholarly journal or presented at local, state, or national professional conferences.

If you take part in this study, you will have the opportunity to reflect upon your experiences with the Maudsley treatment approach within your child’s eating disorder treatment process. The interview questions are intended to allow you and your parenting partner to reflect on this experience. Participation in this project is entirely up to you, and at any point you may stop participation without consequence. No one will hold it against you if you decide not to participate in this study. At the conclusion of the first interview, you will receive a $25 gift certificate to Target to thank you for your participation in this study.
If you would like to understand more about this research project, please contact me at 216.246.7883 or claire.mccullough@yahoo.com. You may also contact my dissertation advisors, Drs. Jason McGlothlin and Jane Cox at 330.672.2662. Dr. Lucene Wisniewski, Clinical Director of the Cleveland Center for Eating Disorders, is also available for any questions at lwisniewski@eatingdisorderscleveland.com or 216.765.0500 ext. 403. This project has been approved by Kent State University Internal Review Board. If you have any further questions about Kent State University’s rules and guidelines for research, you may contact Dr. John L. West, Vice President and Dean, Division of Research and Graduate Studies at 330.672.2704.

You will also receive a copy of this consent form.

Sincerely,

Claire Boyette McCullough, LPCC-S, NCC
Doctoral Candidate, Kent State University

CONSENT STATEMENT(S)
I agree to take part in this research project. I know what I will have to do as a participant in this research project and that I may stop participation at any point.

Signature Date
APPENDIX N

DEMOGRAPHIC QUESTIONNAIRE
Appendix N
Demographic Questionnaire

1. Age of mother: ________________________________
   Age of father: ________________________________

2. Occupation of mother: ________________________________
   Occupation of father: ________________________________

3. Marital/Partner Status: ________________________________

4. Racial/Ethnic Identity of mother: ________________________________
   Racial/Ethnic Identify of father: ________________________________

5. Has your child ever had any eating disorder treatment?
   ______________ Yes  ______________ No

6. Has your child ever had any psychological treatment?
   ______________ Yes  ______________ No

7. Number of children in your home: ________________________________
Appendix O

Audio Tape Consent Form

I agree to audio taping at _______________________________
(Location)

with Claire B. McCullough.

___________________________________________ _____________
Signature        Date

I have been told that I have the right to hear the audio tapes before they are used.

I have decided that I:

_______ Would like to hear the tapes
_______ Would not like to hear the tapes

Sign now below if you do not want to hear the tapes. If you want to hear the tapes, you
will be asked to sign after hearing them.

Claire McCullough may / may not use the tapes made of me. The original tapes or copies
may be used for:

_____ This research project ___ Publication ____Presentation

_____________________________________________ ____________
Signature        Date

Address: __________________________________________________
APPENDIX P

SECOND INTERVIEW TOPICS SCHEDULE
Appendix P

Second Interview Topics Schedule

1. I will provide you with a brief summary of our last interview. I will then ask you the following questions:
   a. How do these ideas compare with your experience?
   b. Have any aspects of your experience been omitted?

2. What additional comments would you like to make surrounding your expectations and subsequent experiences of the Maudsley treatment approach?
APPENDIX Q

CODING EXAMPLE OF “ALL-CONSUMING” FROM NVIVO
Appendix Q
Coding Example of “All-Consuming” From NVIVO

Reference 6 - 1.34% Coverage

Mr. Gold: It was all-consuming – I kind of look at this as our “eating disorder year” – because we all missed out on a lot of things that we normally do and normally because of the eating disorder . . .

Reference 7 - 1.84% Coverage

I mean, the priority was for her to get weight restored and eat and get nourished . . . but I often wonder if we wouldn’t have felt such a disruption if we had somehow been able to incorporate some school initially and when the guidance counselor asked well what about in the mornings

<i>Internals\Masey second Interview</i> - § 3 references coded [15.03% Coverage]

Reference 1 - 6.94% Coverage

it’s not about my breast cancer, it’s about my daughter right now and that was the way I tried to focus in on being there for her and taking care of it. But there were times when we were at home where – your comment about mom and dad sticking together, she would pull me into this emotionally and I learned later on the process that I would stop it when I’d see that happening and we’d go to my husband and the three of us would work it out together. Because it was all-consuming. Again, coming back this time, I have boundaries on this that I did not have last time. And that has really made a difference in our family and we’re relating with one another. My daughter has an eating disorder, but before it was crucial that we had her treated and getting the weight up, but we’ve been there now – there are some other things that need to – keep tearing up her life . . . does that make sense? All-consuming . . . am I allowing it to happen this time?

Reference 2 - 2.99% Coverage

Correct. I feel more of a determination and if my husband and I have an anniversary coming up and we want to go for dinner and not talk about my daughter and the eating disorder, that is okay. Does that make sense? I kind of had a liberating feel about all of this – that we’re giving it all we can and so is my daughter. This is not a quick process, but we’re not gonna stop life while we’re moving along.

Reference 3 - 5.11% Coverage

Yes, in fact I would think if I was introducing a fear food, thankfully I could do it here rather than at home. And CCED has – you know, I was walking this morning and
thinking what an impact this whole place has made on our lives. You know, I really don’t know where we would be without this place.
REFERENCES


