

Rescripting: A Grounded Theory study of the
contribution that fathers make to Family Based
Treatment when a young person has anorexia
nervosa

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ABSTRACT

Background

Anorexia nervosa (AN) is a serious eating disorder that most commonly develops during adolescence. Across Scotland, child and adolescent mental health (CAMH) clinicians have been trained in the delivery of manualised Family Based Treatment (FBT) for AN. FBT is an approach that requires the involvement of all family members. The limited evidence available is indicative of fathers initially attending FBT but disengaging during the treatment process. Parental alignment and empowerment have been associated with improved treatment outcomes. As such the absence of fathers during the treatment process represents cause for concern.

Aim

The aim of this study was to develop an understanding of the experience of fathers and the contribution that they made to FBT when a young person had anorexia nervosa.

Methodology

Grounded Theory was chosen because it is a valuable methodology where little is known about an area of human experience and because it supports the development of a substantive theory.

Methods

Fifteen fathers with previous involvement in FBT took part in individual interviews. Data was collected and analysed simultaneously, utilising the process of constant comparative analysis. Field notes and memos informed and guided the construction and generation of analytic categories from the data.

Findings

Four categories emerged from the data: Being on the Outside, Finding a Way In, Finding a Way to Be and Finding a Way to Let Go. The core category of Repositioning reflects the way that FBT changes the father's position within the

family. The substantive theory of Rescripting describes how fathers, in the context of AN in the family, redefine themselves and their role for the duration of FBT; it identifies the challenges fathers face within this new and different role.

Conclusion

This study addresses a gap in knowledge regarding the paternal experience of and contribution to FBT. It informs CAMH clinicians practice in relation to supporting and involving fathers in treatment.

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DECLARATION

I declare that the work in this thesis is my own.

Karen McMahon

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Chapter 1 Introduction

1.1 Introduction

The aim of this research was to explore the contribution that fathers make to Family Based Treatment (FBT) when a young person has anorexia nervosa. FBT is the most researched treatment for child and adolescent anorexia nervosa but to date surprisingly little research examining the role of the parents within treatment has been undertaken. There have been no studies specifically focused on the paternal perception of being involved in FBT and little attention has been paid to the specific contribution that fathers make to the treatment process. The research that has been undertaken to date has focused predominantly on treatment efficacy from a clinical perspective. A small number of studies have addressed parental views, but these have not focused exclusively on the paternal experience. The maternal contribution to eating disorder treatment has received most attention. On one hand, this is unsurprising given that fathers are frequently viewed as distant and peripheral figures who have less contact with services when their child is ill (Lamb, 2004). On the other hand, it is puzzling that the paternal role has not been given more consideration since FBT requires equal investment and involvement from both parents. Currently, there is a lack of understanding regarding the specific contribution that fathers make and how this influences the outcome of FBT. The aim of this research was to address this significant gap in the knowledge base by focusing on the paternal contribution to and experience of FBT when a young person has anorexia nervosa.

In this chapter, an overview of anorexia nervosa, causation, risk factors and treatment options is provided in order to contextualise the current study. The Child and Adolescent Mental Health Services (CAMHS) context and guidelines relating to the treatment of eating disorders are discussed next. Thereafter, my clinical background, a summary of FBT and a clinician/carer review of the proposed study is discussed. The chapter concludes with a summary and organisation of the thesis.

1.2 Anorexia Nervosa

Anorexia nervosa (AN) is a disorder that is increasingly viewed as developing from a complex interplay of genetic, biological, psychological and socio cultural factors (Hooper and Williams, 2011, Lask and Bryant-Waugh, 2007, Nicholls et al., 2010, Price-Evans and Treasure, 2011, Strober and Johnson, 2012). Historically, socio cultural theories of aetiology have predominated in the academic literature (Nunn et al., 2008), but, to date, no single causative factor has been identified as being of central significance or primacy to development of the disorder. The complexity of anorexia nervosa makes it a challenging disorder to both treat and research (Morris and Twaddle, 2007).

There is agreement that anorexia nervosa is a serious psychiatric illness characterised by pathological thoughts and behaviours about food and weight leading to a refusal to maintain a healthy body weight (Lock et al., 2001). Within the general population in the developed world, it is a relatively rare disorder, which has a prevalence rate of approximately 1% in females and 0.5% in males (Smink et al., 2012). Anorexia nervosa significantly impairs physical health and psychosocial functioning (Fairburn and Harrison, 2003, Le Grange et al., 1992a, Zipfel et al., 2015). It most commonly emerges in adolescence, with a peak age of onset between 15 and 18 years of age (Gowers et al., 2007, Gowers et al., 2010, Zipfel et al., 2015). Anorexia Nervosa has the potential to become a chronic illness with lifelong detrimental effects (Treasure and Russell, 2011). Early intervention increases the likelihood of a positive outcome and improves the chances of a full recovery (Ebenreuter, 2015, Espie and Eisler, 2015, Olivo et al., 2018, Jones et al., 2012, Treasure and Russell, 2011). However, barriers to early identification and intervention are evident in the literature. These barriers include issues with the applicability of diagnostic criteria, the ego syntonic nature of the illness (symptoms of illness are experienced as consistent with the individual's personal values) and difficulty differentiating symptoms from normal adolescent development (Loeb et al., 2011a). These insights highlight that research focused on how parents recognise and react to anorexia nervosa and the type of support they find most useful when trying to help young people is required.

The needs of fathers, who remain the most peripheral figures in relation to clinical treatment and research, require to be considered and addressed if the paternal contribution is to be harnessed and maximised. Within FBT research some attention has been paid to how the involvement of fathers influences treatment outcomes. Hughes et al. (2017) found an association between paternal involvement in FBT and improved weight gain and remission of eating disorder symptomatology. But limited attention has been paid to how fathers view participating in FBT. No previous studies have focused specifically on the paternal perception of being involved in FBT, and this research addresses this gap in the literature. Attendance of fathers has been shown to decline across the course of FBT (Hughes et al. 2017) which raises a concern regarding the factors that preclude ongoing paternal engagement. Addressing the potential to maintain paternal involvement in FBT could enhance the contribution made by fathers and lead to improved treatment outcomes for young people.

Historically, theories regarding the causation of anorexia nervosa and risk factors for development of the disorder focused on the impact of relationships within the family of origin. The mother-daughter relationship has been subjected to most scrutiny. In the literature, mothers have been presented as over involved figures. They have been viewed as preventing the sufferer from developing an awareness of their own emotional state, leading to severe psychological disturbance and associated eating disorder psychopathology (Bruch, 1962, Bruch, 1966). Dissatisfaction with attempts to treat anorexia nervosa on an individual basis, using psychoanalysis, has led to the development of systemic approaches targeted at addressing family dysfunction (Minuchin et al., 1978, Palazzoli, 1974). Recent approaches to treatment have moved away from viewing dysfunction within the family as being responsible for the development of anorexia nervosa (Eisler, 2005, Le Grange et al., 2010, Lock et al., 2006, Treasure et al., 2005, Whitney et al., 2005). A legacy of parent blaming within the eating disorder field has influenced a radical shift away from a focus on causation and the attribution of blame towards an explicitly agnostic stance. That is: no assumptions are made by professionals about possible causes of the eating disorder. Recent iterations of family based approaches are founded on the premise that it is not fruitful to invest time in the

search for a cause (Eisler, 2005, Lock et al., 2001, Lock and Le Grange, 2012). To an extent, this has led to a polarisation within the eating disorder field, with some clinicians viewing consideration of causation as associated with out of date approaches to treatment. Others take the view that paying attention to possible causative factors has a contribution to make to our developing knowledge of a much misunderstood and difficult to treat disorder.

Significant advances in modern technology have enabled neurobiological influences to be researched. These advances have demonstrated that particular neuropsychological deficits are associated with development of anorexia nervosa (Agrawal and Lask, 2009). Improved understanding of biological influences has the potential to lead to improvements in early identification and intervention and a wider range of available treatments (Brewerton et al., 2009, Frampton and Hutchinson, 2007). Recognition of the significance of neurobiological influences as potential predisposing factors may lead to reduced parental guilt associated with the development of the disorder (Nunn et al., 2008). Currently there is a lack of awareness and understanding regarding how fathers perceive causation, the beliefs they hold in relation to contributory factors and the impact that this has on paternal willingness and ability to engage with and treatment at the point of need.

Internal risk factors, including genetic influences, are associated with the development of anorexia nervosa, and a strong link has been demonstrated in both family and twin studies (Hinney et al., 2010). Heritability is estimated to be as high as 58% to 76% (Holland et al., 1988, Klump et al., 2001). Strober et al. (2000) found that female relatives of those with diagnosable anorexia nervosa are eleven times more likely to develop anorexia nervosa than individuals with no family history of AN. The increased attention being paid to genomic influences, within the eating disorder field, has led to the development and coordination of the global studies, which include a large number of participants, and have the potential to contribute to an understanding of the way that biological influences interact with environmental risk factors in anorexia nervosa. In the future, the potential exists for the development of individualised and targeted care for those with anorexia nervosa (Breithaupt et al., 2018).

Developmental factors, including those of infancy, childhood and adolescence, have been associated with an increased risk of developing anorexia nervosa, as have personality traits linked to obsessionality, perfectionism, anxiety and autistic spectrum disorders (Zipfel et al., 2015). Other factors thought to contribute to the emergence of anorexia nervosa include a perceived pressure to be thin, the pursuit of thinness, weight and body shape dissatisfaction, dieting, negative affect and substance abuse (Jacobi et al., 2004, Stice, 2002).

Anorexia nervosa is a complex disorder; no one gene or individual risk factor is sufficient for its development and individual young people are rendered susceptible to its development by virtue of a complex interplay of genetic, individual and environmental factors (Nicholls et al., 2011). Understanding the level of complexity associated with anorexia nervosa places clinicians in a stronger position to be more effective in their treatment of adolescents in a family context (Strober and Johnson, 2012).

The treatment options in adolescent anorexia nervosa are inpatient treatment, day patient treatment and outpatient treatment (Fairburn, 2005). In each of these settings a range of treatment approaches, including individual, family, group and pharmacological interventions, can be implemented. The largest UK multicentre randomised controlled trial of adolescent eating disorder treatment, conducted by Gowers (2010), found that inpatient care does not offer an advantage over good quality outpatient care while being considerably more expensive. Specialist Eating Disorder services do not necessarily deliver better care or treatment outcomes than multidisciplinary generic CAMHS, where a family based approach is adopted as the standard mode of treatment (Gowers et al., 2010).

1.3 CAMHS Context and Eating Disorder Guidelines

Across Scotland, FBT is delivered within CAMHS. Over time, there have been significant issues within CAMHS in relation to access to assessment and treatment, and workforce planning (Audit Scotland 2018). In 2014 the Scottish Government set Health Improvement, Efficiency, Access and Treatment (HEAT) targets in an attempt to ensure that young people referred to services were engaged with psychological services within 18 weeks. Waiting times

statistics, published by the Information Services Division (ISD), a division of NHS Scotland, published in September 2018 show that 70.7% of young people were seen within the 18 weeks, 23.5% within 19-35 weeks and that 5.8% waited longer than 36 weeks for treatment. The number of young people with disordered eating as a precursor to anorexia nervosa or with early signs and symptoms of an eating disorder within these groups remains unknown. The scale of unmet need has a significant impact on frontline clinicians providing assessments and treatments across a range of child and adolescent mental health presentations.

The Mental Health Strategy: 2017-2027, which is predominantly focused on children and adolescents, details only one eating disorder-related action. This action is the development of a digital tool to provide support to young people with eating disorders. No reference is made to the support needs of parents or carers. Given that young people are the least likely to identify signs of the disorder, this one action alone cannot address the early intervention and treatment needs of young people and their families.

Once a young person has been assessed by CAMHS, The Matrix (2015) guides the delivery of evidence-based psychological therapies. Quality Improvement Scotland (QIS), National Institute for Health and Care Excellence (NICE) and the Royal College of Psychiatrists (RCP) Marsipan (CR189) and Junior Marsipan (CR 168) guide the management of physical risk in severe anorexia nervosa and offer some guidance on specific eating disorder interventions. QIS (2006) Eating Disorders in Scotland has effectively been superseded by NICE (2017). A proposal has been submitted to the Scottish Intercollegiate Guidelines Network (SIGN) for the development of a SIGN Eating Disorders Guideline to address the specific needs of the Scottish context and population (Morris, 2017). In this proposal, Dr Morris, Chair of the Faculty of Eating Disorders of the Royal College of Psychiatrists in Scotland, expresses a view that NICE (2017) has been developed to fit an English model of care that does not necessarily adapt to Scotland.

The Matrix (2015), A Guide to Delivering Evidence Based Psychological Therapies in Scotland, describes FBT as a high intensity intervention and gives

the strongest recommendation to conjoint FBT (all family members seen together), and also recommends separated FBT (young person and parents seen separately). Junior Marsipan guidance is most applicable to the management and treatment of very sick young people with anorexia nervosa. While it guides medical monitoring and assessment of medical risk, it is less focused on psychological intervention.

The most current clinical guideline is from NICE (2017). Eating Disorders: Recognition and Treatment recommends that outpatient anorexia focused family therapy (FT-AN) should be delivered as the first line treatment option for children and young people with anorexia nervosa. These guidelines advise considering single family therapy or a combined single and multi-family therapy (MFT), where a number of families are seen together. FBT is a form of FT-AN which focuses on addressing the eating disorder directly and prioritises weight restoration as the primary goal of therapeutic intervention (Lock and Le Grange, 2012). The research underpinning the recommendation of FT-AN relates to studies that have been conducted utilising FBT.

Much of my career has been spent supporting young people with eating disorders, prior to the institution of guidance to support treatment. My clinical background is discussed next, as it informs the development of this study.

1.4 Clinical Background and the research area

During my career as a mental health nurse, I have worked with children and young people with eating disorders in both inpatient and outpatient settings. When working in generic CAMH services 20 years ago, there was no evidence available to guide clinical practice and the approach adopted was dependent on the preference of members of the multidisciplinary team (MDT). Within the MDT, systemic approaches were implemented and parents were included in interventions. If the young person was being seen individually, supportive sessions were offered to parents. Being involved in these sessions drew me close to the confusion, distress and powerlessness that parents feel when their child develops anorexia nervosa.

As a generic CAMH clinician, I saw young people with a wide range of mental health issues. Being involved in the treatment of young people with eating disorders most frequently left me feeling that I did not have enough to offer. In the absence of an evidence base to guide my practice I read widely about eating disorders and invested time and energy in trying to find useful ways to support both the young person and their parents. I discovered the book *Eating Disorders: A Parents' Guide* by Rachel Bryant-Waugh and Bryan Lask (1999) and found that it developed my understanding and enabled me to begin to develop a treatment approach. Along with a dietetic colleague, I began to meet with the young person in the family context and to integrate supportive psychological work, dietetic advice and weight monitoring into treatment sessions. Medical monitoring was provided by the psychiatrist within the service. Parents were receptive to this approach, and most young people who entered the clinic in an emaciated and physically compromised state made gains physically and emotionally over the course of treatment. To begin with, I was surprised by our success, and attributed it to luck, but with experience and positive outcomes, my confidence grew. We moved to a position of having a clear treatment plan and goals that could be implemented when young people were referred. We had developed a model of care informed by researching the available literature designed to address the needs of the young people presenting to the service. When it became available access to the *Treatment Manual for Anorexia Nervosa* informed, enhanced and developed my practice (Lock et al., 2001).

Specialist training in eating disorders and direct clinical work with families developed my interest in working with all family members. I routinely included fathers in treatment sessions and recognised the positive impact of both parents being involved in therapy sessions. When I moved to a specialist role delivering FBT across eight CAMH teams, I observed a striking disparity between my perception of fathers and those of my colleagues. I noticed that fathers were seldom involved in the CAMH assessment process, and when I discussed with clinicians involving fathers in FBT they were reluctant to invite them to the clinic, stating that the father was “too angry” or “too busy at work”, that the young person did not want him involved or that he was uninvolved or

disinterested. This did not resonate with my own experience of meeting with fathers to deliver FBT in my previous role, as when I contacted the family to invite fathers to treatment the vast majority attended, engaged and remained involved for the duration of FBT. This left me puzzled regarding clinicians views and their reluctance to involve fathers, and I wondered about the potential for fathers to be excluded from conversations about their young people and to remain absent from or on the periphery of the therapeutic process. I noted that colleagues did not express reluctance to include mothers in assessment and treatment and that they were better represented within the clinic than fathers.

In order to explore fathers' experience of being involved in FBT, I wanted to access the opinions, thoughts and feelings of those who did not attend treatment and those who did attend. I was interested to find out what it is like for fathers to meet up with services, how included they felt and what they contributed. Consequently, for my research, I pursued researching fathers who did attend, primarily because I thought they would be more accessible, and I had to focus on what I believed was practically possible within the available timescale and resources of doctoral research. The process of recruiting fathers who had been involved in FBT turned out to be a time-consuming and challenging process. Nevertheless, in pursuing this area of research, I have learned so much about FBT; a treatment that I now realise knowing from a clinical perspective is very different from experiencing as a parent. By researching the fathers' experience of FBT, I had the opportunity to look at a disorder with which I was familiar through a new and different lens. In so doing, it is possible to look at the familiar from a different perspective (Spindler and Spindler, 1983). My recognition and appreciation of the impact of anorexia nervosa and FBT on fathers, and of how they are changed by the process, has been deepened in a way that would not have been possible without undertaking this research. An explanation of what FBT involves is presented next.

1.5 FBT

All CAMH services, across Scotland, have clinicians who have undertaken two-days training in FBT. Some health board areas have clinicians who have progressed to accreditation level in the delivery of treatment, and a small

number of clinicians are accredited supervisors. FBT has been widely adopted across Scotland, but the provision of supervision is organised within individual services and no national structure to support the implementation and supervision of FBT has been agreed.

FBT is a manualised approach to treating anorexia that requires the attendance of all family members (Lock and Le Grange, 2012). The limited literature available indicates that fathers engage initially but do not maintain involvement across the course of treatment (Hughes et al., 2017). This is in contrast with mothers who have been shown to remain involved over the duration of the FBT process (Hughes et al., 2017).

FBT is delivered in three phases; in phase 1 appointments are convened on a weekly basis, in phase 2 appointments are fortnightly and in phase 3 appointments take place at monthly intervals. A typical course of FBT incorporates 20 sessions delivered over approximately one year.

In the initial phase of treatment, parents are asked by the therapist to take over responsibility for all issues related to managing eating and weight. The second session of phase 1 incorporates a family meal, which involves the therapist coaching the parents to develop strategies for managing anorexia nervosa. In phase 2, responsibility for eating and sustaining weight gain is gradually handed back to the young person, and in phase 3 the focus is on maintenance of a healthy weight while exploring adolescent developmental issues (put on hold by the eating disorder) and on concluding treatment. Over the course of treatment, parents take over “control” of eating in order to halt weight loss and to address physical concerns/risks. They then work towards restoring weight to the healthy weight range while supporting the young person to take back responsibility for managing their own dietary intake and maintenance of a healthy weight to support physical and psychological development. The treatment process is seldom linear, and there is often movement forwards and backwards between phases depending on how the young person copes with increased responsibility and how the parents cope with relinquishing control and handing responsibility back to the young person.

Within FBT clinic-based appointments, which usually last one hour, the FBT therapist coaches and supports the parents to develop strategies for managing the eating disorder. These strategies are then implemented in the home setting. During treatment, the therapist reviews the parental efforts at providing support to the young person. The young persons' weight is recorded at every session and is used to monitor their physical state and as a proxy measure of parental effectiveness. Weight gain is associated with successful implementation of strategies and progress while weight loss raises a concern that strategies implemented at home are not being effective and require to be revised. Tackling the eating disorder can involve dealing with behaviours that are part of an eating disorder presentation including: vomiting, over exercising, hiding weights on the body; water loading etc. These compensatory behaviours are seen as increasing physical risk and allowing the eating disorder to exert control over the young person so that they become increasingly unwell. Within FBT, anorexia nervosa is conceptualised as a force that has taken over the young person and that they are powerless to fight against. As such, parents are responsible for managing anorexia nervosa and helping the young person to eat, despite the influence the disorder is exerting. The attention of the therapist remains focused on weight until convinced that the parents are sufficiently in charge of the young person's eating and behaviours. Once weight gain has been established, treatment can then progress to phases 2 and 3.

1.6 Clinician and Carer Review

Prior to embarking on this research project, I discussed my interest in fathers and their involvement in FBT with clinical colleagues (Clinical Nurse Specialists, FBT Specialists and Dieticians) within my clinical team (Child and Adolescent Eating Disorders team). My colleagues were interested in research involving fathers and said that they often found fathers to be more peripheral than mothers during treatment. When fathers were involved, they often felt less confident in their communications with them and thought that they found eating disorders difficult to understand in a way that influenced treatment. Following discussions with clinicians, I discussed my research idea, on an individual basis, with a small number of fathers on my clinical caseload who were

currently receiving FBT. These fathers were interested in the idea of research focusing specifically on their experience of and contribution to FBT. One father in particular was very keen to participate and disappointed that I could not include him because of our contact in a clinical setting. In order that his views could be captured and contribute to service review, I arranged for him to meet with the Lead Clinician as part of the eating disorder service audit. I also had email correspondence with leading international clinicians/ researchers involved in delivering and studying FBT in the USA and Australia to establish their interest in and views on my area of study. These professionals brought extensive involvement in both quantitative and qualitative studies related to eating disorder treatment, including FBT, to the consideration of my research idea. Fathers, clinicians and researchers were supportive of my idea, in principle, and this encouraged me to proceed to develop my research proposal.

The research proposal was developed and presented to clinicians and carers from across Scotland at the Eating Disorder Research Network in 2012. The Network endorsed a qualitative enquiry, focusing particularly on the fathers' experience of FBT, as having an important and necessary contribution to make. It was recognised at this meeting that no similar studies had been undertaken and that carers feel overwhelmed and confused when a family member is struggling with an eating disorder. A study exploring the experience of fathers, who are underrepresented in the literature to date, was encouraged and supported by those in attendance. By undergoing this process, I was reassured that the subject held purpose and relevance for those with direct personal or professional experience of eating disorders. Such characteristics are associated with good social research that has the potential to make a difference within the field of study (Denscombe, 2010).

1.7 Summary

Anorexia nervosa is a serious mental health disorder that predominantly develops during adolescence. There is an absence of research relating to the parental experience and in particular the paternal experience of being involved in treatment for anorexia nervosa. FBT that necessitates the involvement of

both parents presents an important opportunity to access information about the experience and contribution of fathers to the treatment process.

1.8 Organisation of the thesis

Chapter Two presents the way in which taking a traditional Grounded Theory approach has influenced engagement with the literature and provides a review of literature pertaining to the implementation and delivery of FBT. Chapter Three explains the choice of Glaserian Grounded Theory methodology and describes the methods employed. In Chapter Four the main findings, including the categories Being on the Outside, Finding a Way In, Finding a Way to Be and Finding a Way to Let Go and the core category of Repositioning, are presented. Chapter Five presents my substantive theory of Rescripting, and the thesis concludes with recommendations for clinical practice and future research.

Chapter 2 Literature Review

In this chapter, the way that Grounded Theory (GT) methodology has shaped the approach to the literature is discussed. The search strategy utilised to identify literature, prior to undertaking the study, is presented. Thereafter, literature accessed across the course of the study is presented under the headings Roots of Family Based Approaches, Controlled studies of FBT, Expressed Emotion and Mode of Delivery of FBT, Treatment Studies, Dissemination Studies, Clinicians and FBT, Adjuncts to FBT and Fathers. The literature is synthesised and critiqued in order to highlight gaps in current knowledge that justify the need for this research study to be undertaken.

2.1 Approach to the literature

When and how the literature is accessed within a GT approach is a contentious issue (Cutcliffe, 2000, McGhee et al., 2007). Glaser and Strauss (1967), in *The Discovery of Grounded Theory*, advise GT researchers to avoid the literature in the specific area under study in order to enter the field with an open mind. Accessing literature directly related to the subject area runs the risk of preconceiving theory development (Glaser, 2001). While reading around the subject area facilitates the researcher in developing an understanding of sociological concepts and enhances theoretical sensitivity (Glaser, 1998). In a classic GT study, it is recommended that a light reading of the literature around the general area of the study is undertaken at the outset followed by more extensive review of the literature once theory development is underway (Glaser, 2001, Walls et al., 2010). By approaching the literature in this way, it is the analysis of the data collected that leads the researcher to relevant concepts in the literature rather than existing literature preconceiving data collection and analysis (Glaser, 1998). According to Glaser (1978), dealing with the literature in this way ensures that the main concern of participants, emergent from the data, takes primacy in shaping the discovery of the subsequent substantive theory.

Within the current research climate, to secure ethical approval, researchers are required to demonstrate that they have sufficient knowledge and the requisite

skills to conduct a research study in a safe way (McCallin, 2003). An initial literature review is conducted to develop a focus and to establish if similar research has been already been undertaken (McCallin, 2003). That is, some engagement with and presentation of the literature is required prior to undertaking a study, and sufficient reading must take place to establish whether a gap in knowledge actually exists or not.

Within doctoral GT projects, it is necessary for researchers to be explicit about their approach to the literature and to justify decisions made about how and when the literature was accessed (Dunne, 2011). As a clinician delivering FBT, I was already familiar with literature supporting the delivery of this treatment for children and adolescents. Clinical interest in the place of fathers in the treatment process, and a desire to support fathers effectively during treatment, had led me to seek out literature related to the paternal role. The absence of material of this nature was central to informing my initial interest in pursuing research in this area. In this sense avoiding literature, relating to the substantive area of study, was achievable as no such literature was readily identifiable.

My approach to the broader literature was to review it with a view to developing an overall awareness of developments, trends and tensions within the field over time. Literature in relation to anorexia nervosa and family based approaches was explored only in sufficient detail to sensitise me to the subject area. In depth consideration of literature, pertaining to families' views of FBT and fathers' involvement in eating disorder or mental health treatment more broadly, was deferred until after data collection had commenced. I suspected that these areas might relate most to my substantive area of study.

Analysis of the data led me to explore a wide range of literature relating to attachment theory, philosophy, caring and identity that I could not and would not have anticipated at the outset of the study. The literature pertaining to these areas is considered within the discussion chapter, as it was not part of my initial literature review. This approach to the literature is consistent with that recommended by Glaser. "The literature is not forgotten or ignored, it is put in proper sequencing of GT phases ... This sequencing allows the literature to be

relevant, fit and work with the data, while it is being modified” (Glaser, 2001,pg139).

Throughout the study, I employed reflexivity, as described by Robson (2002), to hold on to an awareness of how my identity and clinical background might influence or impact on the research process. I made a concerted effort to remain focused on participants’ emergent concerns, to guide literature accessed, rather than allowing myself to be guided or driven by my own thoughts, ideas or views. I utilised research supervision to keep me focused on the words and views of participants.

2.2 Search Strategy

In order to develop the research proposal and to apply for ethical approval, an initial systematic search of the literature search was conducted. The keywords FBT, family therapy, anorexia nervosa, eating disorders, parents, fathers, young people and adolescents were employed. These search terms were employed in a variety of combinations to search on the Cochrane Database of Systematic Reviews, CINAHL, EBSCOhost, MEDLINE, Psycarticles, Psycbooks, Psychology and Behavioural Sciences Collection and SocIndex. The fields were limited to research published in the English language between 1985 and 2012, for the initial search. This search was repeated at regular intervals between 2012 and 2018 in order to capture new research published once the study was underway.

This search identified 136 articles. Of this number, 87 articles were reviewed. I read all of the abstracts in order to decide which to include and exclude. I excluded articles that primarily focused on bulimia nervosa or anxiety, rather than anorexia nervosa, and those that looked at adults rather than young people. I chose to include family therapy literature that directly related to the evolution of FBT. This is discussed in the sections headed Roots of Family Based Approaches and Controlled Studies of FBT. I excluded articles that focused on other forms of family therapy, such as systemic family therapy or behavioural family therapy.

I focused on reviewing articles related to the implementation and delivery of FBT and adjuncts that have emerged since publication of the first edition of the treatment manual in 2001. Literature relating to the clinician perspective of FBT was included in order to inform an understanding of the current context within which FBT is delivered. However, literature relating to the family experience of FBT, or components of it, was set aside for consideration once data analysis had commenced. This was in order to avoid risking the preconception of categories within my study. The literature on family perceptions and experiences of FBT is integrated into the discussion in Chapter Five. While it was not feasible to include a comprehensive literature review of the role of the father in child development, a number of papers were selected that related to fathers' engagement with clinical services and with eating disorder presentations and treatment. These were included to contextualise the involvement of fathers in FBT.

Additionally, alerts were set up on Zetoc and Current Opinion in Psychiatry to identify newly published journal articles in the area, references were followed in sourced articles and textbooks to access cited literature. Once data collection was underway, and substantive codes and categories were emerging from the analysis, the search terms attachment, mental health, identity, role and caring were added when searching for literature.

A brief summary of the roots of family based approaches is considered. Thereafter this review primarily focuses on the literature directly pertaining to the development and institution of the manualised model of FBT developed by Lock et al (2001) and concludes with a discussion of the father in relation to young people and health services.

2.3 Roots of family based approaches

William Gull (1873) first used the term anorexia nervosa; he counselled against the involvement of family members and described their influence as detrimental. Early treatment approaches to anorexia nervosa excluded rather than involved family members. The exclusion of families from the treatment of anorexia nervosa prevailed until the 1960's when attention turned to the family

mechanisms and dynamics underpinning the development of anorexia nervosa in young people.

The place of the father is implicit in early texts focusing on the development of family based approaches to the treatment of adolescent anorexia nervosa. Case studies, published by the influential structural and Milan schools of family therapy, clearly document the participation of fathers in the treatment process (Minuchin et al., 1978, Palazzoli, 1974). The father, as part of the parental subsystem, was viewed as having contributed to the development and maintenance of anorexia nervosa in the young person, and was required to be present in order that dysfunctional patterns of communication and conflict resolution could be addressed (Minuchin et al., 1978). While subsequent studies have found no evidence to support the premise that families of anorexic offspring are characterised by the specific make up described by Minuchin (Kog and Vandereycken, 1989, Røijen, 1992), his early interest in and study of AN has been central to the development of systemic approaches.

Minuchin (1978) reported a case series of 53 families seen for six months of family therapy, where 86% of young people were deemed as recovered medically and psychologically at follow up (one to seven and a half years post treatment), and the drop out from treatment was 5.6%. While it is not explicitly stated, the findings imply that 94% of fathers remained involved across the course of treatment. This stands in stark contrast to the current participation of fathers in FBT, which can be as low as 33% across the entire course of treatment (Hughes et al., 2017). Within the structural school of family therapy early sessions were conjoint, with all family members present, while, later in treatment, individual sessions for young people and 'marital sessions' for parents were delivered. The reason given for splitting the therapeutic task in this way was to "foster disengagement" (Minuchin et al., 1978;pg 132). That is: to facilitate space and time for the young person separate from the parents. In contrast to FBT, this approach of meeting with the parental unit separately, may have contributed to better retention of fathers across the course of treatment. In line with publications of the time, the case series reported on work taking place within a specific clinical context, and, as such, a range of unknown variables

may have influenced the issue of paternal retention. Nonetheless, two accounts produced almost 40 years apart highlight a decline rather than an increase in paternal participation in FBT approaches over time.

Writing of one particular father (Mr Kaplan) Minuchin said, “If one ignores the noise, his pain becomes apparent” (Minuchin et al., 1978; pg9). Minuchin describes Mr Kaplan trying to take an authoritarian position but undermining himself by over explaining his position rather than taking firm action. He observes that underlying this father’s presentation is a fear of the consequences of taking a firm approach and pain associated with being ineffectual. This narrative comment reveals an important observation of one father’s reaction to anorexia nervosa within the family and highlights a paternal experience largely overlooked within the academic literature.

Minuchin advocated that controlled studies of AN, and in particular of family therapy approaches to treatment, should be undertaken. FBT, that incorporates many aspects of Minuchin’s original approach, has progressed the study of anorexia nervosa and its treatment by engaging in the controlled study he advocated. The controlled studies undertaken in relation to FBT are discussed in the next section.

2.4 Controlled Studies and Family Based Approaches/FBT

Russell and colleagues conducted the first controlled study looking at the efficacy of a family based approach for treating anorexia nervosa in the UK (London) in 1987. This study examined different approaches to treating AN and found that for younger patients, with a short duration of illness, family therapy was more effective than individual supportive therapy (Russell et al., 1987). Although the term FBT was not coined until well after this study had been undertaken, the family therapy delivered was consistent with FBT as it is described today. The integration of this approach to treatment marked a significant shift away from focusing on parental or familial disturbance as contributory factors to AN and towards a more strength based and resource focused model. While there were some notable limitations within Russell’s study design, including a lack of rigorous assessment of therapist competence

and no differentiation between clinicians delivering individual and family interventions, it provided the first robust evidence that outpatient treatment, following a period of hospitalisation, had a contribution to make to the treatment of anorexia nervosa. Significantly, young people who received family therapy continued to do well in a follow up study conducted five years later (Eisler et al., 1997). This form of family based approach was examined in two further controlled studies conducted by Le Grange et al., (1992a) and Eisler et al., (2000, 2007), which are discussed in section 2.9. These studies, often referred to as the Maudsley studies, are foundational to subsequent research on Family Therapy for anorexia nervosa (FT-AN) and MFT conducted at the Maudsley and to studies conducted on FBT globally.

FBT as a distinct form of family intervention has been studied since the publication of the first edition of the treatment manual in 2001 (Lock et al., 2001). Globally there have been six randomised controlled trials (RCTs) focusing specifically on FBT in adolescent anorexia nervosa (Agras et al., 2014, Le Grange et al., 2016, Lock et al., 2005, Lock et al., 2010, Lock et al., 2015, Madden et al., 2015a). The small number of published studies reflects the challenges inherent in conducting RCTs within the eating disorder field (Strober, 2014). In terms of controlled trials, these six studies constitute the current evidence base available to guide the treatment of anorexia nervosa in young people. A key risk or challenge when delivering treatment for adolescent anorexia nervosa is over reliance on what is a relatively small body of evidence. Downs and Blow (2013), in their substantive review of family based approaches, conclude that there is a need for a more extensive range of studies to further develop the evidence base and to address how best to include all family members. Strober (2014) states that while there is clear evidence of treatment efficacy for young people with a short duration of illness and functional families, scientific evidence is not robust enough to support the blanket implementation of FBT as the only treatment approach offered to all young people struggling with an eating disorder. In response, Lock and Le Grange (2014; pg 291) acknowledge that the eating disorder field is “challenged by the paucity of RCTs for adolescents” but that currently FBT has the most convincing evidence to support its institution with medically stable young people

with a short duration of illness. These six RCTs, specifically designed to address efficacy, have been influential in moving forward the treatment of adolescent eating disorders and have informed the developments of guidelines around the world, including NICE (2017) in the UK. While the value of these studies is beyond question, they do not capture the human experience of participating in treatment. In addition to expanding the evidence base by conducting further RCT's, addressing treatment efficacy research focused on the experience and views of those who have participated is required. The literature pertaining to clinician experience of FBT is considered in section 2.13 and the limited research on the families and FBT is integrated in to the discussion in Chapter Five. The way that FBT is delivered and the factors influencing this are discussed next.

2.5 Expressed Emotion and Mode of Delivery of FBT

The way that parents manage and express emotions during family based approaches has been considered since the mid 1980's, and over time this has influenced consideration of different modes of delivering treatment. An early study conducted by Szmulker et al., (1985) found an association between higher social class, increased critical comments and treatment drop out. Building on this, a subsequent study considered parental expressed emotion (EE, a concept widely studied in relation to other mental health disorders at the time) to anorexia nervosa (Szmulker et al., 1987).

Recognition of the potential impact of parental EE on treatment has informed consideration of the way that family based interventions are delivered. Le Grange et al. (1992b) compared two forms of family based intervention – conjoint family therapy (all family members seen together) and family counselling (separate sessions for parents and young person). The Le Grange study represented the first attempt to compare two different ways of delivering FBT i.e. / conjoint and separated family work. The findings of the study were indicative of both types of intervention conveying similar therapeutic benefits. However, family counselling (separated FT) was found to be more effective at reducing parental criticism of the young person. The number of critical comments made by parents during treatment sessions has been associated

with poorer treatment outcomes in anorexia nervosa (Le Grange et al., 1992a, Sepulveda et al., 2008, Szmukler et al., 1985). The small-scale size of the Le Grange et al. (Le Grange et al., 1992b) study that included only 18 participants requires that these findings are treated with caution. Van Furth et al. (1996) found levels of EE to be generally low within families affected by anorexia nervosa but did find a strong association between maternal criticism and poorer outcome. No similar association was demonstrated between paternal criticism and treatment outcome within this study.

Two further RCTs conducted by Eisler et al (2000) and (2007) involving 40 families followed up over a five year period found that critical comments made in the course of treatment negatively impacted on treatment outcome. The larger sample size included in these studies improves the statistical significance and generalisability of the findings. This study supports other findings that conjoint family therapy is less helpful for families where parental criticism is high (Eisler et al., 2000, Le Grange et al., 1992a). Despite this significant finding, a separated form of treatment is not advocated within the first or second edition of the FBT treatment manual (Lock et al., 2001, Lock and Le Grange, 2012), and clinicians are advised to see parents and children together throughout the duration of treatment.

Le Grange et al. (2016) conducted the most recent study looking at the form in which FBT is delivered. In this study, Parent Focused Therapy (PFT) (parents are seen together while the young person has a brief medical/ psychological review with a nurse) was compared with standard FBT. Treatment was delivered over a six month period, and, at end of treatment, superior outcomes in terms of remission from anorexia nervosa (defined as reaching an ideal body weight of 95% or above) were seen within the PFT group. Although this difference was not sustained at six and twelve month follow up it does suggest that different modes of delivering FBT have the potential to produce similar outcomes. Findings would indicate that flexibility in relation to the mode of delivery of FBT could be considered.

Duclos et al (2012) in a systematic review of the literature on expressed emotion in anorexia nervosa treatment identified a lack of understanding

regarding the factors that influence and shape EE. Subsequently, they turned their attention to consider the impact of parental involvement on treatment outcome (Duclos et al., 2014). Traditionally, over involvement by parents has had negative connotations, and this study demonstrated that maternal emotional over involvement (EOI) rather than being a negative factor actually had a positive impact on outcome. However, paternal EOI did not lead to improved outcomes but did negatively influence the fathers' anxiety levels. Rienecke et al., (2016) found paternal criticism adversely affected treatment outcomes. Currently, little is understood about the impact on fathers of being involved in the treatment process, how becoming involved, practically and emotionally, affects them and how this relates to the levels of criticism they express. An understanding of how fathers manage the demands placed upon them within the treatment process and what support they are able to seek and secure is absent in the literature.

2.6 Treatment Studies

A number of treatment studies have addressed the factors that potentially influence outcome within FBT. Family engagement with treatment was first examined by Lock et al. (2006a). Since then some attention has been paid to the relationship between components of FBT and treatment outcome (Ellison et al., 2012, Le Grange et al., 2012, Lock et al., 2006b). Specifically, the influence of early weight gain on response to treatment has been considered (Doyle et al., 2010, Madden et al., 2015b). Most recently, the influence of the therapist/parent alliance has been examined (Couturier and Isserlin, 2010, Forsberg et al., 2013 Murray et al., 2012a, Zaitsoff et al., 2015). Only two studies have addressed the perceived helpfulness and acceptability of FBT to patients and families (Krautter and Lock 2004 and Singh 2017).

Lock et al. (2006a) compared a short course of FBT (ten sessions over six months) with a longer course (20 sessions over twelve months) and found at follow up that both had been equally efficacious in the majority of cases. But for those with the most severe eating disorder symptoms, obsessional presentations or non-intact families a longer course of treatment was more often required. Two significant implications of this study are: in terms of cost-

effectiveness, short course FBT represents a useful treatment for most young people, but important moderators, such as severity of illness, co-morbid symptoms and family make up appear to influence response to treatment. The treatment manual describes a longer course of treatment, and this continues to be offered as the first line treatment intervention across Scotland.

In a connected study, Lock et al. (2006b) reported on the factors that influence a young person's response to FBT. This was the first study to demonstrate a link between early weight gain and end of treatment outcomes. Within the study co-morbidity and longer course of treatment negatively impacted on treatment retention, while co-morbidity, difficult family atmosphere and being an older adolescent affected rate of remission. The significant burden of supporting young people with a range of complex mental health needs was recognised as affecting both disengagement and treatment outcome.

Doyle et al., (2010) reported on a two centre study looking at the impact of early weight gain on treatment outcome. Within a relatively small sample of 65 adolescents a strong correlation was demonstrated between early weight gain and positive outcome. Establishing weight gain in the first four treatment sessions is associated with parents being able to successfully find ways to work together to support the young person and relies on the availability and willingness of participation from mothers and fathers. Madden et al. (2015b) moved consideration of weight gain towards identifying those families where FBT alone may not be sufficient to promote recovery. This introduces the potential of recognising when alternative or more intensive treatment is required rather than persevering with FBT when the young person is not responding as hoped.

Le Grange et al. (2012) looked more closely at the factors that moderate and mediate outcome in a comparison study between FBT and Adolescent Focused Therapy (AFT). AFT is a manualised individual treatment within which parents are seen separately and encouraged to support autonomy. During FBT parents are encouraged to directly address and manage anorexia nervosa. Adolescents with more severe eating disorder psychopathology and obsessional symptomatology were found to respond better to FBT than AFT and this held

true even where high levels of EE or critical comments were apparent. This study adds weight to the evidence supporting the importance of parents taking charge on a behavioural level prior to adolescents being able to make cognitive changes. In contrast, Darcy et al., (2013) found that higher levels of critical comments within FBT equated to a slower response to FBT, reflected in poorer early weight gain. The authors advised that adaptations to treatment may be necessary to mitigate against the impact of parental criticism in order to promote weight gain at the beginning of treatment.

Ellison et al. (2012) undertook the first study designed to specifically consider how the five key components of FBT affect weight gain across treatment. Parents being united, adopting a non-critical stance and externalising the disorder were all found to predict greater weight gain. Additionally, the paper considered the role of parent-therapist alliance on weight trajectories. Maternal alliance with the therapist was found to positively influence weight while a strong father-therapist alliance was found to have an adverse impact on weight gain. The authors speculate that fathers may have been reacting against therapist demands to take on a feeding role more traditionally ascribed to mothers, while acknowledging that this hypothesis does not entirely make sense of their findings. Given the significance of parental unity in relation to outcomes this study highlights the pressing need to understand more about how fathers engage with and manage within FBT and the influence this has on response to treatment.

Therapeutic alliance is recognised as significant within psychological interventions and positive engagement is associated with a better response to therapy (Jewell et al. 2016, Tschuschke et al. 2015). It is more challenging to assess alliance in family approaches, as the competing needs of all family members require to be considered. Pereira et al. (2006) found that overall therapeutic alliance is strong for both young people and parents over the course of FBT. A small-scale pilot study established a link between parental engagement with the therapist during the family meal session as having a bearing on treatment outcome (Isserlin and Couturier, 2011). This is indicative of therapist-parental alignment in the session most focused on behavioural

coaching, potentially influencing how treatment progresses and the young person's response. In contrast Forsberg (2012, 2014) concluded that although therapeutic alliance was significant in FBT it bore an uncertain relationship to treatment response.

Two studies have specifically examined parental perceptions of helpfulness and acceptability of FBT (Krautter and Lock, 2004, Singh et al., 2017). Krautter and Lock (2004) recruited a significant number of fathers and 77% of them described finding FBT helpful overall. No one single component of treatment emerged as most or least helpful, but the absence of individual therapy was most frequently commented on by all family members. In qualitative accounts there was a sense of an absence of space to discuss 'other issues' within FBT. Singh et al. (2017) reported that parents find FBT 'extremely helpful' despite the fact that fathers were significantly underrepresented within the study. 32.6% of the sample was made up by fathers. This raises a question about how many fathers were engaged in treatment, but chose not to participate in the research, and how many were entirely absent from the therapy process. In relation to fathers who did participate, the young person's outcomes were not found to be significantly associated with their father's perceptions of treatment helpfulness. This study raises more questions than it answers in relation to how fathers perceive FBT.

It is significant that the majority of treatment studies have looked at the delivery of FBT, the response to treatment in terms of weight gain and the components that influence this. Within the treatment literature the parental contribution is primarily considered in relation to how successful parents are at promoting weight gain rather than the day to day challenges faced in trying to manage both the physical and psychological aspects of anorexia nervosa. Parents appear to be willing to engage with FBT, but we continue to know and understand very little about their experience of it. The paternal voice in relation to this is almost entirely absent and represents a significant gap waiting to be addressed.

2.7 Implementation Studies

Publication of the treatment manual has enabled dissemination of FBT beyond the centres at Chicago and Stanford where the original research on FBT was conducted. To date four FBT dissemination studies focusing on implementation of FBT across the Americas have been published. These studies were conducted in the USA, Canada, Australia and Brazil. To date no similar studies detailing implementation in a Scottish or United Kingdom context have been published. The Loeb et al., (2007) study undertaken in the USA reported high recruitment and retention rates; however, FBT was offered free of charge in exchange for participating in the study and this might have influenced the engagement process. An Australian paper published in the same year, by Wallis et al., (2007), details changes in the outpatient treatment approach at the Children's Hospital at Westmead, Sydney since the introduction of FBT in 2003. A change in team culture, a reduction in hospital admissions, and a positive response from families and dissemination across the country is reported. Turkiewicz et al., (2010) reported clinical improvements and concluded that FBT is acceptable to families in Brazil based on original sample size of 11 that reduced to seven (78%) across the course of the study and included no measures of parental satisfaction. Attendance appears to have been correlated with acceptability, and that may or may not be the case. Couturier et al., (2010) reported similar clinical improvements in a Canadian study that included 14 participants. They included a measure of adolescent and parent satisfaction the Outcome Effectiveness Scale (Krautter and Lock, 2004) and reported that parents were pleased to be involved in treatment.

While these small-scale studies usefully demonstrate that FBT can be implemented in a range of different health contexts they do not provide insight into the parental experience of involvement. Outcome measures of effectiveness do not have the scope to capture the meaning that lies behind acceptance of treatment or what it means to be pleased to participate. These studies do not inform us about the paternal experience of participating in FBT.

2.8 Clinicians and FBT

Successful dissemination of a specific treatment modality relies on initial clinician uptake of the model and perseverance in relation to implementing it over time. There can be no parental experience of a treatment without clinician led provision of the specific treatment modality. Research on clinician perception of FBT is discussed next.

A number of studies have looked at clinicians' views regarding implementing manualised FBT into their clinical practice. Couturier (2012) identifies parent/family factors as a potential barrier to implementation. In this study, some therapists expressed a view that parents do not understand the seriousness of the eating disorder and do not recognise the need for change. These factors were identified as barriers that can preclude effective engagement with FBT. In contrast, Dimitropoulos et al., (2015a) emphasises that clinicians see parental empowerment as the single most important and significant factor within FBT. These studies do not explore where the responsibility for parental empowerment lies. It is unclear if clinicians expect parents to arrive in a state of readiness to be empowered or if they view empowerment as a clinical responsibility, regardless of the barriers presented.

Plath et al., (2016;pg 394) cautions that agreeing to modifications of the FBT approach is a "potentially risky path to take" and relates this to issues of treatment fidelity. Plath overlooks the risk of not hearing the need for a modified or different approach if this leads to discontinuation of or disengagement from treatment. Within the same paper, the risk of a power imbalance and oppression inherent within FBT is recognised, as is the potential emotional vulnerability of parents and the impact of life experience on parental ability to engage with and manage the approach. The requirement to deliver FBT with fidelity to the manual, while taking account of individual circumstances, presents therapists with a dilemma when delivering treatment. The treatment manual (Lock and Le Grange, 2012) provides a framework for practice, and fidelity to the model is associated with implementing an approach that has some evidence to support it. There is also evidence that "one size does not fit all" (Hay, 2017 pg 130). Families may wish treatment to be delivered in a

different way and providing a responsive service has been demonstrated to improve treatment retention (Cottee-Lane et al., 2004).

2.9 Adjuncts to FBT

A small number of studies have looked at complementing FBT with adjunctive treatment components. In relation to supporting parents within FBT, Rhodes et al. (2009) looked at the addition of one, parent to parent, consultation session to standardised FBT. Ten families received standard FBT and ten families received standard FBT plus two additional sessions where they met with other parents dealing with similar issues. Those who had the opportunity to meet with other parents described finding it useful to have a space within which they could reflect on and discuss their own emotional experience. These parents reported reduced isolation, increased confidence and improved family interactions.

A number of studies have looked at capitalising on family to family support by delivering the principles of FBT within an MFT approach (Eisler et al., 2007, Eisler et al., 2016b, Mehl et al., 2013). This approach involves bringing families together to experience intensive treatment, usually over the course of a number of full days, with follow up family sessions at intervals thereafter. While not clearly demonstrating an advantage over single family therapy or FBT approaches, MFT has been found to effectively reduce isolation and increase support in a way that positively influences outcomes.

A perception of limited scope, within manualised FBT, to consider emotional distress in young people and parents led Peterson et al., (2016) to add emotion communication skills coaching to standard FBT for a 14 year old boy with anorexia nervosa. Within this case study, emotional coaching of the father is presented and a link between this and decreased anger and tension at home are made. The inclusion of only one case limits the generalisability of this study; however; it carefully details the addition of an emotionally focused component to a primarily behaviourally orientated treatment. Intensive family coaching, as an additional component of FBT, has been demonstrated to be helpful for young people who do not achieve early weight gain within a standardised FBT approach (Lock et al., 2015). Wallis et al. (2012) implemented a two week

family admission programme to address the needs of young people who did not respond to outpatient FBT. The principles of FBT were integrated into care provided in a more intensive inpatient environment, where the whole family could be admitted, avoiding separation and providing an opportunity to intensively coach and harness the resources of the family.

Wagner et al., (2016) focused on consideration of relationships within the family and adapted a model of attachment based therapy to the treatment of adolescent anorexia nervosa. They propose that a shift to an attachment focused treatment should be considered when a family fails to progress beyond phase one of FBT and suggest that the risk of not switching approaches increases the likelihood of 'stuck' families feeling damaged by the process designed to help them. Within the model of Attachment Based Family Therapy the focus is on relationships rather than behaviour.

The evolution of adjunctive approaches represents a significant step forward for FBT that has the potential to improve clinical outcomes for young people who do not make progress within the manualised approach. A full systematic review of augmentative approaches to FBT is presented within the European Eating Disorders Review by Richards et al. (2017). This review concluded that, although the majority of studies were of weak to moderate quality, evidence regarding the potential for adjunctive treatments to enhance outcomes is emergent.

Lock (2018) argues that newer approaches to treatment require further empirical support prior to dissemination and suggests that the stronger evidence base for manualised FBT maintains its position as the current treatment of choice. In relation to the future direction, Lock and Le Grange (2018) recommend further rigorous study of adjunctive treatments to increase an ability to match treatment to the needs of the individual. They propose that resources be targeted towards further dissemination of FBT in order to ensure that more families can receive treatment at the point of need. What has not been considered is how parental experience of contributing to FBT can shape the clinical evolution of the approach. The paternal perspective of being involved in treatment has a contribution to make to the research agenda in a

way that can inform and shape clinical practice. The place of the father in relation to child development, research, clinical services and eating disorders is considered in the next section.

2.10 Fathers

The involvement of fathers in raising children has a positive impact on social, psychological, behavioural and cognitive development (Sarkadi et al., 2008). Fathers influence the development of their children directly i.e. / by the way they behave, the messages they convey, and indirectly by the effect they have on others and the social circumstances they confer on the family (Lamb, 2010). The place of the father in child development has moved from the position of “forgotten contributor” (Lamb and Lamb, 1976) to the subject of extensive empirical research (Holmes and Huston, 2010, Jackson, 1987). Increasingly, attention has been paid to how fathers’ behaviours may influence the development of psychopathology in their children (Flouri and Buchanan, 2003b, Phares and Compas, 1992).

However, despite this increased interest on the way in which fathers influence both healthy and disturbed development in their children little attention has yet been paid to the impact of paternal involvement in clinical work with children/ young people. In therapeutic or clinical settings where families are seen and offered help, fathers are frequently absent (Phares et al., 2010). The involvement of fathers in treatment is associated with better outcomes for children and adolescents with mental health problems (Flouri and Buchanan, 2003a, Flouri and Buchanan, 2003b). However, this has received very little attention from a research perspective (Carbera et al 2000, Flouri and Buchanan 2003a). In relation to child and adolescent anorexia nervosa the involvement of both parents, including fathers, is increasingly recognised as a key determinant of positive outcome (Eisler et al., 2000, Eisler, 2005, Lock et al., 2001, Lock et al., 2006b).

Much of the research that has been undertaken regarding the paternal contribution to treatment has focused on clinicians perspectives of fathers’ involvement (Dienhart, 2001, Duhig et al., 2002, Phares et al., 2005b). The

emphasis on the views of clinicians perpetuates a power imbalance where the professional perception overshadows the paternal view of involvement.

In relation to eating disorders, fathers are described as finding eating disorders difficult to understand. They are presented as choosing to remain on the periphery of both the illness and the treatment process (Kyriacou et al., 2010). Anorexia nervosa is recognised to be a disorder, which invariably isolates and alienates the young person from their family, and this isolation can create a space where the disorder can grow in strength and intensity (Loeb et al., 2011b, Perkins et al., 2005, Treasure et al., 2001, Winn et al., 2004). This is significant in relation to how young people perceive their fathers and how they are represented in the literature.

Fitzgerald and Lane (2000) describe the father in relation to anorexia nervosa as neglecting their daughters' needs while contributing personality characteristics, which lend themselves to the development of anorexia nervosa. Elliott (2010) considered the father-daughter relationship in anorexia nervosa from the daughters' perspective. This study explored the perceptions of women who were recovered from anorexia nervosa regarding their relationship with their father before, during and after the eating disorder. No similar research has been undertaken regarding the paternal view of the father/ daughter relationship. In relation to FBT, the fathers' perspective of involvement in the treatment of anorexia nervosa represents a significant gap that remains to be addressed. Treasure (2018) suggests that it is essential to prioritise fathers in relation to inclusion in clinical work and in eating disorder research (Treasure, 2018).

This review of the literature has demonstrated that research related to FBT has made a significant contribution to the treatment of adolescent anorexia nervosa. Early studies, understandably, set about establishing treatment efficacy, and, although a relatively small number of RCT's have been undertaken, FBT is the most robustly researched treatment for anorexia nervosa. Smaller scale uncontrolled studies have started to look at the components of FBT that have the most impact on progress, and ultimately recovery, but much less attention has been paid to the experience of the families who have participated in FBT. I

identified no papers that specifically focused on the experience of and contribution to FBT that fathers make. This study addresses a significant gap in the literature regarding the role and contribution of fathers to FBT, when a young person has anorexia nervosa. By focusing specifically and exclusively on the paternal experience, the views of an underrepresented group have been gathered and presented.

The research questions that were formulated following the literature review were: what is it like for fathers encountering services when a young person has AN, what factors promote and hinder paternal participation and what is the experience like for fathers. Chapter 3 details the methodology chosen and methods employed to address these questions within this Grounded Theory study.

Chapter 3 Methodology and Methods

The aim of my research was to develop an understanding of the experience of fathers and the contribution that they make to FBT when a young person has anorexia nervosa. The research questions were developed following the review of the literature.

3.1 Research Questions

- a) What is it like for fathers encountering services when their child or adolescent is receiving treatment for anorexia nervosa?

- b) What are the factors that promote or hinder fathers' ongoing involvement in FBT for anorexia nervosa?

- c) What is the experience of FBT like for fathers?

The research questions informed the choice of research methodology.

3.2 Deciding on a research methodology

Potential research methodologies available to the researcher include quantitative, qualitative or mixed methods (Creswell, 2009). Researchers are advised that the research aims and questions should guide the choice of methodology (Holloway and Galvin, 2017). However, Munhall (2012) claims that most research questions can be addressed using a variety of methods, and, as such, advises the researcher to select the method which represents the best fit with their worldview and thinking style and which they consider will capitalise on their individual strengths. Quantitative strategies are particularly useful where there is an established knowledge base and a theory to be tested or refuted (Bryman, 2008) Qualitative strategies are considered most useful when the purpose of the research is the discovery and generation of new knowledge (Creswell and Creswell, 2017).

Given the lack of knowledge base regarding the contribution that fathers make to FBT, it was not possible to formulate a hypothesis or theory in advance

which could be tested using quantitative methods. Recognising the absence of a knowledge base, and the desire to contribute to the literature in a meaningful way, led me to decide that a qualitative research study would be the most useful way to proceed in relation to addressing the research questions.

Within a qualitative paradigm, there is a range of strategies from which to choose. The common features and differences between the various methodologies are briefly considered before the choice of Grounded Theory study as a methodology is discussed.

3.3 Qualitative Research

The term qualitative research is an umbrella term that refers to a range of approaches aimed at developing an in-depth understanding of the social world. Ellis (2016) describes qualitative research as a way of collecting person centred information focused on the individuals lived experience, including their attitudes, opinions and beliefs. The pursuit of new knowledge is central to qualitative enquiry, as the researcher embarks on the research process in order to discover new knowledge and to utilise data generated within the study to inform the development of theory (Bryman, 2008). Different qualitative approaches share a number of common characteristics (Creswell, 2009). Qualitative research takes place in the natural setting and utilises the researcher as the key instrument of data collection. Engagement with participants is central to data collection, and meaning is attributed to the experiences of participants. Data analysis is an inductive process focused on discovering the underlying themes in participants' accounts of a shared phenomenon. The research design is shaped by the researchers' interaction with participants.

Holloway and Galvin (2017) identify that the qualities central to the delivery of excellent healthcare e.g. / commitment, patience, trust, openness and flexibility are transferable to conducting a qualitative inquiry. Qualitative research is particularly useful for developing knowledge where problems are complex and poorly understood (Fossey et al., 2002). Mental health nursing is primarily concerned with how individuals think and feel, and, for those caring for an individual with a mental health issue, the depth and impact of the experience

would be impossible to capture by taking a quantitative approach. The nature of my research topic, the questions I was seeking to answer, and evidence and beliefs about the best way to approach the subject, led me to choose a qualitative research approach.

3.4 Selecting a Qualitative Approach

The five qualitative research methodologies most frequently employed within health and social science are Narrative Research, Phenomenology, Grounded Theory, Ethnography and Case Study (Creswell, 2007). Each research design has its own merits in relation to developing an insight into and an understanding of the human experience. An ethnographical approach involving direct observation and interaction with individuals during the lived experience of FBT would have been extremely challenging to organise and undertake, and, as such, this approach was discounted from the outset. Case study research involves in-depth and detailed examination of a subject of study (the case) including context. This approach was unsuitable due to the absence of a pre-existing theory and the desire to secure multiple participant views of FBT. While a Narrative Research approach, focused on gathering multiple participant stories, could have been selected, the absence of a clear direction regarding how analysis should be undertaken led me to decide against it. Phenomenology, which considers how individuals experience certain phenomenon, would have been an appropriate methodology to employ because it enables the researcher to engage with individuals' lived experience of a situation. After considering the five approaches, I was drawn to Grounded Theory because of its focus on identifying the basic social process in order to develop a substantive theory. A key aim of my study was to contribute new knowledge, and, on balance, I decided that Grounded Theory was best suited to fulfilling this aim. Denscombe (2014) advises that the choice of methodology should be informed by how useful and appropriate the strategy is to address the research aim and answer the research questions identified at the outset of the study.

Grounded Theory is useful when considering a situation where there are related areas of research to draw upon but as yet no substantive theory of the

particular area under study (Birks and Mills, 2015, Gibson and Hartman, 2013, Glaser and Strauss, 1967, Glaser, 2001, Holton and Walsh, 2016, Martin et al., 2018, Urquhart, 2012). It can focus on the perspectives of participants and allow space for the articulation of the issues that are of importance to them. A feature of GT is that it can facilitate reflection, leading to greater understanding and the development of new insights (Glaser, 1998). In particular, Grounded Theory is recognised as suitable for investigating social situations where people need to adapt to a changed or changing situation (Dey, 1999, Glaser and Strauss, 1967, Glaser, 1978, Stern, 1980, Stern et al., 1982).

In relation to young people with anorexia nervosa, a number of GT studies have contributed to the existing knowledge base (Koruth et al., 2012, Newell, 2007, Tan et al., 2003, Whitney et al., 2005). I could find no GT studies specifically addressing the involvement in or contribution of fathers to treatment in anorexia nervosa in general, or within FBT in particular. Reading and reviewing the studies cited increased my interest in GT as an approach, and further reading about GT led me to choose it as my methodology within this research study.

3.5 Grounded Theory

GT as a methodological approach has its roots in the Barney Glaser and Anslem Strauss study of patients dying in hospital in the 1960's. *Time for Dying*, published in 1968, provides a compelling, insightful and easily accessible account of the findings of this first GT study. The seminal text, *The Discovery of Grounded Theory: strategies for qualitative research* (Glaser and Strauss, 1967) presents the methodology in its original form but in a way that is difficult to access particularly for those with little or no research experience. Since the publication of this book, GT has developed in a number of different directions. A brief summary of the different variants of Grounded Theory follows, and thereafter I present my reasons for choosing Glaserian GT.

The three main schools of GT are Glaserian, Straussian and Constructivist (Charmaz). Within a Glaserian or Classical GT approach, the main features are theoretical sampling, concurrent data collection and analysis, constant comparative analysis, theoretical coding, theoretical memoing and theoretical

sensitivity (Glaser, 1978, Glaser, 1992, Glaser, 1998, Glaser, 1999, Glaser, 2001). The Straussian school is the result of collaboration between Strauss and Corbin. It offers explicit guidance on data analysis by providing direction on coding procedures (Strauss and Corbin, 1990, Strauss and Corbin, 1994, Strauss and Corbin, 1998). An additional coding step, axial coding is incorporated into the Straussian approach to GT (Strauss and Corbin, 1990). The key arguments Glaser had with this modified GT approach are made within *Emergence vs. Forcing* (1992). The main concern expressed by Glaser was that prescriptive coding procedures would lead to theory being forced on to the data rather than theory development being inductive and emerging from within the data. Strauss argued that, these additions enhanced the methodology by providing useful guidance to researchers and improved rather than detracted from the original approach (Heath and Cowley, 2004). The most recently developed school of thought, Constructivist GT, rejects a purely inductive approach to theory discovery and development and incorporates an interpretivist stance; that is, it views what is 'discovered' as a co-creation between the researcher and the participant (Charmaz, 2006, Charmaz, 2014). Charmaz (2006) views Constructivist GT as compatible with previous schools of thought and as a development that builds on the original approach.

When considering which school of GT to follow, I found the focus on theory generation from within the data the most compelling aspect of the Glaserian approach (Glaser, 1992). The importance of not knowing what will emerge from the data, and staying open to all possibilities during the process of constant comparative data analysis, is central to Glaserian GT (Glaser, 1978, Glaser, 1998, Glaser, 2005). Within Glaserian GT the process of induction and emergent theory development is emphasised (Heath and Cowley, 2004, Cooney, 2010). The nature of inductive enquiry involves approaching the data with an open mind, by setting aside any preconceptions, and remaining focused on exploring what is happening within the data. In order to engage with this process, the researcher must be able to tolerate uncertainty while staying focused on the data (Glaser, 1998). Hunter (2011) advises researchers to take account of their own influences when deciding on a specific approach. Within clinical practice, an important influence for me has been my experience that by

tolerating confusion and anxiety, new learning and understanding can develop. Mental health practice is seldom neatly defined or organised; it requires engaging with human distress in a meaningful, responsive and flexible way. My experience within clinical practice had an influence on my choice of research methodology. I was naturally drawn to select a methodology that seemed least prescriptive in relation to analytical processes and which emphasised being able to sit with uncertainty, to tolerate not knowing and to trust in emergence. I was drawn to these aspects of Glaserian GT. Within GT, historically, emphasis has been placed on the researcher entering the field as a blank slate with no preconceptions (Glaser and Strauss, 1967). Recent iterations of GT recognise that those conducting clinical research often have prior knowledge of the area under study.

When reflecting on the process of considering and choosing a research methodology, the following quote by Ely (1991) really resonated with me. “No doubt about it, one of the maddening though constructive truths of becoming a qualitative researcher is that one must learn by doing” (Ely et al., 1991;pg15). Glaser (1998) stated that you had to be involved in Grounded Theory to begin to understand it. The research methods employed within this study of the fathers’ experience of and contribution to FBT when a young person has anorexia nervosa are discussed next.

3.6 Ethical Approval

The ethics application was submitted to the university School Research Ethics Committee (SREC) and gained approval to proceed to seek ethical review from the NHS. It was submitted to West of Scotland Research Ethics Service (WoRES) in September 2013. Subsequently, NHS Research Ethics Committee 3 (REC 3) granted approval for the study to proceed in December 2013 (Appendix 2). The REC reference given to the study was 13/WS/0303. Changes to the recruitment strategy required me to seek minor amendments to the research protocol, which were approved by SREC in May 2015, REF 14/NE/1168 and by NHS WoRES REC 3 in September 2015 (Amendment number AM01) (Appendix 3).

The role of university and NHS ethics committees is to pay careful attention to the proposed research to protect all involved parties, including participants, the researcher and the university (Holloway and Galvin, 2017). When submitting the application, I was clear that I would not recruit participants with whom I had any clinical contact, or any individual under the age of sixteen years. At the WoRES committee meeting the possibility of recruiting fathers and young people from the same family was considered. Concerns were expressed by committee members regarding the potential impact that simultaneous involvement may have on the father/ young person relationship. To address this concern, I agreed not to recruit fathers and young people from the same family. Prior to seeking ethical approval, I paid careful attention the ethical issues associated with interviewing participants who have been through a difficult and stressful experience. I built into my proposal structures to provide support to participants throughout the research process, in order to ensure that they were not adversely affected by agreeing to participate. Involvement in the ethics process increased my confidence in the research protocol I had developed. I felt reassured that my study design complied with the required standards for research conducted within the NHS.

Guillemin and Gillam (2004) differentiate ethical approval, as described above, from 'ethics in practice' and highlight the responsibility of researchers to conduct all aspects of the research study in an ethically sound way. Being granted ethical approval, from the relevant bodies within academia and health, provided a sound foundation from which to undertake the research study. Consideration of ethical issues at all junctures of the research process is woven throughout the discussion.

3.6.1 Informed Consent

Informed consent must be established prior to undertaking any research based activities (Creswell, 2009, Denscombe, 2010, Holloway and Galvin, 2017). Prior to interviewing participants, I ensured that informed consent was established both verbally and in writing. A written information sheet about the study was given by the CAMH clinician to all participants when the research was initially discussed. When I met with each participant, I checked that they had read and

understood this information and also had copies of the leaflet available that fathers could take time to read if necessary. Fathers had the opportunity to ask any questions about the study. Once I established that fathers felt that they had been provided with sufficient information to proceed, I asked them to sign a consent form (Appendix 7) retaining a copy for my file and providing each participant with a copy for their own records. It was made clear to all fathers that they could withdraw consent for the study at any point and that the interview would be terminated at their request. In the event, all fathers provided written consent for participation, and no father elected to withdraw from the interview or the study.

3.6.2 Data Storage

Ensuring that confidentiality is maintained and individual data is protected is a requirement of a quality research study (Ritchie et al., 2013). All personal data gathered in the course of the study was handled in accordance with General Data Protection Regulation (2018). All participant information and data was anonymised, in order to protect and maintain confidentiality, and was stored on a password protected laptop that only I had access to. The laptop was kept in a locked cupboard when not in use. When a participant opted into the study, they were allocated an anonymised code, and the transcript of their individual interview was identifiable only by this code rather than by their name. Only the researcher was aware of the individuals' actual identities and this was not revealed to any other person. In depth interviews were audio recorded and transcriptions were stored in a locked cupboard, which only I could access. My research supervisors had access to the anonymised versions of the transcripts. Anonymised data was stored in NVivo 11 for the purposes of data analysis. Personal data will be stored for three months after the conclusion of the study and then destroyed/ deleted. Anonymised research data generated within the study will be stored for ten years and then destroyed.

3.7 Recruitment

Prior to commencing recruitment, it was necessary to determine inclusion and exclusion criteria. Inclusion and exclusion criteria are represented in Table 1.

INCLUSION CRITERIA	EXCLUSION CRITERIA
1. Fathers who have taken part in treatment for their young person with anorexia nervosa.	1. Fathers and young people with whom the researcher has had or will have any clinical contact.
2. Young people who have taken part in FBT for treatment of their anorexia nervosa.	2. Fathers and young people who are unable to give informed consent to participate in the study.
3. Fathers and young people who are able to read the written information provided and give informed consent to participate.	

Table 1 - Inclusion and exclusion Criteria

Initially, I set out to recruit participants from two health board areas: NHS Greater Glasgow and Clyde (NHS GG&C) and NHS Lothian. Difficult circumstances within my own team (NHS GG&C) required me to take on clinical responsibility for all active FBT cases. This had an impact on recruitment to the study. Ethically it was good practice to avoid recruiting individuals with whom I had clinical contact, in order to avoid exerting unconscious coercion to participate, and to prevent introducing bias. My primary responsibility was to deliver good clinical care to the young person and their family. These circumstances, coupled with slow uptake of the study within NHS Lothian, led to significant recruitment difficulties in the first year. In order to address these difficulties, the number of research sites was extended to eight across Scotland.

I provided information packs about the study to clinicians/ case managers who were meeting up with families where young people were receiving treatment for anorexia nervosa.

CAMHS clinicians delivering FBT identified potential participants, both fathers and young people. The clinician/ case manager in phase 3 of FBT, or at the end of treatment, provided fathers or young people with an information pack about the study. This pack contained a covering letter (Appendix 4), an information sheet (Appendix 5), a contact sheet (Appendix 6) and a stamped addressed envelope. Fathers and young people were given time to read the information provided, and, if they wished to take part in the study, to return the completed contact sheet in the stamped addressed envelope provided. I only contacted those fathers and young people who returned a completed contact sheet.

The involved CAMH clinician (who already had clinical contact with the family in relation to providing treatment) had access to identifiable personal information of young people and their families, and selected personal information provided by potential participants was only made available to me once they had agreed to take part in the study. The information sent to me included the individual's name and the contact details, their postal address, telephone number (mobile and/ or landline) and email address. The potential participant could decide which personal identifiable data they wished to share with me to allow contact to be made.

In response to ongoing recruitment issues, the recruitment protocol was revised:-

1. Recruitment took place at the end of phase 2 of FBT as well as in phase 3. This gave clinicians more time to discuss the study with families prior to discharge from the CAMH service.
2. Fathers and young people, interested in participating, completed a contact sheet while present in the clinic and the case manager/ clinician passed this on to me. Thereafter I contacted potential participants directly.

CAMH clinicians/ case managers were advised when I had arranged to meet with participants to whom they had provided study information. Fourteen interviews took place in NHS buildings during clinical hours and one took place by telephone. Informed consent was obtained verbally and in writing from all participants prior to undertaking the research interview.

3.8 Participant Information

Basic demographic information was gathered about each participant in the study. All were biological fathers, thirteen were married (to the mother of the young person with anorexia nervosa) and two were divorced. Thirteen fathers had daughters with anorexia nervosa and two had sons. In eleven of the families, the young person with anorexia nervosa had one sibling, two had more than one sibling and two were only children. Based on the Office for National Statistics classification system (NS SEC) thirteen fathers were employed in professions that placed them in socio economic class one or two and two fathers were in to class four or five. This raises questions regarding the underrepresentation of fathers from a range of different socioeconomic groups in this study. Fathers chose pseudonyms for themselves prior to being interviewed. Demographic information about fathers is presented in Table Two.

Pseudonyms	Occupation	Marital Status	YP with AN	Other Children	Age of YP at start of FBT
Michael	Fabricator	Married	Daughter	Sibling	14
James	Dentist	Married	Daughter	Sibling	16
Anthony	Sales Manager	Married	Son	Sibling	12
Graham	Lecturer	Married	Daughter	Sibling	14
Curtis	Manufacturing	Married	Daughter	Sibling	14
Kevin	Regional Sales Manager	Married	Daughter	Sibling	14
Mark	IT Consultant	Divorced	Daughter	Sibling	11
Andrew	Pharmaceutical Executive	Married	Daughter	Siblings	15
David	Plumber	Married	Daughter	No sibling	13
Martin	Head Teacher	Married	Daughter	Sibling	15
Arran	Accountant	Married	Daughter	No sibling	17
Harry	Materials Engineer	Divorced	Daughter	Sibling	16
Gordon	Scientific Manager	Married	Daughter	Siblings	17
John	Civil Engineer	Married	Son	Sibling	12
Robert	Administrator	Married	Daughter	Sibling	17

Table 2 - Demographic Data (Fathers)

3.9 Sampling

The sampling strategies available to the qualitative researcher are purposive or criterion, theoretical, opportunistic and convenience (Ritchie et al., 2013). Purposive sampling involves selecting participants who by virtue of their experience are well placed to address the research question (Bryman, 2008, Creswell, 2009, Etikan et al., 2016, Silverman, 2000). Thereafter, theoretical sampling informs how information is obtained from participants during the study. Theoretical sampling involves collecting, coding and analysing data prior to deciding which data to collect next and where to gather it from (Glaser 1978). It is a process utilised to ensure that theory is emergent from and grounded in the data (Birks and Mills 2015, Draucker et al., 2007, Gibson and Hartman 2013, Glaser 1978, Glaser 1998, Urquhart 2012). Early sampling decisions are informed by the problem area under investigation and then the data guides the direction in which future sampling proceeds (Glaser, 1978). Within my study I

intended to use purposive sampling, but recruitment difficulties led me to employ convenience sampling.

I utilised a convenience sampling strategy to identify the areas where the research would be conducted and to identify potential participants. In order to develop an understanding of the paternal experience of participating or contributing to FBT, I was clear that I required to speak to fathers who had been directly involved in the treatment process. In 2014 only two health board areas employed clinicians trained in FBT and had structures in place to support the delivery of FBT for anorexia nervosa. As such these areas were identified as potential research sites. Initially recruitment was restricted to fathers in phase three of FBT (this is the final stage of treatment when the young person has made progress and is close to discharge) in order to try to protect potential participants. This restriction was to avoid placing undue demands on fathers earlier in treatment at what was likely to be a difficult point in their lives. The small number of cases in phase three of treatment at any given point in time placed me in the position of attempting to purposively sample from a very small group of individuals. As FBT training and delivery extended across Scotland, I was able to increase the number of health board areas included in the study to ten in total. CAMH clinicians identified the majority of fathers, and a small number responded to an advert on an online eating disorder forum. The entire sample was comprised of biological fathers who had participated in FBT for their son or daughter with anorexia nervosa.

Once data collection was underway, theoretical sampling was employed; data was gathered and simultaneously analysed using the process of constant comparative analysis. Categories emerged, from the initial interviews conducted, that informed the questions that were asked in subsequent interviews.

It is widely acknowledged and agreed that sample sizes in qualitative studies are smaller than those used in quantitative studies (Creswell, 1998, Guest et al., 2006, Morse, 1994). Robson (2002) identifies that it can be challenging to make decisions in advance regarding the exact number of interviews to undertake. Thomson (2010) states that theoretical saturation, the nature of the

research question, the subject area and the skills and understanding of the researcher determine the sample size. By focusing on including participants with the most knowledge and experience of a phenomenon, the number of individuals required can be reduced (Morse, 2000). At the point of developing my sampling strategy, only a small number of fathers in Scotland had been involved in FBT.

The initial total sample size I hoped to include was 20, incorporating 15 fathers and five young people. This is in line with the number Creswell (1998) proposes for a GT study and represents a practical number within which 'saturation' can potentially be realistically reached.

An estimated sample size of 15 fathers was decided upon, informed by looking at similar GT studies in relation to "typical" sample sizes (Calvin, 2004, Caron and Bowers, 2003, Jeggels, 2009 and Mason, 2010). Additionally, the decision was informed by taking account of what I believed was realistically possible and achievable within the scope of this particular clinical doctorate project, regarding timescales for recruitment and time to conduct and analyse the data. The sample size would have been reduced if saturation had been reached with a smaller number of participants, or increased if the data was not sufficiently rich or saturation had not been reached.

I hoped to add depth to my findings by the inclusion of a smaller group of young people (n= five) but recruitment of fathers took significantly longer than anticipated. Consequently, I had to reach a pragmatic decision to use the time available to focus on collecting and analysing data from fathers rather than continuing to try to identify and recruit young people.

In relation to fathers, I achieved the sample size that I set out to recruit and 15 biological fathers of young people who developed anorexia nervosa agreed to participate in this study. This number of fathers was sufficient to reach theoretical saturation, as no categories were emergent in the data after 13 interviews had been undertaken. Interviews 14 and 15 were used to verify the codes, categories and core category identified, and to confirm that saturation

had been reached. This is line with recommended good practice within a GT study (Strauss and Corbin, 1998, Glaser and Strauss, 1967).

3.10 Data Collection

There is a range of data collection methods available for use within a qualitative research enquiry including: observation, in-depth individual interviews, focus groups and narrative analysis of life histories, documents and texts (Ritchie et al., 2013). The research question and purpose of the study inform both the methodology and the method of data collection selected within it.

Dick (2006) suggests that focus groups are well suited for use within a Grounded Theory study, although they are less frequently used in practice than individual interviews. A small number of Grounded Theory studies elect to utilise focus groups as the only means of data collection, for example Nordvik and Broman (2005) and Stewart (2007). Alternatively, focus groups have been integrated into studies to complement individual interviews (Barnett, 2012, Hill et al., 2009). Focus groups are useful in encouraging participants to share experiences, and this can produce rich data (Birks and Mills, 2015). But a potential drawback is the opportunity for individual voices to be lost in the group dynamic, so that those with different or more controversial points of view are not heard, and potentially useful data is missed (Kitzinger, 1995). While I did initially contemplate trying to integrate focus groups as part of my study design, alongside individual interviews, I anticipated that the small number of fathers engaged in FBT within each health board area would make this logistically extremely difficult, if not impossible, to organise. Individual interviews were chosen as the mode of data collection. In order to answer my research questions, I required to collect detailed accounts of participants' lived experiences, and I felt this was most achievable in a one to one interview setting. Qualitative interviews are particularly useful when considering social processes and facilitate the gathering of rich and meaningful data (7, 2016, King et al., 2018). Individual interviews are more likely to be used where the topic is emotive or difficult to talk about (Dempsey et al., 2016, Elmir et al., 2011, Sydor 2013). I anticipated that fathers might be reluctant to discuss their experiences in a group setting and that speaking with them on a one to one

basis would be more comfortable for them. Within the study, fathers welcomed being seen individually and having the opportunity to discuss their experience. Most fathers stated that in this setting they were able to discuss their thoughts and feelings about FBT openly for the first time, and they were surprised by the level of detail they were able to recall once involved in the research interview.

Data collection took place over a 16 month period between December 2015 and April 2017, during which time 15 individual interviews with fathers were completed. Craig (2000) highlight the risks that social researchers can face when involved in conducting interviews in the field. I ensured my personal safety by conducting 14 interviews within CAMH clinics located on NHS premises and liaising with local clinical and administration staff to ensure they were aware of when interviews were commencing and concluding. One interview was conducted by telephone from my work base. Clinical colleagues in my base team were aware of where and when interviews were taking place, and I called by mobile phone to advise when the interview was concluded and when I arrived home. No issues related to safety arose in the course of undertaking the interviews. With regard to support for myself in the role of researcher, I had regular contact with both academic supervisors who provided advice and guidance in research supervision sessions and by telephone as the interviews progressed.

In order to obtain ethical approval for the study an interview schedule to guide to the semi-structured interviews required to be developed (Appendix 8). Within classic GT the researcher is advised to enter the field with an open mind and as few preconceived ideas as possible (Glaser and Strauss, 1967, Glaser, 1978). Initially I was concerned that by developing an interview schedule, I would be introducing preconceptions in to the study and that inclusion of this in to the design would go against the very tenants of Glaserian GT. Within a constructivist, Grounded Theory approach Charmaz (2014) advises that writing an interview guide is good preparation for inexperienced researchers and that it supports the development of questioning to enhance data collection. In her view, by thinking through potential questions in advance, how and when questions might be asked becomes clearer. In practice, I found the position

taken by Charmaz to be consistent with the Glaserian Grounded Theory approach of entering the field with an open mind. In the first interview, the interview guide provided me with a platform to start from and opened up initial exploration of the subject area. Beyond that, the guide provided an aide memoire and informed areas that I might ask about, but it did not come to define or direct those areas. In line with theoretical sampling, I focused on following up areas of emerging interest from preceding interviews while being open to new categories arising by asking probing and exploratory questions.

There were a number of key areas that I identified as important to explore. These included the constitution of the family, who attended FBT, the referral process in to Child and Adolescent Mental Health Services (CAMHS), meeting up with CAMH clinicians and FBT therapists, information seeking, attendance at treatment sessions, the different phases of treatment and transitioning between them, the family meal, balancing competing demands, involvement in day to day care, particularly eating, ending treatment and beyond.

Interviews were audio recorded to capture what fathers shared with me in its entirety. Glaser (1998) does not consider audio recording of interview data to be necessary and expresses concern that researcher skill development and sensitivity to the data is reduced by over reliance on this process. However, the advantage of audio recording is that it provides the researcher with ongoing access to the data in its complete and original form. Birks and Mills (2015) argue that it is possible for the researcher to manage the interaction with the interview material in a way that maintains sensitivity to it. Being a novice researcher, I decided that audio recorded interviews would support me in working with the data and sharing my coding and analytical processes with my supervisors. In my opinion, the benefits of taking this approach outweighed the risks.

I transcribed the majority of audio recordings myself (n=10) and had five transcribed by an NHS secretary who was bound by confidentiality. Although transcribing was time consuming, I found that it brought me closer to the data and that this level of engagement increased my theoretical sensitivity. By moving between audio recordings and typed transcripts, I was able to develop

and maintain sensitivity to the data. In relation to the task of conducting research interviews, I initially felt confident that I could transfer clinical interviewing skills directly to a research setting. I think, in part, this did prove to be the case, as familiarity with meeting fathers in a therapeutic setting helped me to engage them in a focused conversation during interviews. However, I quickly discovered that I had not fully anticipated or realised how responses utilised in clinical work to convey empathy were potentially leading in the research setting. Research supervision and repeated engagement with early interview audio recordings and transcripts enabled me to take a step back, revise my questioning/ commenting style and to develop an increasingly curious stance within the interview. I found that as time went on, I became more competent at fully engaging with what fathers were telling me, at the same time as managing my responses and follow up questions. From the outset of the study, I incorporated active listening, summarising and probing questions into my interview style (Brinkmann and Kvale, 2018). With experience, I learned to rely more on these skills and moved away from thinking like a clinician, whose role is to provide help and support. to listening like a researcher in order to learn about and develop an understanding of the paternal experience and contribution to FBT. McNair et al. (2008) recommend that clinician/ researchers recognise the multiple identities that they bring to the research task and seek feedback and supervision from research supervisors across the course of the process. My research supervisors provided feedback, including strengths and weaknesses, and advised that I had developed a sound interview technique that was producing good quality data.

3.11 Participant and Researcher Considerations

It is important that the research process itself does not cause upset to participants and to be aware that it might. The desire to gather new and important information needs to be carefully balanced with the costs to individuals of sharing their experience (Denscombe, 2010). Given the sensitive nature of the material being discussed, I remained mindful that fathers may become upset/ distressed in a way that they themselves may not have anticipated at the point of agreeing to participate in the study. I utilised my

mental health skills to ensure that all interviews were conducted safely, and had a plan in place to take a break or conclude the interview if myself and the participant agreed that it was not in their best interest to continue. Four fathers did become tearful during the course of the interview, and were given the option of taking a break, but all chose to take a moment to gather themselves and to carry on with the interview. No father chose to terminate the interview process. At the outset all fathers predicted that they would not have very much to discuss and at the conclusion they all commented on having had much more to say than they had anticipated. Several fathers commented on having been able to talk openly and to discuss their thoughts and feelings for the first time, and said that they appreciated having had an individual space to process their experience. All fathers were provided with contact details of services that could provide support after the interview.

3.12 Field notes and Memoing

Glaser and Strauss (1967) position the use of field notes and memos as of central importance in relation to the development of theory within a Grounded Theory study. These are separate but inter-related documents that record the way that data is thought about and analysed over the course of a Grounded Theory study (Montgomery and Bailey, 2007).

Holloway and Galvin (2017) describe field notes as a way of recording things that happen or are said during interviews that seem to the researcher to be of particular interest or importance. By writing about these instances, the researcher can capture “in the moment reminders of incidents that may indicate potential concepts” (Holton and Walsh, 2016 pg 71). Early thoughts about concepts are written down as they occur during data collection and are returned to repeatedly as patterns in the data emerge. Within Glaserian GT, there are no set rules regarding the structure of field notes and their form is likely to evolve as the research progresses (Evans, 2013, Holton and Walsh, 2016). Transcripts and field notes, produced during the study, form the foundation from which theoretical memos are developed.

Memoing occurs from the beginning of the research and is a process that encourages the researcher to think analytically and abstractly about, the data that has been collected (Charmaz, 2006). Writing a memo captures ideas as they develop regarding what might be going on in transcripts and produces a record to remind the researcher of their thoughts and impressions at a given point in time (Glaser, 1978). The researcher starts out with the freedom to create memos about anything that comes to mind during the analytic process (Glaser, 1998, Montgomery and Bailey, 2007). As analysis, proceeds memos become more focused on raising ideas from a descriptive to a conceptual level (Glaser 1978, Glaser 2014). The concepts identified in memos are compared and contrasted and play an important part in the development of theory (Montgomery and Bailey, 2007). The data is fractured and then put back together to generate a theory with field notes and memos tracking the emergence of themes and concepts during the analytic process (Glaser and Strauss, 1967).

The lack of guidance within a GT study regarding how field notes and memos should be constructed was both liberating and anxiety provoking. Therapeutic training undertaken in the past required me to produce content and process narratives of observations on a weekly basis. This training supported me to integrate field notes in to my study from the outset and after leaving the interview I noted down impressions, thoughts and feelings that I could later utilise when working on analysing and coding the narratives collected. In this way hand written field notes were created soon after data collection and before initial impressions could be forgotten. Later while working with the transcripts of the interviews typed memos were created in word documents and in the annotation section of the computerised software package NVivo 11 that I used to store and analyse my data.

Glaser (1978;pg 83) describes memos as the “bedrock of theory generation” and advises the researcher to develop a “memo fund” which captures all thoughts and ideas that could potentially contribute to the analytic process and the development of a substantive theory. As time progressed, I began carry the data in my head and I used the notes section on my smart phone to create

memos in the moment when a thought occurred. These thoughts were later compared with the data and previous memos and field notes to support the ongoing analytic process. The process of data analysis is discussed next.

3.13 Data Analysis

An iterative approach to analysis was taken and as soon as the first interview was transcribed the process of analysing the data and memoing commenced. That is, I began to interact with the data in order to identify concepts or codes contained within it (Urquhart, 2012). “Conceptualising data by constant comparison of incident with incident, and incident with concept to emerge more categories and their properties” (Glaser, 1992,pp38) facilitated the collection of rich data and allowed me to explore similarities and differences between participants. Patterns or recurring incidences identified using the process of constant comparative analysis informed the development of 14 substantive codes, four categories. Connections between categories informed the emergence of one core category from which the substantive theory developed.

The data collected in individual interviews informed me about issues that appeared to be particularly important to or significant to participants and thoughts and ideas sparked by these observations were recorded in memos. These memos were utilised to guide the direction of the study. My early memos were descriptive and focused on trying to identify substantive codes that seemed to be emerging from the data. These were tentative in nature as I tried to stay focused on what was emerging, and I was very conscious of trying to guard against forcing the data with my preconceptions. As a result, these early memos contained more questions than answers. In addition to documenting my thoughts about what might be going on in the data, they captured my struggle to think and express myself conceptually. Initially I felt fearful that by making conceptual links I would be transposing my own position on to the data rather than elucidating connections that existed within it and across participants. I found that persevering with the process of memo writing did improve my ability to think and write in a more abstract and conceptual way. I recall being preoccupied during the memoing process that a more experienced researcher would be doing a better job of analysing the material and as a result would be

able to come up with a better or 'right' theory. Theory took on mythical and magical proportions at this stage that at times was completely paralysing. I read extensively to try to manage my anxieties before realising and accepting that to master them I had to work with them and find my own way through the analytic process in order to produce a theory of what was going on. Morse (1992) positions theory as a 'best guess' about what is happening, and I found that field notes and theoretical memos supported me to move to a position of feeling confident enough to find a way to make my 'best guess' based on careful and thoughtful coding and memoing of participants words.

Memos were utilised to inform the process of theoretical sampling within my study. In this process, "the analyst jointly collects, codes, analyses his data, and decides what data to collect next and where to find them, in order to develop his theory as it emerges" (Glaser and Strauss, 1967;pg 45). Within my study, I could not use theoretical sampling to guide which informant I interviewed next, as participants did not know other fathers with experience of participating in FBT, but I could employ it to inform the areas that I explored with participants. When a question resonated with fathers, they provided additional data on that topic which I then analysed and memoed. If it did not, they introduced new data that informed future substantive coding and category development. Examples of the process of theoretical sampling are presented in Table 3.

<p><i>Father</i>-Having looked in to anorexia and other experiences of it an awful lot of people seem to have had an awful lot worse experience than we did to start with any way.</p> <p><i>Interviewer</i>-I am interested to think more about a couple of things you mentioned there. You said having looked in to it and I am interested to know where you looked in to it and what you found most useful?</p> <p><i>Father</i>-Just websites related to anorexia, the organisations that were set up rather than individual blogs or anything like that. Whether that is just not being tech savvy but it was easier to find a website for an organisation than going in to a blog or something like that. I am aware my daughter has looked at stuff but I wouldn't have known where to go for.</p>	<p>INTERVIEW 2</p> <p>The father introduces looking up information about anorexia nervosa which the researcher explores within the interview.</p> <p>A memo was created noting the apparent significance of this so that it could be followed up in future interviews.</p>
<p><i>Interviewer</i>- So thinking back on that do you think it would be helpful if there was more clear information for parents. Somewhere you could be prompted to go to?</p> <p><i>Father</i>-Yes I mean the FBT was very helpful and very successful but I think what we both felt was that it was very much focussed on the child which obviously it has to be. But there wasn't much of an opportunity, there wasn't much of an opportunity for us on our own to talk to various staff without Suzanne being around. And that was what we felt we needed at the time when we needed because there were things that we wanted to discuss but not with her being present. And that was quite difficult to actually find that time.</p>	<p>INTERVIEW 4</p> <p>In a subsequent interview seeking information is introduced by the interviewer and in response the father discusses separate time with the therapist.</p>
<p><i>Interviewer</i>-That is the thing that has come out from several fathers I have spoken who have maybe only done FBT which has been with all the family together and one of the things they said they would have appreciated was some time with the professionals on their own, face to face rather than phone ?</p> <p><i>Father</i>- It's the same with a review... the reviews used to be quite interesting because you could say frankly where we were and ask them where they thought we were.... if you have a review with the patient present and the patient has got a mental illness the danger is that most of the review is... professionals sitting round saying how well things are going and err nothing is achieved really, apart from making the patient feel better, which is not really what a review is meant to be.</p>	<p>INTERVIEW 7</p> <p>In order to compare data separate time with professionals is explored in subsequent interviews and memos were created capturing my thoughts and ideas as they developed.</p>

Table 3- Theoretical Sampling

All schools of Grounded Theory agree that analysis must occur alongside data collection if a theory grounded in the data is to emerge, but they differ in how

exactly this analysis should be undertaken (Chen et al., 2009). In *The Discovery of Grounded Theory* (1967) Glaser and Strauss loosely described an analytic process that was later expanded upon by Glaser (1978) in the seminal text *Theoretical Sensitivity*. Glaser (1978) detailed two levels of analysis: substantive and theoretical coding.

Glaser (1999) suggests being a GT researcher requires three characteristics: the ability to conceptualise, the ability to tolerate confusion and a commitment to waiting for the confusion to diminish. In combination, these characteristics enable the researcher to wait for concepts to truly emerge from the data (Glaser, 1999). Wuest (2012) states that the researcher must be able to think theoretically and analytically.

I used open coding to break the data down and to facilitate the discovery of initial categories and properties (Glaser, 1992). An example of open coding is provided in Table 4.

INTERVIEW 4	OPEN CODES
<p>Did you find the Beat site helpful?</p> <p>Yes I mean up to a point. I think in general we found there is a slight, I mean perhaps we weren't looking in the right place; the information for parents is not always necessarily easy to come by. So, you kind of feel a bit in a vacuum and it was very handy to have, to know someone who had been through a similar thing.</p>	<p>Feeling alone and struggling to access useful information.</p> <p>Importance of support from someone who understands what you are dealing with.</p>

Table 4 - Open Coding

These open codes represent my early attempts to name and label incidents within the data as concepts or open codes. By comparing data with data, the recurrence of concepts and codes from different data segments started to build up a picture in my mind regarding possible shared concerns and preoccupations across participants. An emergent pattern in the data led me to develop provisional thoughts and ideas regarding what the core category might be. The core category represents the main concern of the participants and the way that it is continually dealt with and worked through (Holton and Walsh, 2016). The concepts or open codes detailed in Table 4 were compared and contrasted with other open codes/ concepts emerging from interviews in order to inform the development of substantive codes. The process of working with data in this way utilising substantive and theoretical coding is cornerstone of Grounded Theory practice (Birks and Mills, 2015, Charmaz, 2006, Charmaz, 2014, Glaser and Strauss, 1967, Glaser, 2001, Urquhart, 2012).

By grouping open codes together, I moved on to selective coding (Holton and Walsh, 2016, Urquhart, 2012). I carried out all open coding on word documents but as I moved towards selective coding, I found it increasingly difficult to manage and work with the data in this format. Thereafter all data was organised and worked with within a Computer Assisted Qualitative Data Analysis System (CAQDAS) Nvivo11. This enabled me to build a clearer picture of substantive codes and categories and the connections between them. I found the process of immersion in the data was supported by storing the data in this way and it moved my analysis on to the next level.

Theoretical saturation is reached when no new codes are emerging and repeated incidents of already identified codes are apparent in new data (Glaser and Strauss, 1967, Urquhart, 2012). Open codes informed the development of substantive codes and categories and from these the core category emerged. The core category identified the main concern that fathers were struggling with and from this my substantive theory of the way that fathers deal with this concern within FBT was developed.

3.14 Quality/Reflexivity

The issue of quality in qualitative research is an area of increased focus but to date no set criteria for making a judgement about this have been universally established (Hammersley, 2008). One approach is to apply the same criteria by which quantitative research is judged to qualitative enquiry that is reliability and validity while another is to develop criteria that specifically relate to qualitative research. Guba and Lincoln (1989) developed five criteria for measuring quality in qualitative research: dependability, credibility, transferability, confirmability and authenticity.

In the seminal text describing Grounded Theory processes Glaser and Strauss(1967) advise that the credibility of a GT study should be discerned by assessing the rigour applied to strategies for gathering, coding and analysing data and for presenting the written theory. Although the construct of reflexivity was not an explicit focus when GT was originally developed issues of quality and how to assess were clearly incorporated in to the methodology. Chiovitti (2003) advises that a lack of consensus regarding what constitutes rigour in qualitative studies generally require researchers to be transparent about the procedures utilised in order that quality can be assessed. In relation to Grounded Theory Cooney (2011) states that if the methodology is applied correctly then rigour will be evident in the development of a theory that fits and makes sense.

Dependability requires the researcher to be explicit about the decision making processes and analytical procedures employed within the study. In discussing the methods utilised within the study I have endeavoured to be as transparent as possible, to describe clearly the process of seeking ethical approval, carrying out recruitment, collecting and analysing data, the challenges faced and how these were resolved in order to produce a research study that could be depended upon.

Credibility or internal validity refers to the 'truth value' of the findings as they relate to the subjective lived experience of the participants (Krefting, 1991 pg 215). In order to achieve credibility, it is necessary for the findings presented to

represent a truth that participants involved in the situation under study would recognise (Holloway and Galvin, 2017). Several steps were taken in order to increase the credibility of this study. When conducting interviews, I employed 'member checking' by paraphrasing and summarising fathers responses to ensure that I had correctly understood what participants were telling me. As such, any misunderstandings could be corrected at the time and this commentary was recorded and could be utilised to deepen understanding and increase sensitivity.

Confirmability was addressed within the study by sharing anonymised interview transcripts and analysis with my supervisors. In so doing, my coding process was made transparent and inter-rater reliability was established. Feedback enabled me to develop my approach to coding and to move towards increasingly conceptual analysis. Thick description was used in relation to presenting participants narratives and in recording my thoughts and feelings as the study progressed in order to reflect on and develop within the process. As my ideas took shape, I subjected them to peer review by discussing emergent themes from the data and my thoughts about them with two specialist FBT clinicians. This process enabled me to test out my thinking as it progressed, but I was also careful to ensure that I remained focused on what was emerging from the actual data rather their interpretation of what might be happening.

In relation to data collection and analysis, Glaser is of the opinion that the process of constant comparative analysis within a GT study provides a robust quality check by ensuring that emergence takes precedence over the preconceptions and concerns of the researcher (Glaser, 1992). Increasingly qualitative researchers are being called upon to demonstrate reflexivity across all stages of the research process from inception to conclusion. This is particularly true of clinical doctorate student where the research relates directly to practice based issues. There is a lack of guidance regarding how to integrate reflexivity in to a GT study (Engward and Davis, 2015). During the study, I utilised the writing, memoing and supervision to develop a reflexive position. Fathers experience of and contribution to FBT was of interest because I had been drawn close to it in my work with families. My clinical involvement with

FBT was both a strength and a weakness; on one hand, it facilitated me being close to clinicians who could help me to gain access to participants on the other it placed me in a position of having experienced FBT from the perspective of the professional 'expert'. Having observed fathers within FBT I wanted to understand treatment from their point of view and as such I had to learn strategies across the research process for stepping back, questioning what I thought I was seeing and separating my thoughts and opinions from those of the fathers, I met. The process of writing and thinking supported my development as a researcher. It enabled me to manage an insider/ outsider position in relation to pursuing answers to my research questions. The thinking processes involved in reflexivity are very challenging to capture in written form (Cutcliffe, 2003) and I hope I have conveyed them at least in part throughout this chapter.

The selection of a Glaserian GT methodology and the methods employed to study the fathers' experience of and contribution to FBT has been discussed in this chapter. My findings are presented in Chapter Four.

Chapter 4 Findings

This chapter explores: what is it like for fathers encountering services when a young person has anorexia nervosa, what factors promote or hinder fathers' ongoing involvement in FBT and what the experience of FBT was like for fathers. These questions were designed in order to address a significant gap in the literature by providing an insight in to the paternal experience of and contribution to FBT when a young person has anorexia nervosa.

An overview of FBT is included prior to the categories Being on the Outside, Finding a Way In, Finding a Way to Be and Finding a Way to Let Go and the core category Repositioning being discussed. Within each category, the substantive codes contributing to their emergence are considered. Verbatim quotes have been used judiciously to illustrate similarities and differences in participants' experiences. Some are longer in length where this provides a deeper insight in to and understanding of the paternal perspective.

Table 5 represents the development of categories from substantive codes. Substantive codes are used as subheadings within the discussion of each category. The core category of Repositioning and the substantive theory of Rescripting conclude the chapter.

4.1 Substantive Codes and Categories

Substantive Codes	Categories
Not Knowing Denying Feeling overwhelmed	BEING ON THE OUTSIDE
Information seeking Starting to find a way Being offered a direction	FINDING A WAY IN
Connections Feelings Personal Attributes & Qualities Lenses Balancing	FINDING A WAY TO BE
Hoping for the best Preparing for the worst	FINDING A WAY TO LET GO

Table 5 – Representing the development of Categories from Substantive Codes

4.2 FBT

FBT was delivered within CAMHS and all family members were invited to attend. All fathers attended the majority of FBT sessions and participated in a clinic based family meal during treatment. Mothers were consistently involved in FBT while sibling attendance was more variable. Fathers, as part of the parental couple, took on responsibility for managing eating and restoring weight during treatment. Most participants experienced three phases of treatment but for some a lack of weight gain precluded progress beyond phase two. FBT

sessions were delivered weekly during phase one, fortnightly during phase two and at longer intervals towards the end of treatment.

Fifteen fathers who had participated in FBT took part in individual interviews. The data collected provided a valuable insight in to what fathers noticed when their daughter/son was developing an eating disorder, what it was like for them to seek help, what taking part in treatment involved, the contribution they made to treatment and what this meant to them.

4.3 Being on the Outside

Not Knowing	BEING ON THE OUTSIDE
Denial	
Feeling overwhelmed	

4.3.1 Not knowing

Fathers had difficulty recognising the start of anorexia nervosa. Only one father described immediately recognising behavioural changes in his daughter as the signs of an emerging eating disorder.

“Prior to referral, I noticed weight loss, there was no question there was a change in her eating patterns at the time and there were behavioural ones running into that. She was becoming more detached, secondly irritable, and there was a lot more arguments than you might remember. But, of course, as a teenage daughter you expect a degree of that, but there was no question that, as her weight was falling, we were watching her portion sizes declining. It was the weight really that was the main indicator.” (Andrew)

Later in the interview Andrew made me aware that his sister developed anorexia nervosa as a teenager and that she has continued to struggle with the disorder throughout her adult life. First-hand experience of anorexia nervosa placed Andrew in a position to recognise the early signs of the eating disorder. The impact of anorexia nervosa on his sister, in her teenage years and continuing into adulthood, informed his concern that without successful treatment anorexia nervosa has the potential to become a chronic disorder with lifelong implications. This recognition contributed to Andrew researching current treatment approaches and concluding that FBT is supported by current evidence and associated with successful outcomes. This level of knowledge and understanding influenced Andrew's decision to participate in FBT.

While past experience placed Andrew in a strong position in relation to early identification of anorexia nervosa, the majority of fathers in this study had no prior experience of eating disorders, and, as such, were in a very different position.

I found that fathers frequently missed the signs of anorexia nervosa as it was developing. Using hindsight, fathers came to attribute significance to changes, made by their son or daughter that they had previously viewed as 'normal' or 'healthy', or as part of adolescence. Commonly the early warning signs were only recognised retrospectively; excessive exercise/ activity was mistaken for positive health improvement behaviours, behavioural changes were confused with normal adolescent development, parental separation affected perception and communication and denial prevented acceptance. These factors acted as potential barriers to problem recognition and influenced when professional help was initially sought.

John felt that highly visible health promotion messages influenced his initial perception of behavioural changes in his son, Tom (12 years), as positive and healthy.

"And he had been, he was doing everything from TV reports that you want your child to be doing; eating healthily; he ate three good meals a day, exercised, was out walking the dog, walking, in school, going to the

gym, playing badminton, all the things that they say, 'Yes, get your child out doing,' and stuff." (John)

But later the impact of these behavioural changes became apparent to John.

"...we hadn't been swimming as a family for ages, and it was in the changing rooms that I saw Tom and was very concerned by how skinny he was. We spoke to him about it, told him that we were really worried about his weight, and then, when we got home, we weighed him. We made a conscious decision to try it ourselves, to deal with it ourselves for about four weeks. So, we would weigh him every week, but he was still losing weight."

For most fathers in this study, the first signs of the eating disorder emerging coincided with their young person becoming or being an adolescent. Adolescence is recognised by parents as a time of change in relation to physical appearance, emotional development and psychological growth. It is a developmental stage during which young people begin to individuate from their parents by seeking independence and increasingly asserting their right to make choices and decisions for themselves. Changes, in the amount of time young people choose to spend with their parents and the way that daily routines are organised and managed, are not unusual, and, as such, are anticipated by parents and seen as part of a normal developmental process. Differentiating normal adolescent development from the onset of anorexia nervosa proved to be problematic.

Martin (51 years) described being aware that his daughter was unhappy and noticing weight loss but initially attributing this to the turbulence of adolescence rather than to the onset of anorexia nervosa. Behaviours like disposing of breakfast were only discovered retrospectively, a piece of the puzzle that Martin did not have access to at the time. When Martin learned that his daughter had been avoiding eating and getting rid of food, with hindsight, he realised that this behaviour had been indicative of anorexia nervosa emerging.

"We first started really to become aware that things weren't right ... we started to think: mmm something is not right. She was very unhappy. She was very unhappy with school. She was very unhappy with herself,

very low self-esteem, incredibly low self-esteem ... but we hadn't yet put two and two together or used the anorexia word, although there had been weight loss ... it's funny the things we subsequently discovered about how she was dumping her breakfast. She was always up first in the morning, and it [breakfast] was going into the dog poo bin in the village. There was just a lot, a lot of wee things ... but there is a lot going on in adolescence, it's difficult to extricate the different strands." (Martin)

Harry, a divorced father of two, attributed not immediately recognising the onset of anorexia nervosa to a combination of adolescence and having less contact with his daughter following marital separation.

"We came on to it as a family a little bit late, and I came on to it later still, because Natalie doesn't live with me. She spent time with me maybe two days a week ... I had seen signs that, in hindsight, we should both have been concerned about, but we passed over for various reasons, assuming it was normal teenage behaviour. Very faddy eating, extreme health consciousness and excessive exercising ... strange behavioural patterns over the summer period." (Harry).

In contrast, Mark (also a separated parent) did initially feel concerned about behavioural change in his daughter but allowed his concerns to be reduced following email communication with his ex-wife who, at that point, did not share similar concerns. Given that anorexia nervosa was diagnosed a few months later, it seems probable that Mark had actually spotted the first signs of the disorder.

"... I remember sending an email to Dawn, when I was noticing that Jane was being a bit strange about food, and Dawn emailed back saying she didn't think there was anything going on back then. So, I forgot all about it, and then a few months later she emailed me to say that she was really concerned and that she had taken Jane to the doctor and did get diagnosis of a problem [anorexia nervosa]." (Mark)

The nature of communication in this situation, electronically rather than directly, may have prevented a shared understanding from developing and early intervention for Jane (11 years) being sought.

4.3.2 Denial

Once the eating disorder had been recognised, some fathers found it very difficult to believe that it could actually be happening to their child.

"I mean, never in a million years could you foresee what was coming with Adam. Especially the type of character, the type of boy he was: he was so bubbly, so sociable and to see that change happening was really hard to take in, but you still believe as a parent that you can control it, that you could turn it round, that it was just a phase ... for so long you are probably kind of in denial. Thinking: there is no way it can be this serious, there is no way that it can be this that is going on in his head. I know my son better than anybody, so you don't accept that for a long time." (Anthony)

Denial contributed to fathers having minimal involvement in the initial help seeking process. Some fathers remained hopeful that a quick solution could be achieved while others were fully immersed in the world of work and did not appreciate the seriousness of the situation they were in. At this stage, most fathers were yet to discover the significant impact that anorexia would have on the young person, their life as a father, and the life of the family as a whole. I found that most fathers adopted a passive rather than an active position in relation to seeking help. The majority of fathers were peripherally involved in relation to help seeking, and they did not begin to recognise how ill their young person had become, or the support they would require, until the family were involved in FBT.

"I didn't go to the initial GP appointment, no. Because, I mean, I knew there was something, but you always think, this ain't happening to me. This is not happening to me, she could not possibly do this ... I mean, naively, I thought that the doctor would tell her the downsides of what she was doing and that she would mend her ways and that there would be no problem ... phew was that a mistake." (Kevin)

Sometimes consulting with a professional compounded denial and delayed rather than facilitated appropriate treatment. Curtis described consulting a sports psychologist when worried about his athletic daughter.

“They said Alison had female triad syndrome, they never said it was anorexia kind of thing. They just said it was that and some athletes do get it and it has to do with a weight muscle thing or whatever and that was basically it, until she came and they told us at CAMHS that basically it was anorexia. So that was the only time we kind of found out and basically how serious it was.” (Curtis)

At the outset fathers had little comprehension of the impact that anorexia nervosa would come to have on their lives. Some fathers decided to take a leave of absence from their work role to be at home full time for the duration of FBT. The transition from being peripheral to central over the course of FBT is discussed later.

For three of the fathers in this study the initial GP appointment led to an urgent CAMHS assessment and immediate admission to either a paediatric ward or adolescent mental health inpatient unit.

“... it was all very sudden. It just spiralled out of control between a visit to the doctors [GP] one day; I got a phone call in the afternoon. Eh, my daughter came up here for a check-up [CAMH Department] and I was phoned at work. My wife was with her, she said, ‘She [Clare] is not coming home. She is going straight to hospital.’ It was sudden as that.”
(Michael)

In this, and the two similar situations, seeking an opinion within primary care led to the young person being immediately admitted to hospital, for weeks or months, in response to a combination of physical and psychiatric risk factors. In these circumstances the family had a more complicated route in to FBT which was not implemented until discharge from hospital.

In contrast, some fathers did take a central role in setting up and attending initial GP appointments and were also involved in supporting their young person with eating between the GP appointment and the first contact with CAMHS.

“... it was, ‘Right, come on, you’re going to the doctors [GP]. We want blood tests done, we want this done,’ and the doctor said she was then on the border line of anorexia ... because of her weight. And we said,

‘Something has to be done,’ ... because it was getting to that stage, and by the time she actually came here [CAMHS], she was at such a weight they were saying, ‘Look, you might be hospitalised.’ So, even in those weeks after the GP, her weight had dropped so much and that was with us trying to get her to eat.” (Arran)

Those who considered that it could be anorexia nervosa that was affecting their young person described having little understanding of what this actually meant.

“Yes, but deep down you just know, you just know, but, I mean, I didn’t know enough about anorexia, you know. I knew there were a few people who died from it, but I didn’t understand why they died.” (Kevin)

Denial kept fathers positioned on the outside of the disorder and precluded them from being in a position to take action.

4.3.3 Feeling overwhelmed

At the point of making decisions about treatment, fathers felt overwhelmed: they lacked understanding of the eating disorder, had no knowledge of potential treatment approaches and blamed themselves for their young person being unwell. In these circumstances, fathers felt helpless and powerless to make treatment decisions and deferred to the opinion of the health professional. So that rather than feeling in a position to make an informed decision or choice about treatment, fathers deferred to health professionals and allowed them to be in control of and take charge of setting up the treatment process. Fathers in this study did make an active choice to participate in treatment but felt that they had no real choice over what it was that they were agreeing to participate in.

“That set the whole process, and at first you are very unsure what to expect ... I was very unsure about what to expect, having no experience. I really didn’t know what to expect.” (Anthony)

FBT was frequently presented as the only available treatment option. Faced with a lack of alternative options, fathers chose to trust professionals who advocated that FBT was the best approach.

“So, I just hope that the path we are taking is the right one ... Well really just accepting that this is the path that has been chosen to be taken. Really, because well, you have no other knowledge to know anything else would work.” (James)

During early treatment sessions fathers were discovering what an FBT approach involved and learning that therapists held an expectation that fathers should adopt a central position in relation to supporting their young person with eating at home. In the early sessions of FBT parents were encouraged to take over all control of eating, which involved supporting young people during and after all meals and snacks in order to promote an adequate intake and prevent compensatory behaviours. For Kevin, initial discussion of this role within the first treatment session did not prepare him for the reality of becoming involved in this task at home.

“You come up here and the initial meeting is quite positive, well not positive, but, you know, you are told what you need to do, and, ‘We can help you,’ and what you have to do. And it sounds easy, but it isn’t anywhere near easy. So, erm, once you come away from here, the first time you say okay there is going to be a bit of work to be done here and, but ... Even after the first time, it was kind of like, ‘We’ll help your daughter,’ and, you know, you kind of come out the room the very first time think: it’s not too bad. It is going to be a bit of work but we will get round this, and you feel okay the first time. It’s when you get into it and it can be, it can be quite bad.” (Kevin)

Kevin was one of the few fathers who discussed the initial treatment session in any detail. He highlighted the disparity between being told about the need to support the young person to overcome anorexia nervosa and the challenges of actually providing the required support.

Where fathers ascribed to a medical model of care, the expectation that parents should or can take on full responsibility for managing the young person’s eating at home was experienced as unreasonable and there was a belief that this task would have been easier or more manageable if the professionals had been more involved in directing and supporting parental input.

Arran described the first few days of trying to support his daughter with eating at home as “hell”. The reality of taking over control, and the challenges associated with this, left Arran feeling that being provided with a plan designed and directed by the professionals would have been much easier to implement in the home setting.

“I suppose it is Family Based Therapy, so it was up to my wife and myself to give her that approach ... we felt we were forcing her all the time. There was always that knocking of heads, gnashing of teeth and everything else that goes with it: tears, emotions, all that kind of stuff, you know, slamming doors ... The first day of doing it probably took me an hour to agree what she was going to eat for that meal, never mind what is going to happen the next day ... the first few days were just absolute hell. Trying to get, trying to push it through that she had to eat this, and she wasn't getting away from the table. It was almost like treating her like a five year old. 'I am not eating my green beans,'... 'I will sit here till you do,'... 'If it is three o'clock in the morning, I will be sitting here with you until that is done,'... Having a plan to implement, if it was coming from the experts, I think it would have been easier for us to implement.” (Arran)

Where young people were resistant to parental attempts to provide support, and where weight loss continued during treatment, fathers were more likely to feel unsupported and overwhelmed by the burden of responsibility during FBT.

“She was diagnosed when she was 17, so we were right at the cusp of adolescent services and then moving into adult health care. And when she was an adolescent, we were involved in the family based therapy through the CAMHS organisation. We found that a very, very difficult time and felt we had very little support, and yet we were being asked to, well, we really felt that the emphasis or the possibility of helping our daughter lay with us. We felt we got no support from professionals, and when we made the transition to adult services the change was huge in terms of the support we felt was available ... at times it felt like we were getting conflicting advice week on week.” (Gordon)

Being expected to take on full responsibility for supporting eating, without adequate guidance and support, resulted in negative feelings about FBT. This was particularly apparent where weight loss was continuing and alternatives to FBT were not discussed. For one father, transitioning to adult services where a different approach was implemented proved positive. In particular, the clinicians being willing to consider an inpatient admission was experienced as more containing and supportive.

In contrast, where fathers felt that they were being effective they became increasingly willing to adopt a lead role during FBT. In these circumstances, perceptions of professionals were more positive and they were viewed as providing sufficient support.

“Because she [the therapist] helped to keep us on the right track and gave us strength at times ... it was us that needed the guidance, and the reinforcement and the reassurance ... It was us that needed the education to save her ... That’s the best way to get your child well, and it is as simple as that.” (Martin)

As mentioned previously a challenge for fathers in relation to contributing to FBT was that they did not really understand anorexia nervosa. Reflecting, at the end of treatment, Arran described a lack of comprehension that persisted across the entire course of treatment.

“Because we still don’t understand it ... I just can’t, I can’t understand why someone would do that to themselves, you know, almost starve themselves to death ... Because, if you know about it you can do something with it, so you can either try and alleviate it or manage it or, you know, you can get a cure for it, whatever it is, but not knowing is difficult.” (Arran)

Indeed, another father, Michael, reported feeling dazed at the conclusion of treatment, demonstrating how feelings of confusion and bewilderment persisted across the entire course of treatment.

Following the initial FBT appointment fathers became increasingly aware of their position on the outside. They recognised that they were looking in on

something happening to their young person that they did not understand. While, at the same time, they were being asked, by therapists, to help the young person. In order to manage the dilemma this presented I found that fathers sought out information about anorexia nervosa and tried to find ways to support the young person who was being affected by anorexia nervosa. That is, fathers started to equip themselves with knowledge that they hoped would enable them to provide better support to their daughter or son.

4.4 Finding a Way In

Information seeking	FINDING A WAY IN
Starting to find a way	
Being offered a direction	

4.4.1 Information Seeking

Information seeking served a number of functions for fathers: it enabled them to recognise the seriousness of anorexia nervosa, to understand what they were facing and to begin to develop strategies for dealing with it. By acquiring knowledge, feelings of powerlessness were offset and fathers' felt more in control of the situation. Recognition that others had faced similar challenges and that their situation was not unique provided comfort and reassurance.

Speaking about the beginning of treatment David commented.

“One article can tell you more, sometimes quicker than having to read through a whole book about, I suppose it would have helped as well, I suppose, but it would be longer thing to read through a book than it would be just to click on this and it’s there because you’ve got the phone, you’ve got the smart phone.” (David)

For David, speed of access to information and availability across a range of settings using mobile technology was important.

Curtis highlighted the importance of receiving information from professionals as early as possible.

“Basically, it was the mental kind of side of it, like she was just changing from the nice girl she was to like a different person altogether. I noticed that bit. When I came to CAMHS, I spoke to one of the girls in here and she gave me a list of the effects of it. I couldn’t believe how many things were coming so true, you know, like the hair loss, the temper tantrums, it was quite phenomenal...” (Curtis)

When fathers utilised the World Wide Web to access information regarding anorexia nervosa, this presented them with a dilemma in relation to discerning good quality information from less useful sources. It was overwhelming, and confusing, when they encountered conflicting and contradictory information.

“Well, I guess when you start looking around you see that there are loads of weird and wonderful forums out there, people who are going through anorexia, people who are anorexic. Yeah, you see the full range of kind of attitudes and information out there about people who are positively trying to reinforce that, and people who are working to try and beat it and overcome it. It is not something, you don’t kind of look at that kind of thing until you are in that situation. Yeah, there were lots, yeah, I guess we didn’t know where, exactly where to start...” (Graham)

An early task in the searching process, for fathers, was filtering out good quality or useful material from negative and potentially damaging information. Fathers often drew on skills developed within their professional lives to support them to navigate the available information.

Kevin described his strategy for coping with the dilemma raised by Graham.

“You obviously do a bit of research online, and the Beat website (website of the national eating disorder charity), and you see success stories and you take positives from that. Ignore the bad ones, ignore the bad ones, but take the positives from the good ones.” (Kevin)

Some fathers said that, although their partners were prepared to look at information accessed, regardless of whether it was negative or positive, they

themselves preferred to focus exclusively on positive material.

“I am different from Elaine. She would look at it all, she would look at it, balanced the bad with the good. I would tend to put the bad to one side and just take the benefits.” (Robert)

Andrew described similar differences between himself and his wife in relation to accessing literature on eating disorders.

“I am not really one for reading books on an issue like that. I read enough in my business life that, when I want to read, I prefer to read other stuff. But, when dealing with this issue, a lot of web sites, leaflets, short articles rather than big long things ... My wife, on the other hand, bought every book that was going and read all sorts of very good stuff by well-known experts in this area, and so my wife would be able to challenge an awful lot of professionals.” (Andrew)

For some fathers an element of self-protection may have influenced how they initially chose to access information, and the approach they took was often complemented or supplemented by their wives' approach of being prepared to look at a much wider range of material.

One father who had read widely at the outset said that he only found the most useful reading material during the treatment process after he had been supporting his young person for several months.

“... there were things I felt might have been different. I brought along a book today that had I been given, you know, whenever Rachel became ill. it would have changed everything for us. And, I mean, I bought everything, but that book there saved [Eva Musby book] our lives. There is no doubt about it, and I don't know why every parent and child isn't given this. I mean, there is a wealth of literature as you know and a lot of it is clinical stuff and all the rest of it ... This was just ... it stands out, and I have read quite a bit, you know. It got damaged one day during an altercation, you know.” (Martin)

Fathers require direction and support to access good quality information to equip them to meet the challenges of the new role and position conferred on

them by FBT. A failure to provide this at the outset delays the development of positive coping strategies, leading to missed opportunities, and hinders rather than promotes the paternal contribution.

Curtis said that he was given information about anorexia nervosa both verbally and in writing within FBT sessions. This combined approach to communicating about the seriousness of anorexia nervosa, hearing it discussed openly while also seeing it written down in black and white, was described as extremely useful by Curtis.

“Until I went to the meetings with Diane (therapist), because Diane wrote it out. She had a big chart, which was excellent, and she put it up every session, and I thought that was really, really good. And she wrote down basically everything that was in the leaflet and everything that could happen and at the bottom of it saying, basically, you could lose your life, you could die, kind of thing ... There was no pussyfooting about ... it could kill you, and I thought: it just hits home. For her to turn round and say, ‘You could maybe die,’ or whatever. Because it was in big letters.”
(Curtis)

It is of note that only one father commented on information being provided in written form within actual FBT sessions in the clinic environment.

Mark also found the book *Anorexia and other Eating Disorders* (Eva Musby), written by a parent for parents about supporting young people with eating disorders, particularly useful.

“I would say I learned the best strategies from the book. It’s getting the right models in your head, like the classic one they talk about, the ‘bungee jumper’ thing, but that, you know, it is those sort of models that really help...” (Mark)

Mark described finding the metaphor of facing a bungee jump himself as useful in relation to developing an understanding of what eating feels like for his daughter. Thinking about the fear associated with bungee jumping helped Mark to recognise and begin to understand the anxiety underlying his daughter’s

struggle with eating. In contrast, discussion within FBT sessions did not connect with Mark in the same way.

“... I am not aware of any of those [strategies] coming from CAMHS. So, you would be told, you know, maybe don’t do that, but do this, but it’s not a memorable context I guess.” (Mark)

This highlights that the way that information is conveyed, and the context in which it is placed, has an impact on how accessible and useful it is to fathers as they begin to develop strategies for supporting the young person. The information fathers sought out and made use of influenced how they adapted to the task of supporting their young person with anorexia nervosa.

4.4.2 Starting to find a way

The most fundamental task ascribed to both parents within FBT is helping the young person with anorexia nervosa to eat. When fathers first became involved in supporting eating, they felt very unsure about the best approach to take, and early attempts at intervening to prevent continued dietary restriction were experienced as overwhelming and frustrating.

“...it is frustrating. How do you make somebody eat that is 14 ... apart from sitting there and force feeding her, I have no idea what I am supposed to do. Just keep encouraging, but it just feels useless because it doesn’t work. Or I think it doesn’t work.” (Michael)

While some young people went along with initial parental efforts to support eating, other young people actively resisted and were extremely distressed at mealtimes. James’ daughter accepted and acquiesced when her parents assumed the role of “feeders”.

“She never, well I mean, she did object occasionally, but that is just like a kid saying, ‘I don’t like sprouts.’ ‘You are having five sprouts whether you like it or not.’ It was the same kind of level of reaction from her. To a certain extent she was just putting up with it ... But she was accepting of what was being done, there wasn’t really a huge amount of, ‘I am not eating that,’ or stop. Initially, there was probably more, when I think back

now, but it never really came to huge, eh, breakdowns ... she treated us like we were the feeders..." (James)

James described an atypical level of compliance from his daughter throughout the process of supporting refeeding. In contrast, Kevin's daughter rejected all initial attempts to support her eating. This is more typically the pattern when a young person is struggling with anorexia nervosa.

"You are kind of getting used to the fact that you know that something is wrong, but you don't know how to deal with it yet ... Kick off would be, 'I have had enough. I can't eat that. I just can't eat that. I am not going to eat that.' ... she refused point blank, literally point blank. And we tried to coax her to take a bit more, 'Please, just take a bit more, it's not going to do you harm.' ... I mean, I had to go into my next door neighbour, we have got a semi-detached so the walls join, and said, 'Listen, we are not killing this girl through there, we are actually trying to help her.' ... the noise that was going on at meal times. And, you know, you have experienced that and they [FBT therapist] are saying to you, 'You're going to have to do more of this,' you think: oh for god's sake..." (Kevin)

As well as displaying extreme distress, some young people also attempted to harm themselves in the context of being supported to eat. This combination of distress and out of control self-harmful behaviour led one father to create a place of safety at home where his daughter could be contained until calm.

"...it might be that she had refused her lunch, erm, the plate got tossed. I said, 'Rachel you have not had enough,' and the next thing she would go berserk ... and I would have to try and get her to the safe room upstairs. And there were days where I had to restrain her for three hours where she was possessed; the strength that she possessed, despite it, was abnormally super human. Erm, and it was about protecting her, you know, she didn't hurt herself, and that was it. It was insane. It was insane. And gosh, it's, it's not typical for a kid with anorexia to go where she went, and I know that." (Martin)

This excerpt illustrates a father trying to manage an extremely ill young person in the home setting; he has a sense that the level of distress displayed by his

daughter is unique, more extreme than would typically be displayed by a young person with anorexia nervosa. His perception of the level of distress displayed by his daughter led Martin to create a safe space within the home where his daughter's outbursts could be contained and managed.

It is significant that Rachel had previously been admitted for a period of inpatient treatment (adolescent psychiatric unit) but discharged early due to parental dissatisfaction with the care she was receiving. When Rachel was in hospital, Martin felt that he was not at all involved in her treatment and this was in marked contrast to his experience of being involved in FBT. The severity of Rachel's symptoms following discharge placed Martin in the position of choosing to "take control" by creating a place of safety and containment within the home.

In contrast to being contained in a safe room Anthony's son, Adam, was encouraged to cope with feelings brought up by eating using a punch bag to release pent up aggression.

"Before he sat down to dinner, he [Adam] had a Tae Kwon Do punch bag, and he would put his gloves on and punch the punch bag and sometimes it could go on for a good few minutes. He would really go for it, and you could see him getting visibly upset and almost crying. And that went on for a while, but you could see over time he would sometimes hit it a few times and then go, 'You know what?'... and the gloves would come off, and I would think: that's it. It is not there as much." (Scott)

Reflecting on the process of trying to develop an ongoing strategy for supporting his daughter with eating at home, Martin described feeling that he lacked the requisite skills and experience to deal with the situation and had to learn by trial and error rather than having a direction to follow.

"These are all the things you shouldn't be doing, and using punishments and rewards and all that kind of thing, and you are dealing with somebody who is mentally unwell. You are not rationalising or reasoning with something. The aim is to get food into your daughter, doesn't matter what way you get that food into your daughter. We didn't know enough

about it, and, again there is no criticism of the service here, you know apart from, I wish we had been given more, I wish we had been given more tools. Because, at the end of the day, it is the parents that are the ones who ultimately are best placed to solve this, you know.”

Fathers recognised that the process of focusing on supporting the young person with anorexia nervosa to eat had a profound and disruptive impact on the entire family. Family mealtimes were perceived as a strength in relation to being together and trying to maintain a ‘normal’ routine but also as a challenge, because every family member was then exposed to the extreme distress and upset associated with eating.

“It was very difficult to actually, to try and get food in. I mean, we struggled for the first few weeks, trying to actually get into a routine ... It is trying to get into the pattern of the meals and the challenges of meals; there were some pretty horrendous times around mealtimes. And I think that was hard for everybody. We have always sat down and eaten as a family ... I think that helped, but it also made it more difficult because then everybody had to go through the horrendous times...” (Graham)

Graham illustrates that while trying to find ways to support eating, he was also holding in mind the effect of being part of mealtimes on other family members. As he describes it, the task is both a practical and emotional one demanding consideration of multiple perspectives and competing needs.

Within FBT, being offered direction in relation to attempting to refeed and weight restore the young person with anorexia nervosa is discussed next.

4.4.3 Being offered a direction

The treatment manual stipulates that a specific direction is issued to parents at the end of the first treatment session. That is: the therapist is directed to invite the family to return to the clinic, either later in that week or in the following week, and to bring a meal for all family members, including a meal sufficient to begin to restore the health of the young person with anorexia nervosa. Within FBT this session is presented as an opportunity for the therapist to observe first-hand the struggle the young person is experiencing with eating and to see

how the parents respond to this struggle. The therapist is advised to focus on supporting both parents to work together to develop effective strategies for helping their young person to eat, and the aim is to “set the parents on their way to working out between themselves how they can best go about refeeding their daughter” (Lock and Le Grange, 2012).

In fathers’ accounts of treatment, there was a notable variability in how the family meal was experienced: some fathers felt that the family meal helped them to develop a different approach at home, while others did not find it useful in relation to helping them to support their young person. For some fathers there was a feeling of being under considerable scrutiny during the family meal session, and they felt ambushed by a lack of transparency regarding its purpose within treatment. These fathers perceived that the purpose of the family meal session within the overall treatment process had not been made clear to them and said they would have preferred a greater degree of transparency. The timing of the delivery of the meal session, and the way in which it was implemented by the therapist, also emerged as significant factors in relation to the overall perceived utility of this particular session.

Graham described the family meal as enabling him to step back and look at what he and his wife had been doing at home and to see where they needed to make changes.

“...we had a family meal as part of the therapy. And I think that at that point we hadn’t really got to grips with everything, we were still kind of giving in and everything, and at that point we realised how much we needed to up our game, I think.” (Graham)

Harry, who is divorced, felt that the family meal gave himself and his wife some direction. It enabled them to try out a different approach to dealing with their daughter’s refusal to eat, which they used out with sessions to prioritise meal planning, expectation setting and sense of purpose during emotionally charged mealtimes at home.

“And we were trying ... I mean it was like she just laughed at us because it was, ‘Be more forceful. Be more forceful, and tell her to eat it.’ And we were trying to be forceful, and she was just saying, ‘I can’t take you

seriously, Dad. You are just not like that normally,' and it was like she was mocking us. It was difficult ... was good though because it gave us the practice ... and that actually worked reasonably well, because she realised that we weren't playing by that stage, and like, we were telling her, 'Natalie, you are going to eat that, and we are staying here till you eat.' ... the meal itself was excruciating, but I think the training we got there was really helpful..." (Harry)

While James found it "quite helpful", he was left wondering about what was being observed about himself and his family and how these observations contributed to treatment.

"Well, I suppose it was a very strange request – come and have a meal and we will sit and watch you. (Laughs) You don't usually get that request from anybody, but, I mean, I can understand the reasoning for it. I am sure they were gleaning from it, and probably I was wondering what they are actually gleaning from this. And who are they looking at, they were obviously looking at all of us and what did, what is the result of it supposed to be ... So, I think it was quite helpful as a starting level and I understand that reasoning behind it." (James)

A feeling of being scrutinised was echoed by Andrew who said that he and his wife had more success finding ways on their own to support their daughter with anorexia nervosa within the home environment.

"Erm, yeah, the family meal, it was extremely awkward and kind of a ridiculous scenario in some respects, and she started to refuse to eat, of course, and then we had to sit there and encourage her to eat, and all these people watching. It just was a bit of a disaster, she burst into tears, and we had more success at home, you know." (Andrew)

The timing of the session, not being forewarned about its purpose and a lack of meaningful guidance or feedback within the session were all important to Arran.

"it was in the fourth week or something ... so, I think, even if it had been done early on, almost the first, second visit it would have probably been better ... We were asked to bring in food ... And again, we weren't

warned why that was the case which it would have been nice to know, from both myself and my wife's point of view, so that we knew what to expect. So, that was a bit of a surprise, but, again, we got through it, demonstrated that we could do it in terms of convincing Faye to eat the food that was there. And, at that point, she was particularly bad with cheese and so we put cheese into the sandwich and stuff like that ... And all they said was, 'You did great, just carry that on.' Whereas, I was saying, 'What was great about it?' you know, I mean, I thought I knew, but it would have been helpful to know actually what was great about that: what did I do right, what could I have done differently?" (Arran)

The potentially excluding impact of the family meal on family members, particularly siblings was highlighted by Michael. He described all family members as feeling very uncomfortable within the session but said that the distress experienced by his elder daughter was so marked that it precluded her from having any involvement in the family meal session or FBT sessions thereafter.

"Uncomfortable, very uncomfortable. Whether it helped Clare in the long run, I don't know, but I certainly would not be rushing to go through that again, but at the end of the day it is not about me. But it was uncomfortable for everybody involved. Keera (sister) refused to come in the room, she sat on the stair. She was too upset." (Michael)

Mark captures the prevailing paternal view of the family meal in the excerpt below.

"Yes, I do remember doing something like that. I don't remember it being significantly insightful though. We have done a lot of coming as a family with Jane. I do remember, I think I do remember doing that, but I don't remember any revelations..." (Mark)

For most fathers in this study the family meal session was not experienced as delivering guidance and support to manage anorexia nervosa. In some cases, the set up and delivery of the session introduced a feeling of 'them and us' which potentially undermined collaboration and failed to empower fathers with taking a position in relation supporting their young people. The presence, or

absence, of feedback within this session proved to be particularly significant; fathers who received live coaching from the therapist within the family meal session found this meaningful and transferrable to the home situation while those who did not were left feeling confused about its purpose and poorly informed about the most helpful strategies to apply at home.

The factors that influence how fathers do find ways to position themselves in relation to dealing with anorexia nervosa and supporting the young person are discussed next.

4.5 Finding A Way To Be

Connections	Finding A Way To Be
Feelings	
Emotions	
Personal Attributes & Qualities	
Lenses	

Within FBT fathers are required to play an active role in supporting young people. This role requires them to take a position in relation to both the young person and the management of anorexia nervosa. I found that in order to become an active participant in treatment, by taking on this role, fathers had to find a way to position themselves within the treatment process. Fathers did not arrive at treatment with a clear idea of how to approach the role that they were being expected to play. As such they had to develop their own understanding of what was required and expected of them. During FBT fathers described finding their own way to be within the treatment process.

Finding a way to be is a feature from the beginning, throughout and at the conclusion of treatment. As mentioned previously, in FBT, the father is called to take action immediately and is faced with taking action while still feeling on the

outside, looking for a way in and trying to find a direction. By nature, anorexia nervosa is a disorder of denial, and, as such, young people experiencing it do not view themselves as unwell, refute the need for help/ support and frequently reject whatever action is taken by their parents. In combination, these factors place fathers in the position of having to take action before they have developed a strategy. That is, the strategy that fathers develop evolves over the course of treatment and is influenced by increased exposure to the impact of anorexia nervosa on the young person. The initial course of action chosen represents the beginnings of a strategy which may or may not be successful. The strategy chosen needs to be revised, reviewed and redesigned, while being implemented, as there is no time to pause and reflect given that action is called for (by clinicians) and required every day (by the life-threatening nature of the eating disorder). Once a strategy has been adopted, perseverance is required to implement it consistently and flexibility is needed in order to be adaptable to the changing needs of the young person as they become more unwell or take steps towards health.

How fathers navigate dealing with anorexia nervosa is influenced by a range of factors. When faced with managing a young person with anorexia nervosa within the home environment, parents attempted to find ways to work together in relation to providing the level of support that was required on a day to day basis.

4.5.1 Connections

The most fundamental connection identified by fathers in intact families was support found within the parental subsystem. Separated fathers did describe increased communication and contact with their estranged partner during the treatment process but had to rely more on their own resources when supporting the young person on an individual basis. Support from one parent to the other, and vice versa, was viewed by most fathers as centrally important when dealing with anorexia nervosa. Some fathers described dealing with anorexia nervosa as uniting them with their partner while others experienced it as having a negative impact on their relationship.

“But we kind of still split it the way that we did when we were working, to a certain extent. Like, at weekends she would often be on shifts, so it would be me that would be doing the housework and maybe doing the cooking and things. So, it is the same kind of split to a certain extent ... it brings you a bit closer together as well when you are dealing with something like that, I suppose it is like with any illness, be it a very serious one or whatever. If somebody had cancer or, our other daughter had quite big operations for scoliosis so we have sort of gone through that kind of thing as well.” (James)

James viewed anorexia nervosa as having strengthened his relationship with his wife. He found that they were able to unite practically and emotionally, in order to meet the demands that supporting their daughter placed upon them, and that this brought them closer together.

Gordon said that small differences in approach, between himself and his wife, were magnified over the course of treatment culminating in a potential breakdown of the marital relationship.

“...there would maybe be small things that we would do slightly differently. For example, my wife always said I was more patient. I would sit for longer and give more whereas the family based therapy was wanting to push and push, and I think she was stronger at maybe pushing extra food or the amounts and ... I wouldn't exactly compromise, but I would give more time, and then those things sort of, those differences I guess, started to feel more and more pronounced even though they weren't because of the pressure of the illness, and yes, I mean, it did culminate in a number of days where whether our marriage would continue was definitely on the cards.” (Gordon)

Despite the strain on their relationship, Gordon said that he and his wife were first to notice the way that anorexia nervosa was influencing their daughter to engage in deceitful and damaging behaviours. Gordon was disappointed at the lack of professional recognition of these behaviours and an absence of therapeutic support for dealing with them.

“...we were saying, ‘Things aren’t right, things are getting worse,’ and the clinicians were telling us, ‘No, no, she is regaining weight,’ and we were saying, ‘No we don’t think she is,’ ... she had stones in her pocket ... ankle weights ... water loading. All those things we identified before the clinicians ... she was definitely in the mode of wanting to get as thin as possible.” (Gordon)

Martin described being vigilant 24 hours a day when his daughter was expressing suicidal ideation and engaging in self-harming behaviour. He remained alert to the potential for her to act on these thoughts at any time of the day or night and consequently felt unable to let his guard down. During the night, when she was sleeping, he remained on red alert ready to intervene should she attempt to harm herself. Then, during the day, he was engaged in the continual task of planning, organising and supporting eating and managing the attendant distress and anger associated with eating. During FBT the task of taking a position in relation to increasing the young person’s food intake was all consuming, and in Martin’s account he vividly captures the relentless physical, emotional and psychological demands placed upon him.

“A typical day would be setting the alarm for before you knew she was going to get up ... there were issues about suicide ... I remember sitting at night at her door, you know, sometimes for hours ... and it would be trying to keep her out of the kitchen while breakfast got made. And sometimes lunch would take an hour, and it might be that she had refused her lunch and the plate got tossed ... she would go berserk and the strength that she possessed ... was abnormally super human ... then it would be down for dinner, and the same rigmarole, and we found different ways to manage it.” (Martin)

Supporting a young person in such challenging circumstances led parents to develop ways to look after each other. On a practical level, parenting tasks previously shared often continued to be shared, and a tag team approach developed in order to deal with the relentless and exhausting demands of providing ongoing support.

“And I think we got to the point where we had to take it in turns so that we had some time out from just being in that position [dealing with the eating disorder] ... No, no I mean I have always done most of the cooking in the evening, so that has been quite consistent. My wife was more involved during the day, obviously with lunches and things, but for the evening meal it was more what I had been used to doing but it had a different take on it.” (Graham)

Graham highlighted relying on sharing the task with his wife but also drawing on previous experience as an involved father in relation to family life and food preparation prior to the onset of anorexia nervosa.

The approach described by Graham was also adopted by Curtis and his wife.

“We were kind of like each other’s rock, you know what I mean? I bounced off her and she bounced off me kind of thing ... and we discussed it between us, and we tried to encourage her in a nice way. And, by god, if my wife was doing it and she was failing, and she failed as many times as I did. She would go away, and I would take over.” (Curtis)

Anorexia nervosa had the potential to strengthen or weaken marital relationships. Some couples came together and became more united in response to adversity. While for others the strain on the marriage almost precipitated the breakdown of the marital relationship.

In regard to supporting young people, fathers were also influenced by their relationship with their own father.

“I mean we are very, very close. I like to think we are very close as a father and son. And my father and I are very close because him and his father didn’t have that relationship. So, my dad set out on a mission: he said, ‘I am never going to be like my father. I want to be very close to my son,’ and I would like to think that Adam and I are exactly like that as well.” (Anthony)

As fathers became increasingly focused on supporting the young person to eat at home, they found their world shrinking and becoming much smaller than the

one they previously occupied. Fathers became increasingly socially isolated, found it very difficult to ask for help or support and felt the effects of stigma associated with mental illness in general and eating disorders in particular.

I found that when a young person is struggling with an eating disorder that restriction often becomes reflected in family life.

“Yeah, I mean, I think we found it very hard because, as a family, we are normally out at the weekends, being active. We would go walking, out and about, and the kids were always into athletics as well. We pretty much shut down for most of that year ... we had to try and take it in turns to actually let each other get out of the house ... My younger daughter she suffered as well ... we had to cancel two holidays, and we just had to stop doing the things we would do normally.” (Graham)

Being isolated during the course of dealing with the eating disorder was accepted by some fathers as inevitable and unavoidable.

“But you are isolated, there’s, there’s you know, I thought I knew what loneliness was ... there is an inevitability about that aloneness. It’s like, you can’t explain, you know, to your family what is going on, or help them or make anybody else understand. It is not possible...” (Martin)

These fathers found it difficult to access support from extended family members who they perceived as having little or no understanding of eating disorders. In these circumstances, contact with extended family increased rather than mitigated against feelings of isolation.

“She [ex sister in law] just didn’t understand it ... in the depths of the crisis, when my ex sister in law came up to help, she just actually in some ways made it worse, because she just didn’t understand.” (Harry)

In contrast, some fathers relied heavily on the involvement of extended family and viewed them as crucial to overcoming the eating disorder.

“Like I said, we are very close, so, getting that support ... fortunately my mother and father are very close with the children as well, so they had that support as well. Obviously not as close as a father and a son but it

just reinforced it as well. So, I think that the family unit is absolutely crucial.” (Anthony)

Beyond the family, colleagues or friends who had experienced an eating disorder within their own family of origin were most likely to be approached for support and to be experienced as helpful.

Often young people were reluctant to include extended family members and when they were allowed to exert control over these kind of decisions families became more isolated and cut off from potential sources of support.

“Suzanne was very unwilling for them to come, and they are quite a long way away so that was difficult ... It took a long time for Suzanne to be comfortable for them to come and see her. And they did come up, but I think we were all having enough trouble dealing with it, we didn’t want to put it on to them. So, we didn’t actually see many people at all over that period, and that is the kind of way we dealt with it.” (Graham)

Some fathers felt it would have been helpful to have had access to a support group. Martin was of the opinion that the availability of a support group would have been useful addition to his treatment experience.

“There was another thing; another trick that I think is missing now ... it always struck me as strange that there weren’t parental support groups ... who better to understand your condition and position than someone who is in it or who has been through it?” (Martin)

Arran reflected on the informal support available to him when his daughter had cancer and this prior experience highlighted the absence of support available during treatment for anorexia nervosa.

“I think, as parents, it is quite intensive, so a better support for parents would have been good. We were quite supportive of one another ... but a wee bit of hand holding would have been quite nice for us as well. How are you feeling? Are you coping? Are you okay? A wee chat would have been quite good. Now whether that is a group of fathers you can go and talk to, or parents going through other things, you know, that might help, just have a laugh about it, because I mean that is what we kind of used

to do with the cancer treatment. We would be in the ward and we would be, 'Oh your kid has got well, we have had that as well, and, you know, don't worry about it and,..' ” (Arran)

Arran identified that when his daughter was receiving inpatient hospital treatment for cancer, he had regular contact with other parents. When she was in the ward environment there were opportunities to meet and talk with other parents and informal networks of support could be established by parents dealing with similar situations. During FBT parents are supporting their young person within the home environment. They undertake tasks that would have been managed by nurses had their young person been admitted to hospital. Because all sessions are delivered to individual families at outpatient clinic based appointments there are not the same opportunities for meeting parents in similar situations. As such, parents involved in FBT have limited opportunities to access informal support networks.

Where these informal support networks do not exist, parents are likely to be increasingly reliant on professional support. In this study, fathers articulated a view that FBT met some but not all of their support needs.

Those who found FBT sessions most supportive valued being involved and included in the young person's treatment, having a space to talk and receive support and the more open style of communication within the family that developed as a consequence of treatment. While those that identified unmet needs found it difficult to be open in sessions including the whole family and to open up about their own thoughts and feelings.

Harry, as a separated father, felt supported and validated by being included in and involved in treatment especially since previous experience of other health situations had left him feeling excluded from his daughter's life.

“It [FBT] wasn't quite what I had expected, but I was very pleased that it did happen that way because, in some ways, being kind of separated from the family I think I had been kept at arm's length for a while, and it actually helped me greatly to actually be pushed right in to it, because obviously I was concerned ... it was very gratifying for me that it did happen, and, in some ways I wasn't expecting it, because Natalie's

treatment for any other issues were largely kept on the mother's side and I wasn't generally involved ... we were kind of thrust together as a family again, and I was made to talk to my ex-wife's new husband, things like that. So, we actually became quite close knit for a while. That was probably the most unexpected thing..." (Harry)

On the whole, fathers valued receiving support and encouragement in FBT sessions. When the young person found a voice and talked about underlying thoughts and feelings during sessions, fathers described developing an enhanced understanding and appreciation of the impact of anorexia nervosa.

"Yes, because over time you realise, well, Sarah is thinking some weird things which she wouldn't have discussed with us had we not been in that situation. And, over time, she has opened up more in the sessions sometimes than she would have done at home, or she wouldn't automatically have come to us ... she voices her thoughts more than she used to..." (James)

It was not always easy for fathers to communicate openly about their own thoughts, feelings or fears during FBT sessions. Graham and Curtis found that having the whole family present restricted their ability to openly express themselves.

"Yes, I mean, the FBT was very helpful and very successful, but I think what we both felt was that it was very much focused on the child, which obviously it has to be. ... but at times it was difficult to access that, it wasn't always easy to get that information and to find that space to talk to staff about concerns we had, or how best to approach things." (Graham)

Curtis described finding it difficult to decide whether or not to discuss issues regarding his daughter openly in FBT sessions.

"You are kind of watching your words because you don't want to upset your daughter who is sitting there every time we went to the sessions ... I was a wee bit iffy whether to say things or not." (Curtis)

John and Andrew viewed opening up about feelings as something that males

don't ordinarily engage in and this made it difficult for them to feel supported in a setting that centres around emotional communication.

"No, no it is just the usual, finding it sometimes tough to open up, but I think that is probably a male thing. You know, when they said it is family based and we all have to go, I was like: oh no it is like my worst nightmare." (John)

For Andrew talking about feelings was an 'anathema' usually avoided.

"...it's just not my area; I just don't feel comfortable with that stuff, as I'm sure a lot of dads will probably tell you the same thing. I don't externalise stuff much and therefore this is an anathema." (Andrew)

The inability of some fathers to discuss their concerns, thoughts and feelings in family based sessions precluded them from being honest about the challenges they were facing and receiving the support they required. In combination, the comments about 'anathema' and 'worst nightmare' highlight the challenges of holding on to and maintaining a masculine identity while engaged in a treatment that requires some level of emotional communication.

The connection of fathers to the world of work emerged as influential in relation to how they positioned themselves with regard to supporting young people at home. Several fathers were in a position to take a leave of absence from work, and, as such, could be centrally involved in supporting the young person at home over the course of FBT. Factors related to the nature of the eating disorder, combined with work related factors, influenced which parent took the lead on being with the young person and managing the eating disorder by staying at home and which parent played a supportive role while continuing to work.

Some fathers held senior professional positions that afforded them a high degree of autonomy that facilitated involvement in treatment while others did not enjoy this degree of flexibility. Factors related to their role within the company and the views of their employer, had an impact on the role that fathers were able to play at home. Those in senior positions expressed concern for fathers who had less autonomy and felt strongly that managing FBT without

support from work and flexibility in your role would be extremely challenging if not impossible. Fathers working in less senior positions within manual or administrative roles, were able to secure support from sympathetic line managers who liaised with senior management to ensure that they could attend appointments or spend time at home.

The severity of the disorder; the behaviour displayed by the young person as a consequence of it or the need for a period of inpatient care also emerged as key factors that influenced how much time fathers chose to spend at home.

For Martin, his daughter behaving aggressively, while in the grip of the eating disorder, led him to seek a period of absence from work and in order to prioritise being available to support his daughter and to protect his wife.

“Yeah, but things fell off the cliff in early August, you know, when we came back again, and that’s when things got really ... then I contacted my employer, and the director, and said I couldn’t come back to work ... I took a whole term off, took a whole term off ... she had become physical and my wife couldn’t ... and this wee thing you know that you would; the loveliest, most gentle girl in the world you know became something else.”
(Martin)

In relation to making a contribution to FBT Martin attributed being allowed to have time and space to focus solely on helping his daughter as the single most influential factor; he felt that by being there he was communicating to his daughter that she was his number one priority and that by positioning himself in this way he played an important role in improving her health.

“What is the one thing that made a difference? ... I think me taking time off work. It caused incredible resentment, but I think it also demonstrated to her illness that we weren’t going away you know. That, that no matter what, I mean, I would have walked away from my job, there is not a shadow of a doubt that I would have walked ... I wonder how other families in that position cope, you know, that haven’t got an employer that was as understanding as mine.” (Martin)

A number of fathers elected to take time away from work in order to be involved in 24 hour provision of care and support to the young person. While others managed to negotiate flexible arrangements with employers that enabled them to manage the demands of both work and home.

“Both myself and my wife work full time ... my work were very understanding and allowed me to work from home a lot of the time so I was actually able to be at home a lot of the time. Whereas my wife’s job involves a lot of fieldwork, so she wasn’t able to be at home as often.”
(Gordon)

Some fathers would have preferred to be more involved in directly supporting the young person, but financial factors precluded them from doing so.

“Work was actually quite supportive but they wouldn’t have been supportive if I had been off for 10 weeks ... the ideal position would have been if I had been the one at home, you know? I had agreed what she was going to eat, I would then implement it and make sure that that was happening, but financially that just wouldn’t have worked.” (Arran)

Andrew expressed concern for fathers who are not able to secure time away from work.

“One other thing about the work balance I should mention. I had probably more freedom for manoeuvre compared to a lot of folks, because of my role., I was very close to the unit so I could nip out, step out of the office for long lunch and get away with it no problem. If I was working out in the Borders, or somewhere else, it would not be straightforward. So, I think that is a factor. Yes, if you were a member of staff where you need permission to take a break, or your breaks are at a certain time, it is very difficult, I am sure.” (Andrew)

On a practical level, issues related to employment roles and responsibilities impacted on how physically available and present fathers were at appointments and in the home environment during the course of FBT. On an emotional level the nature of the eating disorder and the fathers’ reaction to it influenced the way that they coped with the demands placed on them during treatment. The

way that fathers felt about and reacted to anorexia nervosa in the family is discussed next.

4.5.2 Feelings

Families affected by eating disorders are brought face to face with their own thoughts, fears and prejudices regarding eating disorders and these have an influence on how they seek and engage with help. These views impact on how fathers share information with the outside world. The perception of a societal view that is stigmatising had an impact on how fathers felt about the position the eating disorder placed them in.

Fathers identified having little or no understanding about eating disorders prior to their son or daughter developing one. It was an issue they had not thought about prior to it affecting their own family. Fears about eating disorders and their implications influenced how fathers shared information and how and when they sought help and support.

When Michael's daughter required a period of inpatient care, to stabilise her condition, prior to the commencement of outpatient FBT he was shocked that she was admitted to an adolescent psychiatric unit.

“For me, I got a fright that it is not so much like a hospital, it was like, well what it is, a mental health unit. And I got the shock of my life when we went in there.” (Michael)

For Anthony, accepting that his son had a mental illness proved difficult, he felt that people observing the family from the outside would not expect this to be the case and chose to tell people, with the exception of close family, that Adam was being treated for a stomach complaint.

“Because everybody gets a bit frightened about going to see the psychiatrist you think ... just it has that kind of stigma about it doesn't it? I remember thinking: god does my son really need this...” (Anthony)

The stigma of having a young person requiring input from mental health services was significant for Anthony.

John described wanting to seek help for his son immediately but said that his wife was concerned about the impact of seeking help and their son receiving a diagnosis of an eating disorder.

“I saw Tom and was very concerned by how skinny he was ... we made a conscious decision to try it ourselves, to deal with it ourselves for about four weeks. So, we would weigh him every week, and he was still losing weight, and it was at that point that I was keen to go straight to the doctor, as soon as, but my wife was concerned about it going on his record and stuff like that, that he had an eating disorder.” (John)

In both families where sons were affected by anorexia nervosa concerns about being seen by mental health services and being labelled were raised. This may have been coincidental but could be related to a perception of eating disorders as female disorders. The fear of an eating disorder going on the young person’s record is more reminiscent of a criminal misdemeanour than a health concern and would not be an issue in relation to a medical condition as opposed to a mental health condition with medical consequences.

Andrew described feeling that physical illnesses such as cancer are more acceptable within wider society and that the stigma associated with mental illness impacts on the reaction of other people to eating disorders.

“You know, if it was cancer, I think the reaction would be different, you know, it is the stigma around mental health that gets in the way. But, you know, I think the reaction would be different for cancer patients.”
(Andrew)

The experience fathers have of support and the stigma they encounter has an influence on how open they feel able to be about their own feelings. Issues related to stigma are further considered within the discussion chapter. An absence of parent only time in treatment seems to limit opportunities for fathers to have an open discussion about their feelings with professionals who are in a position to provide support and understanding.

The process of trying to manage anorexia nervosa and engaging with treatment is a journey of navigating rough terrain for fathers. During this journey fathers

need to find ways to manage their own emotional reaction to the situation in which they find themselves. The way in which fathers manage their own emotional reaction influences how able they feel to be helpful to the young person. Managing emotions is now discussed and encompasses the range of emotions experienced by fathers and how they come to cope with or manage these.

Initially fathers felt guilty and to blame for the onset of anorexia nervosa.

“Looking for someone to blame, aye, somebody to blame, something to blame. At the end of the day it is your fault...” (Michael)

Fathers were dealing with feelings of blame and emotional overwhelm at the same time as feeling responsible for finding a solution to the problem.

“I am dad. I am supposed to be sorting all this stuff. I am responsible for it, but, I couldn't, I was helpless ... I was thinking to myself that they must be thinking I am useless at this or I am not trying a leg [not trying at all]. He is not even trying to make his daughter eat, does he care or does he what? That is how I felt.” (James)

James articulated a fear that his inability to feed his daughter was being observed and judged by others as reflective of how much or little he cared about her. At this point, James is measuring his success as a father by how much food he is succeeding in getting his ill young person to eat. This sense of responsibility for finding a solution, that feels elusive, can result in feelings of distress and/or anger.

For the most part, feelings of distress were something that fathers felt they had to hide particularly from the young person who was struggling with the eating disorder.

“And your own thoughts and feelings, you go out have a cry at midnight out the back door by yourself and that's fine, are absolutely of no consequence... So, it's not about my pride or about my hurt or whatever else ...” (Martin)

“...generally being fairly strong in front of both the boys all the time, I try and be very loving with them but not that sort of emotional wreck that I was feeling inside all the time.” (John)

As such, fathers reported feeling vulnerable and struggling on the inside while trying to present a strong external face to their young person who was unwell.

However, anger was an emotion that could not always be hidden and at times it made its presence felt in an unplanned and uncontrolled way. That is, it took over and could not be hidden from view.

“I think at first you feel a bit angry towards yourself that you have not been able to resolve it yourself. Because everything else that has been thrown at us, we have resolved...” (Anthony)

For Anthony the struggle his son had with eating brought up powerful feelings of anger. These feelings contributed to a loss of control, the extent of which Anthony said he had never experienced before.

“Adam was sat the breakfast bar, and Susan (wife) was with him and they were trying to eat dinner ... and I almost grabbed the spoon and wanted to just force it into him ... I just had enough, and I grabbed him off the stool and told him to get upstairs. The way I grabbed him, and I could see my daughter got upset, my wife got upset, and I got upset.” (Anthony)

Anthony described becoming very angry and losing his temper with his son. Anorexia nervosa proved to be a difficulty that could not be ‘controlled’ and solved in the same way that previous problems within the family had been. Underlying feelings of powerlessness and inadequacy in the face of an apparently intractable situation were expressed in an angry outburst that Anthony later regretted and felt very guilty about.

Curtis, who said he found it difficult to be open in FBT sessions, spoke at length about feeling overwhelmed but turning this anger in on himself.

“It was definitely the tension with the anorexia. I know that for a fact, it was the tension in the house, it was just, it kind of just came to a head ... I know for a fact that that triggered it ...I have had depression and I had

been thinking about, you know ... I felt like taking the knife and putting it in me, and you know it's crazy, you know but as I say I have never had these things for years and years ... There comes a time when you are going to go into overload, you know, and probably lose it or whatever."
(Curtis)

Curtis illuminated how the stress of dealing with anorexia nervosa exacerbated a pre-existing depressive disorder and led to suicidal thoughts and feelings. These thoughts and feelings were not disclosed or discussed during FBT and no professional help or advice was sought in relation to them. While feeling this way on the inside, Curtis was in the position of trying to present a strong front in relation to supporting his daughter. With regard to this he said:

"I'm the kind of person who goes with the flow, if something needs to be done, it needs to be done, and, you know, if there is a problem, it's got to be sorted. That is basically my mentality of life, nothing will ever get me down, you know it doesn't matter what comes up in life I will beat it. My wife has the same outlook as me, you know, everything can be beaten. No, I wouldn't let anything dominate me or take away my life."

Curtis talked openly about becoming depressed and suicidal (feelings he had not previously discussed) in the context of trying to support his daughter during FBT, but then claimed that nothing ever gets him down. These two positions are highly contradictory; Curtis acknowledges and then denies having overwhelming and potentially life-threatening feelings. During the course of the research interview he moves from a position of exposing his vulnerability to minimising and denying its existence. After opening up about his underlying emotional turmoil and vulnerability, defence mechanisms appear to come into play to enable Curtis to move to the safer position of presenting a coping, happy go lucky face within the interview and to the world. This possibly mirrors the way that Curtis tried to present himself within the therapy situation, where difficult feelings were kept at bay, by making jokes and remaining one step removed from the process. Humour is used as a mask to hide very difficult and troubling emotions.

“I can never say I went to an FBT session and came out bored. It was always quite intense, you know, you were always kind of glued, it was like watching a good film or something ... To me it was a relaxing hour as well. I really enjoyed it, don't get me wrong, I really enjoyed it. And I probably opened up a wee bit more than I thought I would have and spoke away and whatever. Diane used to call me the joker, I wonder why.” (Curtis)

This quote illustrates how Curtis protects himself by observing rather than fully participating in treatment sessions. He adopts a jokey persona within sessions that belies the serious level of psychological disturbance he is actually struggling with. The striking contrast between his internal world and the external persona he chooses to present draws attention to a paradox that exists when fathers are engaged in FBT. When anorexia nervosa is experienced in the family it brings fathers into close contact with a challenging, perplexing and potentially fatal mental illness; they observe the impact it has on their young person's behaviour but do not understand what is happening or how they should respond. When fathers agree to participate in FBT they are informed that anorexia nervosa represents a crisis over which they must exert authority in order to help their young person (Lock and Le Grange, 2012). Exerting authority is associated with adopting a confident and competent persona and position. Within FBT fathers are required to try to find ways to present this authoritative front while dealing with underlying emotional turmoil and confusion. Curtis presents an extreme example of simultaneously holding two polarised views of himself, but, to a greater or less extent, all fathers during FBT must integrate an external self that feels at odds with how they feel on the inside. This raises a question regarding how much of the paternal experience remains invisible to therapists throughout the treatment process. The surface level presentation of the father may preclude recognition of underlying turmoil and prevent consideration of additional adult focused individual support.

The paradoxical position that fathers are placed in during FBT and the way that they attempt to manage this is further considered in the discussion chapter.

Most fathers acknowledged experiencing some feelings of anger related to not knowing how best to help and support their young person.

“Frustrating. Because to me I just felt useless, powerless ... A couple of times I lost the plot, I was shouting and screaming. It didn’t make any difference.” (Michael)

“It is just that I think I was less patient about it. I would see her behaviours coming back and I would be less patient about how I dealt with it I think.” (Mark)

Fathers described coming to recognise that they needed to find different ways of responding to the young person in order to be more helpful.

“I know you kind of get to the point of not getting wound up it’s not helping, it’s not helping anything, it’s not helping me, it’s not helping Maria so...” (David)

A realisation emerged that feelings of anger could be channelled into helping the young person in the grip of anorexia nervosa.

“...we got better at not blaming her. We got better at having a clear sense that what we were dealing with here was an illness that was separate from our daughter.” (Martin)

James described his internal dialogue; in his thoughts he counselled himself against losing his temper and in particular focused on the impact it would have on his daughter if he did.

“So, there were times she would just refuse to eat, leave the room and storm away, that kind of thing. I mean, we didn’t, we did do some head on stuff which in retrospect didn’t really help matters. So, okay, don’t lose your temper, no point in losing your temper because you are losing your temper at anorexia not at Sarah. It was trying to split it into that, not to lose your temper, not at the victim kind of thing.” (James)

James demonstrated an emerging recognition that expressed anger hurts the young person who is already struggling and has the potential to damage the father/ young person relationship. He illustrates the complexity of empathising with the position the young person is in; which requires holding in mind an idea of the eating disorder as taking over the young person and exerting an influence over the way they are thinking and behaving while believing that the

healthy young person still exists and is trying to find a way out. James draws attention to how a key principle of FBT, separating the eating disorder from the young person, requires fathers to engage with complex thinking processes in order to conceptualise the disorder as something that has taken over the young person. Developing insight into and empathy for the position that the young person finds themselves in is a challenging process that requires fathers to be both able and willing to change the way that they think about and relate to the young person.

In addition to managing their own emotional reaction to the situation, fathers also have to find ways to manage and balance their ongoing relationship with the young person during the course of treatment.

Role reversal within the family was a common experience when dealing with anorexia nervosa.

“It was just really, you know, about the temper thing, the controlling. She was very controlling, my daughter, as well. Basically, controlling you, telling you, that was the way it was with anorexia. It was, like she was the adult and I was the child ... very controlling. And she would just go on, off on one, and start banging doors and jumping on floors and banging and all these kind of things. It was just unnatural; it wasn't the kind of things she used to do.” (Curtis)

The presence of anorexia nervosa introduced a new dimension into the father/daughter relationship and fathers feared that taking a position and assuming 'control' of behavioural aspects of the eating disorder might jeopardise their relationship with the young person. A fear that by taking charge of behaviours or communication the father/ daughter relationship could become fractured or damaged emerged.

When Gordon was concerned that his daughter was falsifying her weight, he insisted on her being weighed in her underwear but felt fearful about the impact that this would have on his ongoing relationship with her.

“We insisted that she was weighed in her underwear, which she accepted when we insisted on it, but again it was sort of putting a bit of a

wedge between us and her, again us coming across as being the bad cops.” (Gordon)

Mark, a separated father, was acutely aware of the fragility of his relationship with his daughter and this had an impact on the way he communicated with professionals regarding the challenges of supporting her.

“... It’s because I don’t want to be seen to be the one, when my relationship with Jane is the most fragile, I don’t want to be the one who is saying, ‘Well, actually, things aren’t going well,’ when everyone else is saying, ‘Oh, they are going really well,’ and Jane is like, ‘It’s that bad man over there again.’ ” (Mark)

A fear of being viewed, by the young person, as the ‘bad guy’ influenced how able fathers felt to challenge the young person’s attempts to retain ‘control’.

When fathers attempted to challenge the young person’s desire to retain ‘control’ they encountered outbursts of extreme anger and aggression never observed prior to the onset of anorexia nervosa.

“My daughter had completely lost it, completely lost it, you know, for about three or four weeks. You know, many a day was restraining her, you know, em, there was incredible violence.” (Martin)

Anger was either internalised (expressed towards the self) or externalised towards parents as they tried to intervene.

“Emma would sit at the table, and, with two sausages in front of her, actually pull at her hair, trying to pull her own hair out, and Christine [mother] would take her away from the table and she was in fits of temper on the floor. And I have seen my wife holding her in a wrestling hold to stop her hurting herself over two sausages, and it is the most frightening thing you have ever seen in your life to be honest...” (Kevin)

Attempts to help were also met by the young person trying to distance themselves from the situation which placed them in a position of increased risk at a point when they were feeling most vulnerable and out of control.

“Natalie, her behaviour was getting quite extreme, and, you know, she would run off, and things like that, and we had to go and look for her. Climbing out of windows, and like almost physically managing her. We kept off where possible the sort of physical restraint, because that is obviously taking it a step further, but there were several times we did have to literally lock her in the house. And I had to help Maria (mum) go and look for her, because she had taken off and things like that.” (Harry)

At the same time, fathers invested hope in the young person coming to realise for themselves the impact the illness was having on them and developing motivation to change and get well. This was particularly apparent with older adolescents but was also evident in the younger age group.

“The more we got to understand the illness by proximity to it the more we could see that really anything we did would get modified, corrupted by the illness and the only way it could possibly be changed was from our daughter wanting to make that change or getting to a stage where she would be able to make that change.” (Gordon)

Gordon considered motivation to change to be the single most crucial factor in influencing a move towards health. When his daughter transitioned from FBT in CAMHS to adult eating disorder services he found the focus on individual motivation and therapy much more acceptable than a family based intervention. To some extent this view was shared by Andrew, whose daughter was an older adolescent at the point of commencing FBT, and who also had experience of a family based approach within CAMHS and individual treatment in adult services. This may be related to the age of the young people, the nature of their difficulties and associated resistance to paternal/ parental support or to beliefs about where the locus of change and responsibility for it should lie.

David and Graham, who have younger daughters, also placed most emphasis on their young people finding the determination to get well than on the contribution that they as fathers made to FBT.

“And, I don’t think, maybe I am taking credit away from myself and my wife, but although we are putting food in front of Maria, it’s Maria that is eating it. We are just sitting trying to, ‘Come on have a wee bit more,

have a bit of this – you need to have this,’ erm, it was more M deciding she wanted to eat it.” (David)

“I suppose, initially, you have no idea where everything was going to go ... We had no idea if she was going to have a year out of school, was it going to work, let alone her exams coming up. It was just complete unknown. We had no idea where things were going to be and to see her back where she is now, I mean, we couldn’t ask her to be doing any better. It’s really great. Incredible to be honest (becoming emotional) ... and I think that is mostly down to Suzanne’s determination.” (Graham)

In contrast, Martin felt that the parental approach to the eating disorder was the most important factor within FBT.

“...parents know their child best and working in consortium with professionals who know about the illness is the best way to get your child well and it is as simple as that.” (Martin)

How young people responded to initial attempts made by their father to help them influenced how much fathers persevered with establishing the skills required to break through the barrier that the anorexic behaviours presented.

4.5.3 Personal Attributes and Qualities

When dealing with anorexia nervosa, perseverance was identified by all fathers as the most important personal attribute. Determination to make progress and succeed can be enhanced by family and clinician support but is not dependent upon it. Gordon described feeling unsupported, but this did not prevent him from being determined to persevere with trying to find ways to reach his daughter in order to make a difference to the outcome for her.

“I always felt that somehow we would get her back, and we just had to keep going.” (Gordon)

The area where feeling unsupported does make a difference is in relation to the practicalities of taking action. With regard to this Gordon said,

“We felt we were, well, we knew we were making mistakes, but we didn’t know whether there was a right way to do anything, but it sort of

felt we were constantly making mistakes and rather than having a path that we could follow.” (Gordon)

In contrast, fathers who reported a more positive experience of feeling supported seemed to more clearly see a path that needed to be followed and felt in a position to persevere in doing so.

“...we would keep trying to narrow down the areas he would fight against things, but we would sort of then focus it down to, ‘No you do that,’ so that would be a bit of the field away and then that would set up a routine for that which became a sort of routine that he always had that at this time. And then we would push in to another little bit and then try and add something else in to it, that he didn’t want to eat, and then just keep doing it that way, which seemed to work.” (John)

Following the path might lead to a dead end, but where support was perceived as being available this could be tolerated and the path rejoined the next day.

“You know, we have sat here for four hours tonight, we have got three burst plates and we have got, you know, is she going to eat or is it going to make any difference that she doesn’t have that two hundred calories tonight. Tomorrow is another day, we start again, and then you have got to. Each day it was about, it was about staring again regardless, you know?” (Martin)

Fathers identified that the same path often needed to be revisited many times before a move forward in a different direction could be achieved.

“And we tried to coax her to take a bit more, ‘Please, just take a bit more, it’s not going to do you harm. It’s your medicine. You know you need to eat. You want to get better, erm you want to go out with your friends,’ you know? Pretty much it was like a broken record, to be honest, every meal time. But you seemed to eventually get through. While you were not always successful, but you were getting a bit more down her.” (Kevin)

“It wasn’t a perfect road, we had good days and bad days and days when it didn’t quite work out, but we learned not to beat ourselves up about those days and just carry on. To move on.” (Graham)

Perseverance did not always guarantee progress, and, when it did not, other treatment approaches were considered. For some a move in to individual therapy or systemic family therapy was required, while for others hospital admission was necessary.

4.5.4 Lenses – the way the eating disorder and the young person is viewed

Fathers were keen to hold on to the individuality of their young person and held an understanding of who young people were as individuals prior to the onset of anorexia nervosa. They brought a lens of fatherhood and a pre-existing relationship to the therapy situation.

Within FBT, the way that anorexia nervosa is viewed and discussed influenced how fathers thought about and coped with anorexia nervosa in their son or daughter’s life. Fathers described that, within FBT, the eating disorder is discussed as if it were separate from the young person and that the young person is seen as being ‘in the grip’ of an illness over which they have little or no control. In response to the young person having been ‘overtaken’, the father, along with the mother, is directed to step in and to assume all responsibility for the young person’s eating (Lock and Le Grange, 2012). Separating the young person from anorexia nervosa is an intervention implemented by the therapist at the beginning of FBT and is particularly prominent early in the treatment process.

Initially, this way of thinking about anorexia nervosa and its relationship to the young person was experienced by fathers as unusual and alien.

“Jan [therapist] always said, ‘Just be vigilant,’ and that, ‘If Bethany tells you she is eating a sandwich that could be the anorexia telling you that and she could be lying, you know,’ ... Oh it was really weird that bit, you know, when she explained it like that, it was like, it was quite a, what’s the word? I don’t know if scary, but just weird, you know, because she

kept saying, 'Well remember, when Bethany is telling you some things or wanting you to do something, that is sometimes anorexia talking.' And you know it was like paranormal stuff but now that I think about it makes sense, it was like it has just taken over her mind, a weird thing ... Bethany would often go shopping with me, and again, I remember, that is anorexia wanting to go shopping." (Robert)

To begin with Robert struggled with separating Bethany from anorexia nervosa and it was hard to believe that a normal activity like shopping could present an opportunity for anorexia nervosa to control the food that was being bought and brought in to the home.

For some fathers, separating the young person from the eating disorder was a helpful approach that enabled them to connect with the healthy part of the young person that was being hidden by the illness. Harry illustrated this in the quote below.

"Yes, but she has been sort of taken over by the condition. And it's fighting her, and I think that was the thing that helped me, the way I viewed it right throughout the condition was that's Natalie, you know, Natalie is still in there. And it is almost like your overlap diagram, the overlap came in and went out again that is what it was like, and there was a time we only had a small crescent of Natalie, but she was still there. It is an interesting model to look at, but, even in the darkest times when she was fighting back and being, you know, the behaviours, it was still reassuring, you could still see the Natalie in there for sure." (Harry)

Some fathers embraced this approach, and anorexia became like a third person in the relationship, referred to within the family as if it actually existed as a separate entity.

"It would be, 'Aww Dad, just leave me alone, will you? I am just going to eat my dinner upstairs.' It is still like that yet, and then we started talking in the house as if anorexia was a person. 'Anorexia is not deciding what we are eating tonight'. I don't know if it helped or not, but sometimes she just burst out laughing and shook her head. I wouldn't say it got easier as

it went on, but it felt as if we were doing something, that's for sure."
(Michael)

Those who were younger at the time of developing anorexia nervosa appeared most receptive to this approach.

"It was Helen [therapist], I remember her suggesting it. You know, give 'IT' a name, and I am sure it was Adam who came up with Gremlin ... and it definitely did separate, you know, it would still, obviously it took a long time for it to disappear ... Yes, the Gremlin was, you know, he went and printed off these pictures of a Gremlin and wrote these messages that said, 'Dad, I am going to do all that I can to get rid of this.'" (Scott)

While older young people and their fathers struggled with it more and found that talking and thinking about anorexia in this way did not sit well with them.

"...looking back, and knowing my daughter, she is kind of a bit like me, she, she was kind of forced to go along with it ... she was very uncomfortable with it ... I think that it's not a one size fits all ... they obviously talk about externalising the disorder and all this stuff, and my daughter always resists that says that's a load of rubbish. But we tried that in the house, and said, 'That is not you, it's the disorder.' We included all that stuff to try and help, and talking to my two other daughters saying, 'She has got an illness, so you have to think about it as if she had cancer or a broken leg or something. She can't help it.'... they didn't talk much or engage with it ever." (Andrew)

When the young person is viewed as having been overtaken by a disorder, a consequence can be that as an individual they are seen as powerless to resist. In these circumstances the potential exists for young people to feel excluded and marginalised within a treatment aimed at helping and supporting them. Strategies focused on highlighting the impact of anorexia nervosa on the young person can dilute or reduce their sense of personal agency. Where the discussion remains focused on what parents need to do, without including or involving the young person, the voice of the young person can be lost within treatment. This is particularly important in relation to treatment for anorexia

nervosa which, as a disorder, has the effect of silencing the young person and prevents them from seeking the help and support they require.

Gordon described his daughter as feeling invisible in therapy sessions.

“...on the whole, Jen [daughter] is open and she certainly listens to what is said to her and she tries to take it on board. While she doesn’t always manage to do it, she is definitely trying, and she is wanting to beat it ... she would say she was completely disengaged. She frequently remarked, more or less: I am here, stop talking about me, talk to me.”
(Gordon)

Separating the eating disorder from the young person can put all the attention on the eating disorder and place the locus of control as external to the young person. This can have an impact on how visible the young person feels in the therapy situation.

The group process within therapy sessions was experienced by one father as placing inordinate pressure on his daughter to change and improve. For him it felt like he was involved in placing pressure on the young person rather than collaborating with or supporting her.

“So, thinking about it I understand the power of FBT is a group sitting round and one person who is obviously suffering and it’s almost like a bullying really that they are expected you know to improve. We are all here to help you get better, and, if you don’t get better, we are all just sitting here wasting our time. And no one said that, but that is how I was feeling at one point. It was kind of a form of peer pressure – maybe even bullying at extremes ... Well maybe I can roll back to the word bullying maybe peer pressure would be a better word. But very strong peer pressure...” (Andrew)

Talking about his daughter’s more recent experience of individual therapy, Andrew has a perception of his daughter as being a more active participant in her own treatment.

“Although she says this [individual therapy] is much better ... whether this is in relation to the more control she has over it or the less we have.

What she says is, 'I like the way they deal with me. I like the way they interact with me. They treat me like an adult. I feel ready to deal with this now. I feel I am ready to do psychotherapy to really get at the issue.' ”
(Andrew)

4.5.5 Balancing

Throughout FBT fathers were concerned with the individuality of their young person and sought to occupy a position where they could maintain a connection with them rather than the eating disorder. Their focus was on both nurturing a relationship with the young person at the same time as trying to stand up to the eating disorder that they could see was affecting their health and wellbeing. During FBT fathers increasingly recognised the impact that anorexia nervosa was having on the young person. They came to understand that the drive to restrict intake and consequent weight loss, when left unchallenged, led to the young person becoming increasingly unwell physically and psychologically. However, they found that challenging anorexia nervosa led to distress, upset and anger and that the young person remained convinced that restriction and weight loss were essential. When fathers tried to take a position by challenging the disorder, they engendered an angry or distressed response from the young person. This response made fathers question the quality of their current relationship with the young person and fear that by continuing to stand up to anorexia nervosa that they would damage or destroy the relationship completely.

One way that fathers tried to hold on to and maintain their relationship with their young person was to focus on and emphasise positive attributes which, in their view, characterised the young person prior to the onset of the eating disorder.

“I mean, never in a million years could you foresee what was coming with Adam. Especially the type of character, the type of boy he was, he was so bubbly, so sociable ... and he is a really smart kid ... He was head boy at the school, he was doing amazingly well” (Anthony).

Initially taking a position predominated and fathers had to learn to relate to their young people in ways that would not have been required in a paternal relationship with a healthy young person. This also had a profound impact on

the father's ability to maintain and manage his relationship with other children within the family. Michael described this in relation to eating, while Graham discussed having to limit his daughter's activity level.

"I suppose as time went on, I was getting used to Clare bursting in to tears and I wouldn't back down. I would not change. I would say, 'Sit down. Dry your face. Let's have something to eat.' "(Michael)

"That was quite hard, to stop her from doing anything, it took everything to say, 'No, you have to stay there. We have to go and get that for you. If you go to the loo, you can't go upstairs. If you want anything from upstairs, we will go and get it.' Yes, it was quite difficult to get her used to that and for us to get used to that as well." (Graham)

The position fathers required to adopt during FBT was developmentally inappropriate and required the father to be much more present and active than would ordinarily be the case. In order to assume this position, fathers had to fall back on and rely on their previous parenting experience. All fathers had been centrally involved during the formative years and they pulled on this experience to help them reposition themselves. Usually, in adolescence, young people are becoming increasingly independent and a distance develops between them and their parents. Part of being a teenager is spending time alone or with friends, and fathers tend to become peripheral figures that are less involved in the day to day life of the young person. When an eating disorder emerges in adolescence, the father is more closely involved with the young person and becomes engaged in supporting their day to day life and activities. The approach that requires to be adopted is in many ways reminiscent of when the young person was a younger child.

"The first day of doing it probably took me an hour to agree what she was going to eat ... the first few days were just absolute hell. Trying to get, trying to push it through that she had to eat this, and she wasn't getting away from the table it was almost like treating her like a five year old." (Arran)

"Yeah, but I don't think it is any different from what a parent should do – putting food down in front of your child and getting her to eat it – we did

that when they were babies, you know, encouraging her to eat, 'Oh, come on, there is a choo choo,' things like that. It's a similar thing, although she is much older, it's a different way of working. You are obviously not putting choo choos." (David)

When fathers felt that they were not receiving sufficient support in the therapy situation, taking a position in relation to anorexia nervosa was experienced as persecutory and this raised a fear that the father/ young person relationship would be irreparably damaged in the process of treatment.

"...that was really in relation to all the family based therapy. It seemed to be pushing all the onus on correction and enforcement on to my wife and I and nothing coming from the clinicians, no support for us in our battle, and it was a battle with the illness." (Gordon)

Where fathers felt unsupported and concerned that their relationship with their young person could be damaged, they described engaging in more negotiating and compromising with the young person over the course of treatment

"...it was negotiation a lot of the time about what she was going to eat, when she was going to eat it, you know ... Having a plan to implement, and it was coming from the experts, I think it would have been easier for us to implement. Whereas what we were doing was, I was negotiating with her. So, it might be, 'Right, so you need to eat, say 400 grams of pasta,' or whatever, well I can't remember the figures tonight. 'No, I am only eating 200 hundred,' 'No, no, you have to eat four hundred. Okay, we will let you eat 300, but then you have to eat a yogurt as well,' you know, so it was much more about negotiation." (Arran)

In contrast, fathers who felt well supported seemed less concerned that their relationship with the young person was under threat and described being able to move on from negotiating with the young person to openly challenging anorexia nervosa.

"...we just dreaded every meal, because you never knew what was going to happen ... I mean certainly initially I think we did negotiate on certain things, then gave in on this and tried to put it in there and it didn't always work. And it's that realisation, it takes you a bit of a while to realise, that

you just can't negotiate. The way we dealt with it was just to get to a plan and absolutely stick to it ... So it was gradual, so that over a few weeks we hit what we needed to hit... we really realised that we couldn't carry on negotiating with this ... We gradually got to the point where she knew what to expect, we knew what to expect, and between us we kind of managed to get that to work. But it was very hard..." (Graham)

Whether or not fathers felt well supported in FBT, they described finding ways to maintain a connection with their young person. They described relying on moments away from the eating disorder to maintain and restore the relationship.

"And I would actually talk to her in the car. I would say, 'How do you feel? How does eating make you feel?' And she would tell me. And I see it helped me understand it more, but I would take her away, take her shopping ... I don't think some of the things she told me to her mum. Because, maybe I asked different questions, erm I don't know. But it would let her get it off her chest, you know, a wee bit anyway." (Kevin)

"Mm, I don't think we ever really did, it was just you would give her a cuddle and whatever else and just realise that she was probably scared as well, but, other than that, no I don't think, I think we probably struggled with that a little bit in dealing with that, just the distress side of things." (Harry)

4.6 Looking Towards the Horizon

<p>Hoping for the best</p> <p>Preparing for the worst</p>	<p>Finding a Way to Let Go</p>
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Within the interviews, fathers were most focused on what happened in the lead up to and during FBT and said less about the end of treatment. This appeared

to reflect that, although FBT was over, fathers felt much less sure that their experience of anorexia nervosa had reached a conclusion. For them the journey felt like it was far from over. This is reflected in this section being briefer than those that have preceded it.

On reflection, all fathers, no matter the outcome of FBT for their young person, felt it was important that they had been included in treatment and said that they would advise fathers facing a similar situation to participate.

"I would be very blunt, like Jackie [therapist] was with us at the start. I would say if you want a fit healthy child again it is crucial that you play that role and you are there as a father, because if you weren't you wouldn't even want to think about the consequences, and it does make a difference." (Scott)

"I think my experience is: if you don't participate as a family it is very hard to beat this, because I suppose it requires everybody to be pulling in the same direction. I mean, my experience is that, as a disease, it exploits any chink in the armour, and if you haven't got a united front, it's no good, it's not going to work." (Graham)

David, having participated in FBT, highlighted that, in his opinion, FBT is not FBT if the father is not part of it. For him a family focused therapy centrally includes the father.

"I don't think there is any doubt he has got to take part in it. It is a family thing it is a FBT, it's not called that for, I mean, it's not called one parent therapy. It is family, he has got to ... even if they are divorced or separated, if he isn't even getting on with his wife, maybe they're having an argument and they don't speak to each other, it is still his daughter or his son. He has got to be there and part of it, as much as he can be. If they are separated, he has got to be supportive to his partner or his ex-wife or whatever." (David)

The two fathers who felt most strongly that their daughters did not engage well with FBT put the most emphasis on the significance of holding on to hope throughout and at the conclusion of treatment.

Arran described using hope to challenge his daughter to do the things the eating disorder made her most afraid of and in doing so he felt she made considerable progress.

“We always had the hope that Faye would get better. Therefore, if she is going to get better, she is going to have to socialise. She is going to have to get used to eating in front of people, so it is something you are just going to have to do, you know? So, we would encourage her to actually go out.” (Arran)

Gordon said that he never lost hope that his daughter would get better.

“Because I never did give up hope ... I always felt that somehow we would get her back, and we just had to keep going ... it did become a difference between myself and my wife that I always was more optimistic, and that definitely drove a bit of a wedge between us too and my wife couldn't see any chance of it ever getting better. But now, I would say (long pause and sigh), we can certainly see that she has improved a lot and I still hope that there are more improvements to come.” (Gordon)

When the young person began to move on with their lives, fathers who felt worried about the re-emergence of anorexia nervosa found ways to continue to maintain a central position in the young person's life. They found themselves balancing the young person's need to get back on track developmentally with their need to provide supervision and support. Fathers did not return to the position they had held prior to the emergence of anorexia nervosa but rather repositioned themselves in order to maintain the close contact established over the course of treatment.

“So, you struggle to find that balance between being intrusive and being supportive ... She is away to university in Glasgow, she had the option of going to Edinburgh or Glasgow and we convinced her to go to Glasgow and stay in the house for at least the first year ... Once we bought her a car it was fine. So, there was a bribe in there and that's absolutely fine. But it made us feel more comfortable, and she, to be honest, I think felt more comfortable with the decision as well.” (Arran)

The fear of relationship breakdown that was present for fathers during treatment did not come to fruition and they found ways to balance their need to stay involved with the young person's need for independence.

"Yeah, oh absolutely, I can see how parental relationships with their children break down badly and never recover. So yeah, I think so. I get on well enough with her I don't think there has been any lasting damage, you know. She's at university, and I have been going up and spending a lot of time teaching her to drive and things. For me that was an excuse to keep an eye on her – do you want to do some driving practice? Well I teach her to drive, and I can keep an eye on her without actually saying anything. We can grab lunch or something." (Andrew)

However, for separated fathers who were pulled much closer to their daughter by virtue of being involved in FBT for anorexia nervosa there were significant losses at the end of treatment.

For Harry, while Natalie was ill and undergoing treatment, he had more contact than he had previously had. But as her condition improved, and she rediscovered life beyond the home and constraints of anorexia nervosa, she established social relationships and had less contact with him. Harry had mixed feelings of happiness that she was moving on but sadness at feeling left behind for a while. Having been drawn much closer by anorexia nervosa than would ordinarily have been the case, the feelings of loss associated with the ending of FBT were profound.

"In some ways the only sort of postscript for the whole treatment thing for me is that it kind of all; I mean it really is a good news story for us, but it kind of left me as a sort of absent father, in a bit of limbo, because things moved on so quickly and it is almost, I wouldn't say, it would be horrible thing to say I have lost my daughter, because we haven't lost our daughter, and she is healthy now and that is absolutely the main priority. So, it was a bit of a shame, in a way, that we are actually slightly more distant now than we were, in some ways, but it was almost like going off the end of a conveyor belt. But everyone's situation will be different, and if you lived with your daughter that wouldn't be the case, you will still be seeing her day to day life." (Harry)

For Mark, ending FBT meant that his involvement in supporting eating also ended and this reduced his contact with his daughter. He was then in a position of feeling concerned about the continued presence of anorexia nervosa while feeling that he had very little 'control' or influence over this or his daughter.

“So, she chose to spend no time, no nights at all at my house, but we would still have meals together. And now what was happening is, we had a meal recently, with some friends as well, and she was, in my opinion, not eating enough and choosing not to have the dessert at all and saying she would get something back at her mum’s. It all just looks like anorexia is just coming back to me. Yes, so you know, I find it difficult having no control. Jane is older; therefore, I have no control. Jane is not at my house I have no control. It is very difficult. I do feel like I have no control, but then, you could argue, you don’t have any control at her age, or you have less and less control. But I feel I don’t even have much influence over her, I guess. So, it is difficult.” (Mark)

For these fathers, the Repositioning associated with being involved in treatment for anorexia nervosa necessitated a level of involvement that is not ordinarily the case when living separately from the young person. Moving to a different position again at the conclusion of treatment had a profound impact upon them.

All fathers remained vigilant for signs of difficulty re-emerging and this was the case for both sons and daughters.

“I think, as long as Beth is living with us, you know, we will pick up on it pretty quickly, I think even if that is 10 years down the line. We will think: oh no, wait a minute, here she has stopped eating something or we would notice that really quickly.” (Robert)

“It will always be there. I cannot see a time in my life when I am not going to be thinking, ‘Has he eaten enough?’ I am sure that day will come, but I can’t see it yet ... I do have a fear about it. I don’t think it will be as large a fear as when we first found out, if it comes back. Which I don’t know, but it may, and, we will, do our, go through it all again if we have to.” (John)

Kevin captured the feeling of the majority of fathers that moving through treatment and towards an ending equated with seeing light at the end of the tunnel.

“Yes exactly. So, If anybody was sat there now, I would, I would recommend it (FBT), but I would warn them, but there is light at the end of the tunnel ... Yes, but there is light at the end of the tunnel.” (Kevin)

In taking part in FBT fathers move from being positioned on the outside, to trying to find a way in, to finding a way to be only to then have to try to find ways to let go. Anorexia nervosa leads to fathers Repositioning themselves within the family and in their relationship with the young person who is struggling. The core category of Repositioning is discussed next.

94.7 Repositioning and Rescripting

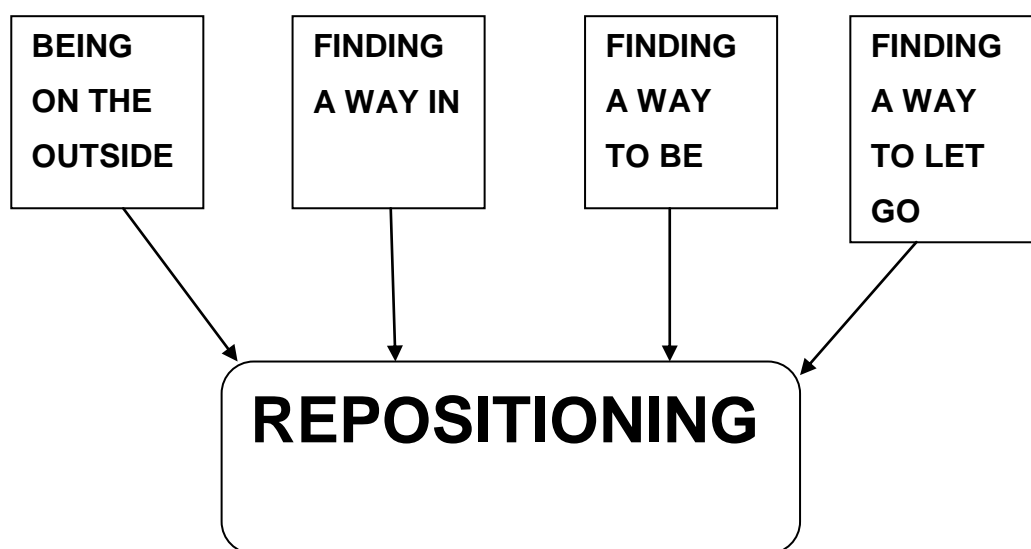


Diagram 1 - Core Category Repositioning

The core category of repositioning emerged from all of the paternal narratives. It takes account of and describes the way that fathers, as a direct consequence of engaging with and participating in FBT, adopt a new and changed position within the family and particularly in relation to the young person with the eating disorder.

Prior to the onset of anorexia nervosa all fathers had attained and maintained secure positions in relation to employment. Their attention was primarily focused on building success in the work environment and in their working lives fathers described feeling competent and confident. They attributed this success to an investment of time and effort in their career over many years. Fathers felt that they had worked hard in order to move to secure and successful positions within their respective employment situations. For some fathers success was defined by having reached a higher managerial position, which brought both greater responsibility and increased autonomy, while for others success was related to feeling valued and appreciated by their employers.

For every father, prior to the onset of anorexia nervosa, work was recognised as of primary significance and value in their life. So that before the eating disorder developed all fathers occupied a position where family life was for the most part organised around work commitments. Their identity as a father was centrally shaped and influenced by a strong work identity, the responsibilities this entailed and providing financially for their families. Sons and daughters were viewed as moving towards independence and requiring less parental influence and input. While this may also be the case for mothers, in this study fathers described their partners as becoming involved in thinking about and supporting the young person from the onset of symptoms and taking the lead in relation to initiating help seeking from GPs. In contrast most fathers did not shift and adopt a central position in relation to thinking about the impact of anorexia nervosa and practically supporting the young person until anorexia nervosa was diagnosed and FBT commenced.

It is significant that the emergence of anorexia nervosa did not immediately change or challenge the work position that fathers had established over time. The lack of recognition of the symptoms of anorexia nervosa combined with denial regarding the potential significance or seriousness of observed behavioural changes (in the young person) contributed to fathers remaining largely unaware of what was happening and as such remaining positioned on the outside. Initially fathers described their work life as largely unaffected and they remained centrally involved in and positioned within their established working identity. For fathers life initially carried on as normal.

The minority of fathers who were involved in initial help seeking engaged with and managed this from a position of continued immersion in the work environment. Physically they took time out of work to attend the general practitioner appointment while psychologically maintaining a position where work responsibilities and commitments took priority. For a minority of fathers seeking help via the GP was sufficient to initiate the process of repositioning.

However most fathers did not become repositioned until FBT commenced. This is a significant finding given that fathers are often reported to remain peripheral and uninvolved when a young person develops an eating disorder. It demonstrates that FBT is successful at impressing upon those fathers, who attend the initial session, a need to become centrally involved in treatment and in providing support at home. Fathers described being convinced by the therapist that they required to make changes in order to take action to deal with the impact of anorexia nervosa and to support the young person caught in the grip of the eating disorder.

In response to discussion and information provided within the initial treatment session, regarding the serious nature of anorexia nervosa and the associated 'call to action', fathers described beginning to recognise that taking part in treatment could not be reconciled with maintaining their previous commitment to the work environment. Psychologically fathers began to reposition their relationship to work and in making this cognitive shift they moved from a position of being immersed in work to being more involved, psychologically and practically, in the home environment. In turn, this increased involvement at home had the effect of increasing the fathers' exposure to the struggle the young person was experiencing.

This exposure convinced and compelled fathers to continue to locate themselves in the home and to increase their involvement in day to day life. The degree of behavioural disturbance and distress exhibited by the young person reinforced for them that they were needed at home in relation to supporting both their partner and the young person. Once repositioned fathers began to reprioritise and recognise that they needed to try to develop strategies for managing the impact of anorexia nervosa on the young person and the family.

Once repositioned, fathers faced the challenge of moving in to closer contact with their ill young person. They are faced with trying to find a way to hold on to who their young person is as an individual at the same time as coping and dealing with the effects of anorexia nervosa upon them. In the course of treatment, fathers try to “find a way to be” by holding their young person in mind at the same time as taking action to deal with the effects of anorexia nervosa upon them. In order to achieve this, fathers must first move into a close enough position in relation to anorexia nervosa to appreciate that they have a contribution to make.

An FBT approach asks fathers to become closely involved in treatment, by engaging with the approach fathers move from a peripheral to a central position. Fathers are positioned by the treatment and then must reposition themselves within it. Fathers who stay involved in treatment see themselves as taking a position in order to protect their young person.

“No, it’s got to be done. I’m her dad. I am the one who is supposed to look out for her, protect her, and doing this is the only way I can protect her against this. I can’t help her in any other way.” (David)

They describe being prepared to maintain this position to provide protection at all costs.

“My role, it was very clear and at the first meeting ... and to me, that was right, my job is: I feed him, doesn’t matter what, I just feed him. So, for me, from that point on, it is right there. You go, ‘That’s mine, I can deal with that. That is mine, I can do that.’ I said to him, as well, that if you, right at the start when he was really worried with it, I kind of made sort of peace with myself that: if he got through it and was okay and hated me for it, that was okay because he was still there.” (John)

FBT supported fathers to be part of organising the family in a different way for a period of time in order to try to support the young person to overcome anorexia nervosa. It positioned them as having a valid and important contribution to make to the restructuring of the family in response to a threat within it.

“Well, I suppose it is really just being there. In normal life that is what you do. Parents, where there are two parents in a family, both would be

giving their own part of it, giving their contribution to how the family runs and basically that is what you are doing, trying to run the family in a different way ... To a certain extent there were things said in sessions that, it was a forum, that was different from the forum at home, so you could say things that you perhaps might not have said at home or say them in a different way, discuss things that perhaps you hadn't really thought about.” (James)

I found that the way that repositioning influenced rescripting within FBT depended on a number of factors. Where early weight gain was secured and the young person was receptive to the fathers efforts to provide help and support fathers received positive feedback in sessions. This combined positive reinforcement of the young person improving physically and encouraging feedback from the therapist led to fathers feeling increasingly confident and competent in their new found role. These fathers were most likely to adhere to the principles of FBT and to continue taking a “by the book” approach. That is these fathers rescripted their role in line with the approach advocated within the treatment manual, they remained focus on weight gain, actively engaged in discussion relating to weight and progress in sessions and experienced a greater degree of alignment between themselves and the therapist delivering FBT. They were able to transfer feelings of confidence associated with their work identity to the task of supporting the young person within FBT. These fathers were the most positive about FBT and viewed it as an approach that represented a good fit for them and their families.

In contrast where young people were highly resistant to paternal support because of the severity of the disorder, co morbidities, age and stage of development (older adolescence), or where weight gain was not secured, fathers were more likely to lose faith in the FBT process and their place within it. A focus on lack of weight gain in sessions intensified feelings of failure and blame and led fathers to begin to question and doubt the validity of the approach. These fathers described feeling uneasy about being asked to take charge in a way that they did not feel they could. Sessions began to feel repetitive and unproductive with weight gain or the lack of it being discussed in a circular way and direction on different approaches was perceived as lacking from the treatment situation.

These fathers did not develop confidence in an FBT approach and could not find a safe space within sessions to address and resolve this. In these circumstances fathers looked for other ways to increase their efficacy and to improve the outcome for their young people. They placed more emphasis and focus on the young person's motivation to change as a primary influencing factor in treatment response and outcome and engaged in more accommodating and negotiating relationships with their offspring. These fathers did not feel confident, competent or effectual with the role assigned to them by FBT and as a consequence modified the role to one that they hoped would be more effective. That is these fathers rescripted their own involvement and engaged in strategies not favoured within the FBT manual such as collaborating with the young person instead of taking charge of the situation. This mismatch between the prescribed approach and the one being taken in practice led to feelings of disconnection within the therapy situation with fathers feeling misunderstood and unsupported. Increasingly fathers felt like they were at odds with the therapist and rather than this being explored and resolved they felt that they had to increasingly develop and rely on their own approach separate from what was discussed in sessions. Attempts to discuss their strategies for dealing with the situation led to therapists encouraging them to "take charge" in a way that was not perceived as feasible or helpful.

The continued and consistent focus in sessions related on weight gain and taking charge was experienced by these fathers as repetitive and unhelpful. Although they remained committed to supporting the young person at home once they had deviated from the FBT script by developing their own strategies for managing, they felt increasingly disconnected from treatment.

In these circumstances an alignment could develop between the father and the young person that potentially excluded mothers and clinicians. Reluctance by clinicians to explore the way that FBT impacts on and changes relationships in the family allowed scope for polarised positions to develop. This polarisation became evident both within treatment sessions and in the home setting. Once fathers had moved in to this position they were more likely to perceive themselves as being criticised by FBT therapists and to be critical of the approach viewing it as a "one size fits all" treatment that did not meet their needs or those of their family.

However, regardless of how fathers rescripted their approach within FBT by the end of treatment they all felt that having participated in FBT actually strengthened their relationship with their young person. At the outset, fathers feared that participating in treatment, and taking a stance, might have an adverse impact on or even damage their relationship, but by the end of treatment every father reported an ongoing positive father/ daughter or son relationship. Regardless of how successful FBT was overall, all fathers appreciated and valued having been part of the process.

“I would certainly rather look forward than back. But she is a very determined young lady, so, I mean, Clare is 10 years ahead of us. She knows what her business will be, what the turnover will be, she will be married to this one ... Yes, which I think is great. She has goals and objectives, and I can't see Claire failing on any of them. But to do that she has got to keep eating ... I will be on the sidelines, watching, cheering her on.” (Michael)

At the end of FBT all fathers scripted their involvement, in treatment and in being close to the young person at a time of great struggle, as something important and significant. They valued have been repositioned by FBT in to a role that encouraged them to prioritise being alongside the young person through the challenges that anorexia presented no matter how defeated they had felt at points in the treatment process. All fathers viewed the paternal role as central and welcomed having been repositioned. Some adopted the FBT script as it is presented in the treatment manual while others felt a need to design and develop an alternative script both within treatment and beyond. This process is represented in Diagram 2.

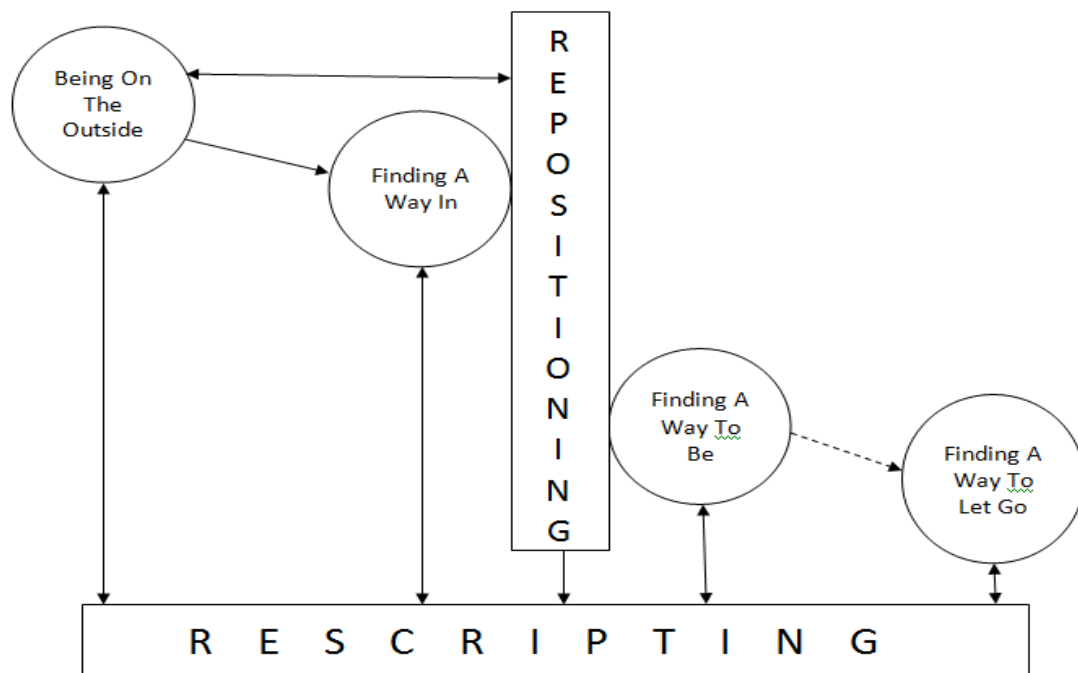


Diagram 2 - Substantive Theory - Rescripting

When fathers accepted the invitation to join treatment it changed their relationships with other family members practically, emotionally and psychologically. Diagram 2 represents how the paternal role is rescripted before, during and at the end of treatment. The most profound changes occurred when fathers' were trying to find a way in to and a way to be within the treatment process. In the diagram this is represented by Finding a Way In and Finding a Way to Be, making direct contact with Repositioning which led directly to Rescripting.

Rescripting is the process whereby the nature of fathers' relationship to family, work, social identity and personal identity is changed by participating in FBT. Involvement in treatment impacts on every aspect of a father's life by shifting the focus of his attention and responsibility from the external world of work into the home and the day to day demands and challenges of managing anorexia nervosa.

Conceptual meaning within the data was sought until the identified categories became increasingly saturated. Thereafter the process of delimiting the categories allowed the boundaries of my substantive theory to be established (Glaser and Strauss, 1967). A substantive theory is a theory developed

inductively from the data that has specificity to a particular area of sociological enquiry, in this case paternal participation in FBT (Glaser and Strauss, 1967).

During FBT the demands placed upon fathers had a key influence on shaping the role they adopted, on how they engaged with treatment and how they came to view themselves. The main concern for fathers, across the course of FBT, was finding a way to adapt to and manage the new role in which they found themselves. Being repositioned by FBT led fathers' to rescript themselves and their role in family life. This discovery informed the development of the substantive theory of Rescripting as it relates to the paternal experience of and contribution to FBT. This substantive theory of Rescripting that emerged from the categories and the core category (Repositioning) is discussed in the next chapter.

Chapter 5 Discussion

This thesis advances an understanding of the way that fathers experience and contribute to FBT when their young person has anorexia nervosa. A substantive theory of Rescripting generated from the categories and core category is discussed in relation to new knowledge, current research evidence and existing theoretical models. Consideration is then given to the strengths and limitations of the research and the chapter concludes by addressing implications for clinical practice and making recommendations for future research.

The aim of this research was to capture a paternal perspective of participation in FBT. The research questions developed from this aim were: what is it like for fathers to meet up with services, what are the factors that promote or hinder fathers' ongoing involvement in treatment and what is the overall experience of treatment like for fathers.

Being repositioned by FBT and rescripting your role within it is a transformative process which significantly alters the way that fathers relate to and are positioned in relation to their families and the young person with anorexia nervosa. Fathers who choose to participate in FBT have their role and position within the family rescripted by the experience. That is, the part that fathers play in family life is rewritten by the experience of participation. By agreeing to be involved in treatment, fathers move from being peripheral figures, immersed in a world of work where they have an established and secure position, to being involved in day to day support of the young person with anorexia nervosa which presents a completely different set of challenges and opportunities. Within FBT, fathers themselves rescript the part that they play by making decisions about how to manage challenges and embrace opportunities. AN occurring in adolescence is a disorder or illness that necessitates family involvement in treatment. Fathers and fathering are changed by encountering the illness and the treatment for it. The findings detailed in this study and the theory of rescripting presented in this thesis may or may not be unique to the paternal experience of FBT. The aim of remaining focused specifically on the fathers' experience precluded consideration of participation from the perspective of young people with eating disorders, their siblings and mothers. Future studies incorporating other viewpoints regarding participation in FBT will enhance and

develop current understanding of the impact of involvement in the treatment process on all family members.

Within this study two fathers had experience of being involved in FBT as a result of their son developing anorexia nervosa. It was interesting to note that concerns regarding the potentially stigmatising impact of being diagnosed with an eating disorder were expressed by both of those fathers. Denial and shame related to an eating disorder diagnosis were particularly evident for one father while the other father described his wife's reluctance for their son to have involvement with mental health services as delaying the commencement of treatment. The sample of boys, with anorexia nervosa, in this study was too small to generalise these findings however they are indicative of gender (of the affected young person) influencing help seeking behaviour and engagement with treatment. The experience of males who develop anorexia nervosa in adolescence and parental responses requires consideration in future research.

All fathers who participated in this study were in employment positions which gave them scope to attend FBT appointments and to be involved in care giving in the home environment. The perspective of fathers in work situations that do not confer this degree of freedom and autonomy is an important area that future research should address.

The impact of chronic illness on the individual suffering from it has been considered in the literature. The theory of biographical disruption developed by Bury (1982) captures the way that enduring ill health impacts on and alters an individual's self-perception and rewrites their personal biography. Chronic illness, experienced as a disruptive event, affects not only practical aspects of day to day life but also alters the way that people think about themselves and how they relate to others. Living with physical pain and suffering necessitates dependence on others, and psychologically individuals are faced with relinquishing hopes and dreams while facing fears about the future and their own mortality (Bury, 1992). Much less attention has been paid to how chronic illness affects other family members. My findings build on the theory of biographical disruption by illustrating how AN, a potentially chronic illness, impacts on the wider family system. While this research focuses particularly on fathers there is little doubt that similar processes are likely to be relevant to

mothers and siblings encountering the same circumstances. Faced with AN, in a daughter or son, the process of Rescripting represents an attempt by fathers to make sense of and manage the experience. Initially, AN pushes fathers out; leaving them on the outside, confused and bewildered, and then FBT pulls them in. By requiring fathers to play an active part in the provision of practical, emotional and psychological support, FBT disrupts and recreates the paternal role. In order to meet the demands of this new and different role fathers rescript their involvement in family life, they develop a new biographical narrative that is entirely driven and shaped by the demands of coping with AN in the family.

The way that FBT pulls fathers in is by introducing to them, as part of the parental unit, a set of sequenced procedures that have been demonstrated to be useful when supporting young people with anorexia nervosa. The premise is that prior success as parents places mothers and fathers in a strong position to help young people to overcome the eating disorder. The dominant discourse, within FBT, is that parents can and must take on full responsibility for the young person's recovery and within this model the therapist acts as an 'expert' consultant who supports them in the task of securing recovery. The serious nature of anorexia nervosa underpins an urgency to proceed and parents are asked/ expected to take action immediately to prevent the young person from becoming increasingly unwell both physically and psychologically. An implicit assumption within the model is that all parents are equally well placed to take on responsibility for facilitating recovery in their young person, and each family is guided by the same manualised approach.

A gap in the literature is the paternal voice regarding the experience of engaging with FBT and being asked to take on responsibility for the young person's recovery. This study addresses this gap from the perspective of the father and considers how the role of the father is repositioned within treatment. Being moved into a new and different position within the family changes the role of the father. It fundamentally alters his practical, emotional, psychological and social connections for the duration of the treatment process. I discovered that hidden narratives shape and influence the paternal experience of and contribution to FBT for young people. The voice of fathers in relation to participation in treatment for eating disorders is particularly absent in the research literature (Treasure, 2018). This is the first research study to focus

exclusively on the fathers' experience of participating in an FBT approach for young people with anorexia nervosa.

5.1 Summary of research findings and new knowledge

I found fathers to be deeply affected on an emotional level by the emergence of anorexia nervosa in the family. Its presence undermined their view of themselves as effective fathers, and their inability to quickly problem solve or exert mastery over anorexia nervosa led to feelings of failure and blame. A state of confusion dominated the landscape for fathers as they observed concerning changes in their previously well-functioning sons and daughters. In this context fathers felt overwhelmed and powerless. The arrival of anorexia nervosa represented an unexpected and unanticipated disruptive event in a life which, up until then, had been predominantly characterised by success and achievement for both themselves and their children. The arrival of anorexia nervosa reshaped and rescripted the father's role within the family. Engaging with FBT for anorexia nervosa changed the paternal narrative.

Prior to, and at the onset of anorexia nervosa, all fathers were in full time employment, had secured career progression over time, were established in a role organised around providing for the family and measured themselves in terms of their success in the work environment. When their son or daughter began to display symptoms of anorexia nervosa, most fathers initially remained fully immersed in the world of work and, only once engaged in FBT, did they move from being peripherally involved in their young person's life in to a position of directly supporting them. Some fathers were centrally involved in the help-seeking process and supporting their young person prior to treatment being initiated. FBT, by placing fathers in close proximity to the young person struggling with anorexia nervosa, enabled them to develop a new and different perspective on the eating disorder and its effects. Accepting the invitation within FBT to actively participate in supporting the young person moved fathers in to a central position, and, in so doing, provided a foundation for their ongoing involvement. In response to this invitation fathers repositioned themselves by committing to create space and time to attend treatment appointments and being involved in supporting eating and providing support at home. As treatment progressed, fathers placed increasing significance on the part that

they had to play in the provision of practical and emotional support to the young person with anorexia nervosa. Within FBT fathers made a practical and psychological shift and moved from seeing themselves as the main provider into a role organised around the provision of care to the young person. Fathers were 'called to action' as part of the treatment approach and responded by Rescripting their role in order to be available to take this action. The life of the father became reorganised around meals and the provision of support to the young person, and work was relegated to a secondary concern.

I found that spending more time at home, adopting a role organised around caring for the young person and coming into close contact with the challenges that coping with anorexia nervosa presented had a profound and hidden impact on fathers. At home, fathers tried to renegotiate their relationship with their partner and the affected young person, while feeling increasingly isolated and cast adrift from the outside world. Fathers dealing with anorexia nervosa in their son or daughter led an increasingly restricted life, and individual interests, previously valued sources of affirmation and support, were no longer available or accessed. The restricted dietary intake associated with the eating disorder came to be reflected in a constrained family life. The family closed in on itself and the focus shifted to day to day survival. During this time, fathers did not prioritise seeking emotional support for the impact that this changed role had upon them. Indeed, fathers were ambivalent about their own need for support. They could recognise the toll that dealing with anorexia nervosa was having on them but felt that they needed to be seen to be strong; to be coping and managing in front of their partner and the young person. In fathers previously hidden narratives, a struggle to maintain this 'strong' position is apparent. I discovered that FBT is successful at encouraging fathers to become active participants in their young person's care but that involvement in treatment and supporting the young person at home places a unique set of demands upon them. The way that fathers perceive these demands and the response of the young person to their attempts to provide help and support influence the paternal experience of and contribution to the treatment process.

Having briefly summarised the research findings, the substantive theory of Rescripting is now considered in relation to the FBT model, other theories and research evidence. The headings Rescripting and the Components of FBT;

Rescripting and Attachment and Rescripting and Caring structure the discussion. Firstly, a recap of the evidence base is provided.

5.2 Evidence Base and Principles of Treatment

Family based approaches to anorexia nervosa have the strongest evidence base in relation to adolescent anorexia nervosa and are recommended as the first line evidence-based treatment (Couturier et al., 2012, Lock, 2018, Lock and Le Grange, 2018). The manualised family based approach, FBT, is supported by the strongest evidence but is not effective in all cases, with a successful outcome being reported in between 34% – 90% of cases across a range of outpatient studies (Couturier and Kimber, 2012).

An advantage of manualised approaches is that evidence-based, standardised treatments can be disseminated beyond the major research institutes. Lock and Le Grange (2001) have demonstrated that FBT can be manualised and a subsequent systematic review supports successful dissemination of the approach to academic centres (Couturier and Kimber, 2015). Within clinical settings, four dissemination studies have reported improved clinical outcomes and reduced hospitalisations with the implementation of FBT (Hughes et al., 2014, Loeb et al., 2007, Tukiewicz, 2010, Wallis et al., 2007)

The actual components or mechanisms that bring about change within FBT remain uncertain and unclear (Darcy et al., 2013, Dimitropoulos et al., 2016). Ellison et al. (2012) found parental control to be most influential in relation to weight gain but how parents actually contribute to the treatment process has not yet been adequately considered (Hughes et al., 2017). While an association has been made between the involvement of fathers in FBT and better outcomes for young people, the sustained involvement of fathers over the course of treatment has been demonstrated to be poor; the majority of fathers who attend initially have been shown to disengage early in the treatment process (Hughes et al., 2017). All fathers in this study remained committed to FBT and no father chose to disengage from the treatment process. When progress was secured early in treatment fathers described feeling confident that FBT was beneficial and this enhanced their belief in the approach. But even when there was a lack of progress and fathers felt unsure about whether or not they were having a

positive impact, they chose to remain involved. The lack of available alternative treatment options was most frequently given as a reason for persisting with FBT, despite a lack of progress.

The principles underpinning FBT are: agnostic (the cause of the illness cannot be known) view of anorexia nervosa (no blame attached to parents or young person); non-authoritarian therapeutic stance (joining the family); parents are responsible for supporting the young person (the clinician focuses on empowering the parents to take action); externalisation (separating the eating disorder from the young person, and pragmatic approach (initial focus on symptoms) (Lock and Le Grange, 2012). These principles underpin the delivery of FBT and shape the components of treatment that have been integrated into the approach. Despite the integration of these principles into FBT fathers frequently described feeling to blame for anorexia nervosa across the course of treatment. This deeply held feeling of blame influenced how able fathers felt to manage anorexia nervosa, and, in particular, affected how they tolerated distress in the young person. Where fathers blamed themselves, they were more likely to struggle with managing the behaviours associated with anorexia nervosa and with tolerating distress and upset in the young person.

5.3 Rescripting and components of FBT

Five components of FBT; parental control, externalisation, restructuring the family, parental consistency and sibling support in relation to impact on treatment outcome were considered by Ellison et al. (2012). A number of studies have considered the family meal component of FBT (Cook-Darzens, 2016, Godfrey et al., 2015, Herscovici et al., 2006 and 2017, Jaffa et al., 2002, Rosman et al., 1975 and White et al., 2017) and attention has been paid to the significance of the therapeutic alliance within FBT (Forsberg et al., 2012, Isserlin and Couturier, 2011 and Murray et al., 2018). However, the aspects of treatment that emerged as most significant for fathers, in this research, were inclusion in treatment, the process of being charged with refeeding, the family meal, the organisation and delivery of sessions and the separation of anorexia nervosa from the young person.

It has been demonstrated that services delivering healthcare to children and young people often ascribe fathers a secondary role in relation to their children's health and wellbeing (Flouri and Buchanan, 2003a, Flouri and Buchanan, 2003b, West and Honey, 2016, Davison et al., 2017). Paternal non-attendance at clinic appointments is likely to be accepted and fathers are permitted to remain in a peripheral role (Phares et al., 2005a, Phares et al., 2010). In contrast, FBT cannot proceed without the presence of the father, and, as such, it is founded on a premise of paternal involvement. I found that regardless of the efficacy or the outcome of treatment at its conclusion, fathers appreciated having been invited in and expected to participate. They viewed FBT as an inclusive approach that placed equal significance on the contribution of both mothers and fathers.

Fathers said that FBT was presented to them as the only available outpatient treatment option. While It is recommended by NICE (2017) that an anorexia focused family therapy approach be offered as the first line treatment option, there is scope within this guidance to consider delivering sessions in different formats i.e. with all family members together, or separately, to incorporate individual sessions for young people and parents alongside family sessions, or to provide an individual psychological therapeutic intervention for the young person (Enhanced Cognitive Behavioural Therapy or Adolescent-Focused Therapy). Where manualised FBT, in the form of conjoint family sessions, was offered as the only treatment option, fathers seeking to do something to help their desperately unwell young person elected to participate by placing trust in professionals who were advising it. Fathers described therapists asserting that this form of manualised FBT was the most effective and as such should be instituted without delay. Within the eating disorder field, concerns have been raised about FBT being seen as the only treatment approach and the family needing to fit in to a standardised approach of which the efficacy is not guaranteed (Conti et al., 2017, Hay, 2017, Murray et al., 2012b, Strober, 2014). I found that overconfident and blanket assertions about the efficacy of FBT at the outset of treatment had the potential to intensify paternal feelings of blame, guilt and failure if treatment did not progress as hoped.

In relation to blame, I found that at the start of treatment fathers arrived carrying within them a narrative of blame: having felt powerless in the face of anorexia

nervosa, emerging fathers blamed themselves for not knowing how to respond or intervene and for not being able to solve the problem without having to seek professional intervention. Moses (2010) hypothesised that parental blame has the potential to increase commitment to treatment when a young person has a mental health disorder. In relation to eating disorders, blame has been found to reduce carers' belief in their ability to effectively promote recovery (Whitney et al., 2005). I found that where fathers felt to blame, reassurance from a clinician did not reduce or mitigate against this. Most fathers kept these thoughts and feelings to themselves, and they were ever-present, but unaddressed, as treatment began and progressed. I discovered that the non-blaming premise of FBT does not effectively redress feelings of paternal blame and guilt. I theorise that having a son or daughter develop anorexia nervosa rescripts how fathers view themselves. As anorexia nervosa emerged, fathers in this study associated its emergence with their failure to protect the young person. They felt that if they had managed to be a good enough father, then the young person would not have become unwell. These beliefs about being responsible for failing to prevent the development of the eating disorder and letting the young person down undermined previously held views of paternal competence. Fathers, prior to the onset of the eating disorder, viewed themselves as competent parents but questioned this in the wake of anorexia nervosa. By associating the presence of anorexia nervosa with their failure to protect the young person fathers rescripted themselves into a position of blame. How the paternal narrative of blame is rescripted again within FBT is dependent on whether or not treatment progresses well (weight gain and behavioural change) or becomes 'stuck' (lack of weight gain and ongoing behavioural/ psychological symptoms).

Anorexia nervosa is experienced as a disruptive event that can alter a father's previously held view of himself as a competent and successful individual (informed by previous personal and professional achievement) by introducing a new narrative of failure and blame. The theory of biographical disruption (Bury, 1982) has been applied to the study of individuals experiencing a range of health challenges; men living with prostate cancer (Cayless et al., 2010), managing chronic illness as 'work' at home (Corbin and Strauss, 1985) and mothers living with HIV (Wilson, 2007). Within the literature, some attention has

been paid to the impact of young people experiencing long-term physical health issues or mental health problems and the way that this impacts on the family biography (Bray et al., 2014, Harden, 2005). These studies move the focus of enquiry beyond the study of the disruptive effect of illness in an individual towards consideration of the systemic impact of illness in a young person on the family system. In these circumstances, carers/ parents reorganise their lives around the illness and this influences and reconstructs their personal narratives. The hidden narratives of fathers who have participated in FBT illustrate the disruptive impact of anorexia nervosa on family life and the way that fathers are required to rescript their role in order to deal with and make sense of the demands upon them. This study makes an important contribution to the small body of existing literature.

Le Grange and Lock (2011) claim that “at the heart of FBT is the belief that parents can generally be effective in changing the behaviour of their child with AN.” This belief informs the way that parents are charged with the task of refeeding the young person. FBT takes the view that the primary task when a young person has been restricting their dietary intake, leading to significant weight loss, is to improve their nutritional intake and this process is referred to as refeeding. Regardless of the pre-existing family dynamics, individual parental characteristics or the young person’s psychological and behavioural presentation, all parents are charged with the task of refeeding. The urgency of the situation necessitates that physical recovery takes priority, and it is accepted that this can only be achieved by weight restoration. However, by charging parents with the task of refeeding the young person, and requiring them to take complete responsibility for weight restoration to them, FBT implies that by ‘following the approach’ a successful outcome can be secured.

Rather than ‘following an approach’ I discovered that fathers developed their own approach. Having accepted the task of taking on responsibility for refeeding the young person, fathers set about trying to understand what was being asked of them. A significant finding of this study is that a striking disparity exists between the extent of paternal knowledge and understanding of anorexia nervosa (how it effects young people and how to help them) and the contribution that is expected from fathers at the outset of an FBT approach. Fathers found being involved in feeding the young person extremely

challenging. On reflection they felt that they had to shift from having little knowledge and understanding of anorexia nervosa to learning as much as possible, including the behavioural and psychological manifestations of anorexia nervosa, as quickly as possible. This included learning about the way that an eating disorder influences and disrupts normal eating behaviour and the psychological and emotional impact it has on young people. For some fathers this learning took place within treatment sessions, particularly where good written material was provided at appointments, but for most it occurred outwith.

I found that while FBT successfully scripted a role for fathers and manoeuvred them into the position of being directly and centrally involved with eating and mealtimes, it did not prepare them for involvement in the practical aspects of supporting a young person with anorexia nervosa to eat. Most fathers looked beyond treatment to find the practical advice and support they required in relation to refeeding the young person. Fathers charged with refeeding, by treatment, felt ill-equipped as they embraced and embarked on this new role and turned to books or looked online for support. In particular I discovered that fathers found information written by parents with similar experiences most accessible and applicable to them when trying to develop strategies for providing practical support with eating and managing associated distress, upset and anger. It may be that reading the experiences of other 'competent' parents who had faced and dealt with similar situations reduced paternal feelings of blame and guilt, and engaging with these materials appeared to relate to both the pursuit of knowledge and to addressing unmet and hidden emotional needs.

It has been demonstrated that parents in receipt of a combination of good quality information, sufficient advice, guidance and feedback feel more confident when supporting young people with eating disorders (Coomber and King, 2012). Overall, I found that FBT, as it is currently delivered, does not meet all of the informational and support needs of fathers. This was particularly apparent during the first phase of treatment and this left many fathers feeling that they were finding their own direction and navigating a way forward with insufficient guidance from involved professionals.

I discovered that when early weight gain was secured, fathers grew in confidence, became increasingly convinced that the position they were

adopting was an effective one and received support and encouragement from clinicians in treatment sessions to persevere with standing up to anorexia nervosa in order to support the young person, despite any distress or upset. Early weight gain has been associated with better outcome (Accurso et al., 2014, Ellison et al., 2012, Lock et al., 2006a, Madden et al., 2015b). For these fathers FBT progressed in an uncomplicated way and they felt reassured that they were taking the best approach to help and support their young person.

In contrast, where the weight of the young person remained static, or started to go down, fathers began to lose trust in the position they had been asked to adopt. These fathers tried to persevere but felt judged by clinicians for not trying hard enough or not 'getting it right' when, despite their best efforts, weight gain could not be secured. Being asked/ expected to promote weight gain and 'failing' to do so influenced fathers self-belief and their confidence in the treatment. Within the literature, parental self-efficacy has been demonstrated to improve across the course of FBT and has been associated with better outcomes (Byrne et al., 2015, Dimitropoulos et al., 2015b, Sadeh-Sharvit et al., 2018, Robinson et al., 2013). As such, it is concerning that for some fathers a sense of personal efficacy is reduced by a focus on weight gain early in treatment and this has may have an impact on the course of treatment and outcome. I found the focus on eating and weight within FBT had the potential to intensify paternal feelings of failure and blame and that when therapists rigidly adhered to the treatment manual, rather than being clinical flexible, fathers started to lose faith in both the treatment and the therapist delivering it. Ironically, the potential developed for fathers to feel blamed for the young person's lack of weight gain, and for their lack of success in successfully supporting refeeding, took place within a treatment predicated on taking a non-blaming approach. In these circumstances, I found that fathers redefined the role that FBT asked them to adopt (taking a stand against anorexia nervosa), focused more on the young person's personal motivation for change and engaged in more negotiating and compromising with the young person.

Within the FBT model, therapists are encouraged to remain focused on securing weight gain prior to moving forward in the therapy process. Cade (1998) coined the term colonizing to characterise the type of approach where

the therapist becomes positioned as holding the solution to the families difficulties by virtue of the professional knowledge they have acquired. If families are encouraged to implement certain techniques in order to address and solve a problem, the potential exists for a disconnect to develop if the therapist is unreceptive to feedback regarding lack of success in implementation. Rober and Seltzer (2010) highlight the need for therapists to avoid adopting 'colonizer positions' when engaging in therapy with families and argue that there needs to be an open dialogue and receptivity to feedback for therapy to move forward in a constructive way. My research found that when fathers encountered difficulties during refeeding, their feedback was not heard or integrated in a way that could shape and inform a change in treatment approach. An issue with the FBT model is that by requiring therapists to adhere to a treatment manual, opportunities to think more creatively and collaboratively with families can be lost.

Regarding the process of communication and feedback within FBT, I found that conjoint sessions (with all family members present) precluded fathers from openly discussing their thoughts, feelings and concerns with their partner and the therapist. Where fathers blamed themselves for the development of anorexia nervosa, and for not responding quickly enough, they found it difficult to openly discuss the challenges faced in supporting a young person with AN. Fathers were fearful of undermining their own position in dealing with the eating disorder by openly talking about their approach. They feared that discussing their struggle to find a way to manage would make them look inadequate and less capable in front of the young person. Having been placed in a position of responsibility fathers were determined to live up to this responsibility and felt unable to openly ask for or seek the support they required. An additional factor that influenced discussion within family sessions was fathers' reluctance to be seen as critical of the young person. Fathers avoided discussing issues if they anticipated that the young person could potentially feel judged or blamed, and become distressed. Consequently, I found that fathers 'filtered out' what they shared in family based sessions; in particular they avoided discussing personal feelings and reactions and tried to present a coping front.

A need to be strong, independent and to avoid exploration of emotions has been shown to impact on how willing men are to engage with psychological

support and therapy for themselves (Galdas et al., 2005). My study demonstrates that in the context of conjoint clinical sessions fathers often felt unable to share and explore their emotions. Family sessions prevented fathers from accessing and receiving the support and guidance they required. Fathers wanted to be able to consult with therapists without the young person being present. PFT, where parents and young people are seen separately, addresses this need and has been shown in one study to produce favourable outcomes (Le Grange et al., 2016). The potential exists for fathers to engage in more open dialogue within a PFT approach.

It is significant that fathers were willing and able to discuss these issues openly within individual research interviews. This indicates that, if individual space had been integrated in to the therapeutic approach, fathers would have embraced and utilised it. It seems likely that where fathers were withholding emotional communication that therapists would form an inaccurate picture of how they were managing and coping.

In particular I found that feelings of anger not discussed during treatment were articulated during the research interview, indicating that these feelings required to be reflected on and processed and that not having a suitable space within FBT precluded this from happening. FBT is fundamentally a behaviourally orientated treatment with a primary focus on supporting parental action to promote weight gain (Le Grange and Lock, 2012). Exploration of emotions and relationships are relegated to a secondary position until weight restoration has been established. Where fathers surface level accounts of 'coping' are allowed to hide the true narrative of their experience, and the focus remains entirely on trying to secure weight gain, consideration of emotional and psychological issues can become lost.

The second session of FBT is a family meal which is designed to provide support to families in relation to the task of refeeding. From the perspective of the therapist, the intention of this session is focused on empowering parents by behaviourally coaching them to develop strategies to tackle anorexia nervosa (Fitzpatrick, 2011, Lock and Le Grange, 2012). The family meal session is one of the most contentious components of FBT (Couturier et al., 2013, Couturier et al., 2017). Eisler (2005) reported it to be an unhelpful session which contributed

to increased rather than reduced levels of distress for families, and, for a period of time, it was dropped from the Maudsley team treatment protocol, although recently it has been reinstated (Eisler et al., 2016a). Lock and Le Grange (2001) and Lock (2015) claim that the family meal has proven to be helpful and acceptable to families and a second family meal is considered a useful adjunct where young people are 'stuck' and failing to gain weight (Richards et al., 2017, Lock et al., 2015). While consensus appears to have been reached among clinicians that a family meal should be included in treatment, my findings indicate that it is the session that fathers find most stressful and least helpful.

The function of the family meal and its impact on treatment outcomes remains poorly understood, and there is an absence of literature relating to the parental/family experience of participation. The parental voice has been represented in two unpublished masters dissertations Squire Dehouk (1993), and Assis Da Silva (2013). These studies present contradictory accounts. The former reports that families find the family meal unacceptable while the latter states that for parents it strengthens the therapeutic alliance. The voice of the father regarding family meals is entirely absent from the academic literature. Given fathers' descriptions of how challenging other family members found the family meal, it is likely that the maternal and sibling perspective would merit further research. Cook-Darzens (2016) scoping review of the role of family meals in eating disorder treatment highlights the need for family experiences to be more systematically explored.

My findings contribute to filling a gap in the literature by providing an insight into the paternal perception and experience of the family meal session. Most fathers were unclear regarding the purpose of this session and felt unprepared for what would happen within it. They felt that professionals had withheld information from them regarding the purpose of the session, and they feared being subjected to scrutiny and judgement within it. In relation to setting up and organising the family meal session fathers perceived clinicians as holding all of the power and control and this had the potential to undermine their experience of FBT as a collaborative treatment approach. When being engaged in FBT parents are advised that professionals and parents are a team helping the young person with anorexia nervosa. The therapist takes the position of expert consultant, with specialist knowledge and experience of anorexia nervosa,

while the parents are positioned as experts in the young person, best placed to take on responsibility for providing 24 hour care and support. A family meal that is not introduced and discussed in a way that includes parents in the decision making process has the potential to undermine the collaborative stance that FBT is founded on, by creating a power imbalance. The way the family meal is currently set up influences how fathers approach the session, present themselves within it and view it in relation to the overall treatment journey.

A strategy that fathers utilised in response to being placed in this position was to be present at the family meal session and go through the motions of being involved without fully engaging or investing in the process. This resonates with qualitative research conducted by Godfrey et al., (2015) that identified fathers as significantly less involved in the family meal session than mothers. The way that the session was introduced and orchestrated combined with the artificiality of the situation appeared to alienate fathers and reduce their participation. Ellison et al., (2012) found that parental unity and control over eating was associated with better outcomes. In relation to the family meal session White et al., (2017) found that both the active involvement of both parents in coaching and supporting the young person promoted quicker weight gain. These findings raise concern about the potential impact of paternal disengagement on the young person's progress and treatment outcome.

The way that the session was introduced and orchestrated, combined with the artificiality of the situation, seemed to influence fathers, along with other family members, to present in a way that was inconsistent with their behaviour and reactions in the home environment. Some paternal accounts of the clinic based meal session were of an insignificant session which they stated had little or no impact on them. This insignificance appeared to be related to participation in the meal not connecting with or representing the reality of the experience they were living. In stark contrast, fathers gave accounts of emotionally charged and frequently out of control meals occurring at the same point in time within the home setting. In contrast, other fathers described a deeply uncomfortable and persecutory experience that they would never wish to repeat. The majority of fathers managed the family meal session by presenting a false or coping persona at odds with their descriptions of feeling emotionally overwhelmed, confused, isolated and in desperate need of support and guidance.

In trying to make sense of the contradiction between fathers accounts of the family meal session and their dramatic and vivid descriptions of family meals in the home setting, I found dramaturgical theory, advanced by Irving Goffman in the 1950's useful (Goffman, 1990). This theory proposes that the way that individuals present themselves is centrally shaped and influenced by the situations they encounter. Over the course of a lifetime people play a range of roles and the way that each role is approached and portrayed is influenced both by the individual's belief in the part or role they are playing and by the presence of the audience that is observing them. In the family meal session, the father is observed and potentially critiqued by multiple audiences i.e. / the self, the mother, the young person, other family members and the therapist. The artificiality of the family meal situation, the potential to be scrutinised and judged appears to contribute to fathers adopting and presenting a persona that hides rather than exposes their true feelings and state of mind. So, fathers adopt and play a part that they hope will be viewed favourably by the therapist within the session rather than present the 'real them' that the young person engages within the home environment. I found that fathers find it difficult to be open about their emotional reaction to supporting a young person with anorexia nervosa and that this reluctance is personified by the way that they engage within the family meal session. The more challenging a father is finding FBT, and the process of supporting the young person, particularly with refeeding, the more likely he is to try to protect himself from feeling exposed by adopting a 'one step removed' position within the family meal session; that is, he is physically there but presenting his 'best self' rather than his 'real self'. The presentation of self overshadowed this session for most fathers, and, as such, its utility in providing meaningful coaching and support that they could truly connect with is questionable.

In relation to efficacy, I found that fathers who felt uncomfortable in the session, but well supported by an active therapist who adopted a position of advising on strategies and directing paternal attempts at supporting eating, generally described feeling more confident after the session and reported a stronger alliance with the therapist across the course of treatment. Parent and therapist alliance during FBT has been demonstrated to be significant in relation to securing good clinical outcomes for young people (Forsberg et al., 2013,

Forsberg et al., 2014, Isserlin and Couturier, 2011, Zaitsoff et al., 2015). Being successful in prompting a young person to eat more within the session has been associated with an increased sense of parental success (White et al., 2015, White et al., 2017). Fathers who viewed therapists as adopting the more passive role, of 'just' observing the family eating and taking notes, felt observed and scrutinised in a way that undermined their confidence in themselves and the therapist. This mixed picture regarding the family meal resonates with a scoping review of the literature which concluded that the evidence regarding the family meal component of treatment remains "contradictory and inconclusive" (Cook-Darzens, 2016;pg 10). Overall, I discovered that for fathers, the family meal did not represent a significant or useful part of the treatment process.

Fathers often spoke about AN as if it were a separate entity and indeed within FBT AN is presented as something that has 'taken over' the young person (Lock and Le Grange, 2012). The technique of externalising the problem has its roots in narrative family therapy approaches (White et al., 1990). Externalisation within FBT is an intervention employed to encourage parents to view the young person as powerless to stand up to the illness for themselves and as reliant and dependent on parental support to break free. Within treatment sessions, an expectation is introduced that the disorder will not relinquish control easily and that a firm and determined parental approach against it will be required. By channelling parental efforts towards defeating the illness, the hope is that parents will be able to persevere and maintain a consistent approach even in the face of the young person becoming distressed and upset.

The way that anorexia nervosa is discussed as a separate entity from the outset of FBT, introduces the concept as the 'correct' or only way to think about the disorder. That is a discourse that is actively developed within FBT and positions the young person as powerless, the eating disorder as a powerful negative force, and the parents as the only possible agents of change able to challenge the power of the disorder in order to bring about positive change. Dreyfus and Rabinow (1982) refer to discourse as knowledge that develops and becomes considered as the truthful or legitimate way to think about a subject or within a particular context. A risk that Foucault associated with the development of a particular discourse within a situation is that acceptance of the presented discourse as absolute truth can limit or prevent the development of alternative

or competing viewpoints. A 'game of truth' develops which informs both how individuals think and behave. Responses and reactions develop in line with the version of truth subscribed to (Gillies, 2013). Foucault referred to the process of being shaped by the discourse in this way as subjectivation and proposed that 'technologies of the self' emerge which characterise the way that individuals present themselves within the discourse. The discourse of externalisation within FBT shapes the treatment journey.

I found that in relation to the role of the father, separating anorexia nervosa from the young person had both advantages and disadvantages. In the initial phase of treatment, presenting the disorder as something separate supported fathers in initiating and persevering with the process of helping the young person to eat. By reframing the young person's upset and distress, associated with eating, as a symptom of anorexia nervosa, therapists enabled fathers to take action in spite of the young person's emotional reaction. That is, distress conceptualised as driven by anorexia nervosa and represented as an expected and necessary part of taking power away from the eating disorder became more tolerable and exerted less influence over fathers' decision making processes. Within treatment, I found that fathers developed a shared language that placed emphasis on anorexia nervosa as a separate entity and located them as adversaries of the disorder focused on 'releasing' the young person from the grip of the eating disorder.

While separating anorexia nervosa from the young person enabled fathers to take action against the eating disorder, it also had the potential to silence the voice of the young person within the treatment process. I found that conversations in sessions and at home developed in such a way that anorexia nervosa took on an identity of its own and that this identity was at times so dominant that it precluded consideration of the young person as an individual. This emerged as a particular issue with older young people who, prior to the onset of anorexia, had developed a more established sense of self. Fathers of these young people felt that their daughter viewed anorexia nervosa as part of them rather than as a separate entity in its own right and that treatment organised around and focused on one narrative of the illness marginalised the 'healthy' aspects of the young person.

The risk of conceptualising anorexia nervosa as a powerful and destructive force is that, if the young person remains unwell, despite parental efforts to help them, a narrative of a force too powerful to be defeated has the potential to emerge. When faced with a lack of progress, fathers rather than accept defeat moved away from externalising the eating disorder as something only parents were responsible for tackling towards a more collaborative view focused on trying to energise and support the young person to fight back against the eating disorder for themselves. These fathers articulated a hope and belief that young people could and would reach a point where they would be able to challenge the eating disorder for themselves and that in this context they would and could take charge of and take responsibility for their own recovery. Over the course of treatment, some fathers shifted their perspective in order to view themselves as sharing responsibility for progress with the young person rather than leading on the process. A continued focus on externalisation as the 'true' approach within FBT can act to preclude alternative narratives from being explored and different potential pathways towards health being discovered.

The father of the one young person who transitioned from CAMHS to adult services felt that her strengths were more accepted and supported within an individual treatment approach than in an FBT approach. While acknowledging that the young person continued to struggle during treatment within adult services, this father viewed individual therapy, with intermittent parental involvement, as promoting the development of a sense of self beyond the illness and fostering a motivation for change. The importance of considering individual work as an integral part of treatment for young people has been identified in a qualitative synthesis of eating disorder studies (Medway and Rhodes, 2016). This analysis identified that, similar to my findings relating to fathers, some adolescents during FBT avoid discussing aspects of their eating disorder experience in the presence of other family members (Krautter and Lock, 2004). This is indicative that a one size fits all treatment strategy cannot always adequately meet all of the needs of individual family members.

In considering the principle and process of externalisation within an FBT approach, it becomes increasingly apparent how involvement in treatment shapes and changes the nature of the father's relationship with and connection

to the young person. The way that FBT rescripts the father/ young person relationship is discussed next.

5.4 Rescripting and relationships

Anorexia nervosa can be viewed as presenting a unique opportunity for the development of a new and different type of father/ young person relationship. A relationship that could not have come in to being had the adolescent remained well. When struggling with anorexia nervosa, adolescents present with a different range and set of needs that cannot be met by 'parenting as usual', and engagement with FBT places both parents in closer proximity to the young person. I found involvement of fathers in FBT sessions reflected their involvement with the young person at home. The more involved fathers were in clinic based treatment sessions, the more they described taking an active role at home in dealing with the challenges that anorexia nervosa presented on a day to day basis. I found that being brought into closer proximity and contact with the young person during treatment sessions was reflected in a transformation in how fathers perceived anorexia nervosa and how they engaged with and related to their son or daughter.

I found that, over the course of treatment, fathers described developing an enhanced appreciation of the young person's position, and this insight enabled them to shift from taking a cognitive approach, thinking about anorexia nervosa as a problem that requires to be solved, to engaging with the young person's struggle on an emotional level. The rescripted emotional connection that develops in the context of anorexia nervosa can be conceptualised in terms of attachment theory and behaviour.

Bowlby initially developed attachment theory in relation to a child or young person's relationship with their mother (Bowlby, 1951). Subsequently, attention has been directed towards the paternal contribution to attachment (Schaffer and Emerson, 1964, Rutter, 1972). Young people who are securely attached develop an internal working model of their parents and can use them as a secure base from which to explore the world and as a safe haven to return to at times of stress/ distress (Bowlby, 2012). During adolescence young people typically turn to their parents for help and support when they have exhausted

their own problem solving capabilities, and, in order to meet these support needs, parents require to strike a balance between encouraging autonomy and being available for support (Bosmans, 2016). Being available and being attuned are both necessary within a healthy attachment relationship. Young people with anorexia nervosa do not think they are unwell, frequently deny having any problems or difficulties and do not explicitly seek help and support from either of their parents (Couturier, 2006). When young people develop anorexia nervosa, they often lose their ability to recognise their own need for support, and, as they become more unwell, they are increasingly likely to avoid or reject parental attempts to help them. I discovered that involvement in FBT supports fathers to see beyond this rejection and to try to find ways to connect with the young person.

I found that in trying to establish a connection with the young person, fathers draw on their relationship with their own father, their previous (pre-anorexia nervosa) relationship with their son or daughter and on a connection with their partner. Having a 'secure base' from which to reach out was particularly significant for fathers as they tried to find new and different ways to relate to and connect with the young person.

Transitioning to new relationships as part of FBT for anorexia nervosa can be understood using the theory of Crossing Borders, developed by Doucet (2006). Critical points in the life of a family are identified as facilitating the dismantling or crossing of gender borders. These points, which include events such as illness in a child, break down the traditional gender borders between mothers and fathers and enable fathers to move into a position of increased emotional connectedness. This increased sense of emotional connectedness places fathers in a position to take on a greater degree of emotional responsibility within the family unit. Doucet (2017) likened this to fathers having their 'hard edges softened' and claimed that it placed fathers in a position to appreciate the value of relating rather than remaining focused on doing.

Fathers moved from a position of trying to fix or solve the problem (doing) towards a realisation that being alongside and supporting the young person was a more useful contribution. Fathers involved in treatment become increasingly relationship focused. The treatment increased their availability to

the young person and, as their understanding of anorexia developed, fathers became increasingly attuned to what the young person needed from them. As such, fathers were available to provide emotional containment to the young person, to act as a 'secure base' for them during treatment. That is, fathers were able to tolerate and acknowledge the young person's emotional state in a supportive and validating way. Previous studies which have looked at the provision of support to individuals with anorexia nervosa have highlighted that fathers not involved in or on the periphery of treatment maintain a cognitive style of coping which keeps them distant from the person struggling and minimises the support they are able to offer (Treasure et al., 2016, Whitney et al., 2005). In contrast, FBT is focused on specifically moving fathers into a role that requires active involvement with the young person and in so doing the nature of their relationship is transformed. This is the first study to specifically address the father's experience of and contribution to FBT when a young person has anorexia nervosa.

However, the lack of a specific relational focus within FBT can mean that opportunities to consider the significance of, and to work with, the changed nature of the father/ young person relationship are missed. A behavioural focus that prioritises weight gain can encourage attending to surface level indicators of change at the expense of less apparent or visible shifts. A risk exists that securing weight gain comes to represent success while a lack of weight gain is associated with failure and that relational shifts occurring as part of the process of trying to address and deal with weight concerns are not viewed as significant or important in their own right. I gathered evidence that where early weight gain is not secured, fathers become increasingly concerned regarding the impact of continuing and persisting in taking a firm stand against anorexia nervosa and change their approach to prioritise preserving the relationship with the young person. These fathers shift towards involving the young person more in decision making around eating, engage in more compromising and negotiating and move away from externalising the eating disorder to placing increased emphasis and significance on the young person's intrinsic motivation and desire to recover. When discussion in FBT sessions remains entirely focused on the issue of trying to secure weight gain, these fathers find sessions repetitive and resent being positioned as 'experts' without adequate advice and support.

Where sessions become repetitively focused on weight gain, as the only indicator of change, this can lead to feelings of paternal frustration, a loss of belief in the efficacy of the treatment model and a lack of confidence in the therapist delivering treatment. In these circumstances, a relational rupture can develop between fathers and therapists that can undermine the ongoing efficacy of treatment.

An untapped potential exists within FBT to focus on relational shifts, particularly when success in relation to weight gain has not been secured. Wallis et al. (2017) found FBT improved family relationships and strengthened attachments in families when a good treatment outcome was secured. For fathers in my study, the impact of 'failing' to achieve weight gain proved to have a detrimental effect on family relationships. This highlights the different trajectories that can emerge, dependent on whether or not a sense of success is associated with participating in the treatment process. Adhering to weight as the only goal of treatment and parameter of success, stifles exploration and can lead to feelings of alienation and blame for fathers who come to view themselves as having failed. It is possible that by creating space for a focus on relational change and commitment within FBT, a different, more positive narrative could emerge. FBT repositions fathers in relation to young people but does not always pay sufficient attention to the rescripted relationship that then develop within the treatment process. I found the changed nature of the relationship with the young person is significant to fathers, and changes initiated during FBT persist well beyond the close of treatment. As such, paying attention to the changes engendered within treatment and focusing on the wider aspects and impacts beyond the narrow confines of weight gain is crucial.

Where parental separation predates the initiation of FBT, fathers are drawn back in to the family circle by treatment. As treatment draws to a close, a profound feeling of loss can be experienced by the father. FBT reorganises relationships in such a way that for a period of time these fathers are once more involved in the daily life of the young person, and the family, and when FBT concludes increased physical and emotional distance must be revisited and coped with again.

Within FBT the father's changed relationship with the young person and other family members moved him from a peripheral work focused role into a new role of being directly involved in the provision of care within the home environment. Being involved in treatment, and supporting the young person, united some couples but led to marital disharmony and potential relationship breakdown for others.

5.5 Rescripting and caring

I found that within a paternal caring role the themes of work, transitioning to a caring role, connecting, social isolation and stigma were prominent.

The anchoring function of a connection to work emerged as particularly significant for fathers involved in FBT. These fathers shifted their primary focus from a role organised around work and providing for the family towards a role centred on caring for and meeting the needs of the young person with anorexia nervosa. Within FBT fathers reassessed their priorities and rearranged work commitments to allow them to be more available at home. I found that fathers who articulated being secure in their working environment and role described feeling confident to negotiate time off which enabled them to prioritise the needs of their young people. For some fathers this meant time to attend appointments or to be at home for meals while others were able to secure a leave of absence in order to assume full time caring responsibilities. The presence of work in the lives of participants represented a secure base; one that they felt able and supported to step away from for a period of time (an appointment or a few months) in the knowledge that they would, at some point, return to assume their responsibilities. Several fathers attributed this flexibility to either being in a senior position within the organisation or having been a good employee over a prolonged period of time. This seniority, in terms of position within the organisation or length of time served and quality of work provided, was perceived by participants as reflecting favourably upon them and positively influencing the decision making of employers. This challenges the traditional viewpoint prevalent within society that reaching a senior position at work is associated with being indispensable to your employer and consequently unavailable within the home environment. Several fathers expressed concern for how fathers without this kind of support from employers would cope with

anorexia nervosa and FBT; stating that they could not envisage how the tasks involved can be undertaken without relinquishing responsibilities in the work environment. It is significant that the fathers who chose to participate in this study were most representative of a higher socioeconomic group and the implications of this are further considered in the section on recommendations for future research.

Being less involved in the world of work, and increasingly immersed in anorexia nervosa and the treatment for it, fractured fathers' personal narratives. When discussing educational experiences or work achievements fathers' portrayed themselves as competent high achievers. In contrast, when discussing anorexia nervosa, they referred to themselves as powerless and described feeling confounded by a disorder that they could neither understand nor control. Initially fathers tried to hold on to their previous work identity, but, gradually, as they became more immersed in treatment, they relinquished this and moved towards a new identity organised around caring for the young person.

The transition to a caring role was challenging for fathers who had to find ways to manage their own emotional reaction before they could be available to support the young person. I found that fathers initially felt confused and overwhelmed by anorexia nervosa and struggled within the role of providing direct care and support. Fathers felt under pressure to take charge of the situation and struggled to live up to their own and what they perceived as others' expectations of them. Early attempts to support the young person led to feelings of frustration that were expressed as anger and loss of control. EE has been recognised as having an adverse impact on treatment outcomes in eating disorders (Duclos et al., 2012, Duclos et al., 2014, Le Grange et al., 1992, Moskovich et al., 2017, van Furth et al., 1996). EE is frequently studied by measuring the level of parental criticism evident during treatment sessions. Allan et al (2017) studied parental EE in a randomised controlled trial comparing FBT and PFT. A reduction in maternal EE during PFT and an increase in maternal EE during FBT was evident, but no statistically significant changes were demonstrated in paternal EE within either approach to treatment. The qualitative nature of my study allowed a descriptive account of paternal EE within FBT to emerge. On reflection, fathers gave an account of coming to recognise that losing control and expressing their own emotional frustration

exacerbated an already challenging and difficult situation. They described benefitting from family sessions focused on the needs of the young person as these provided an environment within which they could reflect on and modify their approach in the home situation. In paternal narratives gathered within this study there is evidence of reduced expression of negative emotion and a move towards a more contained, measured and positive approach during treatment. This suggests that EE, rather than being an entirely negative phenomenon, can be a stage that fathers pass through while learning how to cope and deal with anorexia nervosa. If fathers can be adequately supported to manage and moderate their responses, they can discover that they have an important and significant role to play in supporting their young person within therapeutic intervention.

Within FBT all fathers primarily relied on their relationship with their partner, and together they worked out how best to support each other and the young person. I found that involvement in FBT had the potential to unite parents or to exaggerate the differences between them and push them apart. The impact of FBT on the marital or parental relationship is not explicitly considered within the FBT model, and, despite significant stress, fathers did not report seeking any external help or support in relation to the impact of treatment on their relationship.

Care giver burden is a well-documented concept within the eating disorder literature and relates to the demands placed on parents/ carers when supporting an individual with an eating disorder (González et al., 2012, Parks et al., 2018, Stefanini et al., 2018, Whitney et al., 2005). In most qualitative studies undertaken to date, exploring the transition to a caring role for young people with eating disorders, fathers have been an underrepresented group, as more mothers than fathers have been successfully recruited (Coomber and King, 2012, Cottee-Lane et al., 2004, Denton et al., 2017, Goodier et al., 2014, Honey and Halse, 2006, Honey et al., 2008, McCormack and McCann, 2015, Rhind et al., 2016, Thomson et al., 2014, Svensson et al., 2013, Weaver, 2012). Whitney et al. (2005) did recruit an equal number of mothers and fathers into a study comparing two different family interventions (individual family treatment delivered weekly or three day intensive workshop involving two families). In each arm of the study, carers were asked to write a letter describing what it was

like to support someone with anorexia nervosa and these were shared in a subsequent clinical session. Within both treatments, the letters written revealed higher levels of maternal than paternal stress. Given that my findings are indicative of fathers filtering what they are prepared to share about their own experience in a clinical setting, it is possible that they underreported their stress levels in material that was being openly shared with professionals and parents. Anastasiadou et al. (2016) also managed to recruit similar numbers of mothers and fathers and identified mothers as taking on the majority of care giving responsibility. In a recent study, conducted by Bezance and Holliday (2014) looking at home treatment for anorexia nervosa, care giving was assumed to be a maternal role and an emphasis was placed on the participation of mothers within the intervention with no mention or consideration of the paternal role. My study provides strong evidence that fathers, involved in FBT, take on an active role in relation to providing direct care to young people. LaMarre et al. (2015) explored parental experiences of engaging with FBT by analysing blogs posted on the FEAST (parent support) website. A range of maternal, but no paternal, blogs were identified. These studies highlight the difference between mothers and fathers in relation to strategies for managing stress and seeking support. They are consistent with my findings of which indicate that fathers are more likely to keep their thoughts and feelings private than to seek external support or validation. Overall, at this point in time, much less is understood in relation to how fathers manage and cope with moving into a caring role for a young person with anorexia nervosa. FBT, by requiring equal participation from both mothers and fathers presents a unique opportunity to explore the paternal transition from provider to carer.

FBT, unlike other therapeutic interventions, requires fathers to be the treatment rather than to support the treatment. This is particularly illustrated by the father (Arran) who had previously supported his daughter during treatment for cancer; during the cancer treatment he described himself as supporting his daughter's medical management while in relation to anorexia nervosa his experience was that he felt immersed in dealing with the disorder 24 hours a day, seven days a week. Although some fathers did continue to physically work outside the home, while others became full time carers, all fathers described complete psychological immersion in the task of supporting the young person with

anorexia nervosa. That is, fathers were cognitively preoccupied by the task even if they did move away from it for periods of time during the day. Those that continued to work assumed responsibility for looking after the young person on their return home in order to provide support and respite for their partner. The delivery of treatment in the home setting placed fathers in the position of replicating the work of an inpatient unit without the shift pattern, multidisciplinary team support on hand, or supervision structure in place in relation to coping with the emotional demands.

While immersed in meeting these demands fathers were often socially isolated. The views that fathers held in relation to how mental health problems and eating disorders are perceived by society compounded this sense of isolation. Stigma regarding mental health labels and involvement with mental health services presented a challenge to paternal involvement from the outset and across the course of treatment. It is recognised that men are often reluctant or ambivalent in relation to seeking psychological help and support for themselves (Berger et al., 2013). Stigma associated with help seeking behaviours has been demonstrated to be particularly apparent in relation to mental health issues and to be more prominent for males than females (Corrigan, 2004, Corrigan et al., 2009, Corrigan and Rao, 2012, Corrigan et al., 2014, Levant et al., 2013). At the point of engaging with treatment paternal reluctance/ ambivalence regarding engaging with external help and support were overridden by the emerging crisis in the family, a recognition that the young person would become increasingly unwell without professional intervention. That is, fathers engaged by prioritising the needs of their son or daughter over their own fears about how involvement with services would be viewed and by placing immediate need ahead of concerns about the future impact of mental health labelling. The crisis underpinned engagement and moved fathers into a care providing role which placed a unique set of demands upon them. In trying to meet these demands, I found that the perception of a society that does not understand mental health issues and eating disorders i.e. / societal stigma coupled with a need to retain a strong sense and appearance of coping made it difficult for fathers to access external support. It was concerning that in their darkest moments, while actively involved in a therapeutic treatment approach, the majority of fathers believed being emotionally and psychologically isolated was inevitable. The father's

need for emotional support following the transition to this new caring role must be considered if the paternal contribution is to be effectively harnessed and capitalised upon.

This research set out to answer what it is like for fathers to meet up with services, what are the factors that promote or hinder fathers ongoing involvement in their young person's treatment, and what is the overall experience of treatment like for fathers? On balance, I think these questions have been addressed. Hidden paternal narratives have been rendered visible by the thoughtful, open and frank reflections of fathers. Their words provide an invaluable insight in to the paternal perspective of the treatment journey.

The changed father/ young person relationship within FBT was highly valued by all fathers, who despite remaining perplexed and confused by anorexia nervosa, felt increased empathy for the struggle experienced by their son or daughter. It was the primacy of this relationship that promoted continued paternal involvement in treatment over time. All fathers said that given the choice they would participate in FBT again and most felt that on balance it was a helpful experience. Living with anorexia nervosa in the family and engaging with FBT represented the most challenging and demanding experience that fathers had encountered in their lives to date but every father expressed a view that their involvement in FBT was absolutely necessary and that it could not be a family based treatment without them.

The substantive theory of Rescripting, as it relates to the components of FBT, relationships and caring has been considered. The strengths and limitations of the study, clinical and research recommendations are made prior to concluding the chapter and thesis.

5.7 Strengths and limitations

A major strength of this study is that it makes a contribution to the limited knowledge base regarding the paternal experience of involvement with CAMH services. Within CAMHS fathers are widely recognised as the most challenging parent to involve in treatment, and, as such, they continue to be underrepresented both within clinical services and in research studies. My

findings have applicability to all clinicians working within CAMHS who have a role in engaging fathers into the assessment and treatment process.

Another strength of this research is that it addresses a gap in the current knowledge base regarding paternal involvement in FBT for adolescent anorexia nervosa. Globally, there are no other studies focused specifically on fathers' experience of and contribution to FBT. Significant challenges were overcome to successfully recruit 15 fathers with direct experience of participating in FBT.

The engagement of fathers with the research and the depth of the data collected represent another key strength. At the outset of the interviews, all fathers expressed concern that they had little to contribute but proceeded to give a detailed, considered and forthright account of their involvement in and contribution to treatment. These fathers chose to contribute to treatment and to research about treatment and their collective voice provides an invaluable insight into an area that remains under-researched and poorly understood.

Although I set out to capture a purposive sample, in line with GT methodology, recruitment challenges led me to proceed with a convenience sample. Within this sample, a good range and spread of paternal characteristics was evident in order to achieve theoretical saturation. This point was reached by interview 13 with no new categories emerging thereafter.

In comparison to studies including both parents, a strength of this research is that by focusing exclusively on fathers' priorities, the least considered (in terms of the literature and often in clinical practice) voice has been represented.

A strength of the study is that by using a classic Grounded Theory approach, the substantive theory, constructed from substantive codes and categories, is fully emergent from and grounded in the data collected. In this way fathers have centrally informed and shaped the development of theoretical knowledge of an experience that only they truly know and understand.

A limitation of the study is that, due to difficulty in recruiting fathers, I did not have time to focus on recruiting the small group of young people I had intended to interview. I had hoped that including young people, who had paternal involvement in their FBT, would bring added depth to my findings. However, as

this thesis demonstrates, the data collected from fathers alone provided a rich account of the experience of being a father involved in treatment, which makes a useful contribution to the literature, and has raised issues of importance for clinical practice.

5.8 Recommendations for clinical practice

Emotional and psychological support should be incorporated in to FBT

Reducing paternal isolation on an emotional and psychological level should be a priority within the treatment process. FBT approaches should be complemented by some form of parent to parent support. If local support groups are not available, then fathers should be provided with information about online support that can be accessed; for example, BEAT Sandpiper group where fathers can access support from fathers in a similar situation. This form of anonymous and confidential support may be more acceptable to fathers who are reluctant to discuss their experiences face to face. CARED Scotland is an online support platform, funded by Technology Enabled Care, which provides guidance to parents and has a section devoted to fathers.

The needs of fathers should be considered from the outset of FBT

Therapists should be mindful of the gender of fathers entering the therapy environment. Females tend to be more comfortable with talking based therapeutic interventions while fathers are moving out of their comfort zone in to an alien environment that does not necessarily play to and capitalise on their strengths. By holding this in mind and paying attention to it from the outset therapists can engage with and support fathers to be part of treatment in a more productive way.

Where the young person with anorexia nervosa is male the impact of this on the identification and diagnosis of the disorder, their engagement with treatment and ongoing intervention, and how it influences the father/ son relationship, requires to be considered.

Therapists should advocate for fathers to take time out of the workplace

In order to contribute to FBT and to supporting the young person at home, fathers require to be supported by their employer. Therapists should be prepared to strongly advocate for fathers to have time away from work for appointments and to be involved in supporting the young person at home. Flexibility in relation to the timing of appointments could be considered.

Opportunities should be provided for fathers to meet individually with therapists

Fathers should have an opportunity to meet individually with the therapist, as part of the treatment approach, to allow space for them to discuss their concerns about the young person and to explore their approach to providing help and support to the young person. This could take the form of a parental session, with both parents present, and an opportunity for each parent to be seen alone if they choose this. Ideally this appointment should be with the therapist delivering FBT but if this is not feasible a different therapist could conduct this session. In these circumstances a mechanism requires to be put in place to ensure that the session is fed back in-to, and informs the FBT sessions.

It is important that opportunities to fully support fathers are not missed and that vital information is brought into the therapeutic arena. If necessary, separate mental health support/ intervention should be accessed for fathers from adult mental health services. It is also important that fathers are offered an individual space, at the end of treatment, to process and reflect on their participation in treatment and to consider their ongoing relationship with the young person.

Therapists should be aware of the differences between mothers and fathers

Therapists should be aware that fathers responses and needs are likely to be different from those of mothers. While mothers are generally more comfortable talking about areas of struggle fathers are likely to find this more difficult to do. Considering how fathers might think, feel and respond within the therapy session may help the therapist to develop and establish a better engagement and more productive therapeutic relationship with the family.

Good quality information should be provided at the outset

Clinicians within CAMHS involved in assessing young people with anorexia nervosa, or other eating disorders, should provide good quality information regarding the physical and psychological effects of eating disorders to parents as part of the assessment process.

Therapists delivering FBT for anorexia nervosa should provide fathers with tailored information regarding eating disorders, treatment approaches and strategies in relation to providing support to young people at the outset of treatment. In particular, material developed by parents with lived experience of supporting a young person with anorexia nervosa should be included. Information provided should include suitable books and also shorter articles or video clips that are accessible at points of crisis when time is in short supply and fathers are emotionally overwhelmed. A number of fathers in this study highly recommend the book '*Anorexia and other eating disorders, How to help your child eat well and be well*' written by Eva Musby. '*Help Your Teenager Beat an Eating Disorder*' written by James Lock and Daniel Le Grange was also recognised as a useful text to complement an FBT approach. CARED Scotland provides online information and support that can supplement FBT sessions.

Treatment should be flexible and responsive to the needs of fathers, families and young people

While there is a tension around delivering a manualised treatment with fidelity, and providing individualised treatment, it is crucial that therapists delivering FBT are open to modifying their approach in order to meet the needs of the young person and their family. While it is essential that the core principles of the manual are adhered to, for example individual time with the young person, the family meal and weighing the young person, there is scope within the manual to provide flexible and tailored treatment. An example of this is that the family can be provided with a written summary of the treatment session which can act as a point of reference and enhance opportunities for generalising therapeutic work to the home setting.

Where weight gain is not secured early in FBT, therapists should consider the importance of the relationship between the father or the parents and the young

person and work with this in treatment sessions rather than continue to focus on weight alone. While weight gain requires to remain an important area of consideration the manual does allow scope for the therapist to explore factors that may be impeding progress. An exploration of relationship issues impeding progress can and should be considered within an FBT approach.

Treatment should be collaborative and supportive

Within FBT, therapists should be open with fathers regarding the purpose of the family meal and actively seek to collaborate with them in order to create a more collaborative environment within the session. Delivering the family meal in a confident and competent way demands a high degree of clinical skill. During the family meal, therapists require to be active in delivering coaching and direction in a way that contains and supports fathers to develop strategies that can be transferred to and implemented within the home environment. In order to provide best practice family based intervention it is recommended that further training and supervision is provided to therapists delivering FBT. This could take the form of workshops following initial FBT training and ongoing supervision/ consultation with experienced FBT supervisors.

Therapists should seek feedback from parents

Over the course of FBT therapists should seek feedback from parents regarding the process of therapy and their emotional reaction to/ experience of being involved in treatment. This feedback will provide valuable information in relation to parental engagement with treatment and will create space for a discussion about the helpful and unhelpful aspects of FBT to take place.

Paternal involvement should be considered for all clinical presentations seen by CAMHS

Clinicians delivering therapeutic interventions for a range of clinical presentations within CAMHS should consider involving fathers in the assessment and/or treatment process.

5.9 Recommendations for future research

Future research should focus on accessing the views of fathers who do not engage with FBT or who initially participate in treatment but thereafter disengage. Given the views expressed by fathers in this study regarding how crucial support from employers is when participating in FBT, it would be particularly important to explore the work situations of those who either do not become involved or who do not maintain involvement over time.

It is possible that fathers from different socioeconomic groups face other challenges, and a better understanding of barriers to inclusion could support clinicians to develop strategies to engage fathers who are harder to reach. Given the important contribution that fathers make to the treatment process, addressing barriers that prevent participation should be a priority area for future research. The small sample size of fathers in this study was pragmatically selected in order to meet the requirements of studying for a doctoral degree. It is recommended that this study is repeated with a larger sample size in order to access a more diverse population and a wider range of paternal characteristics and experiences, including representation of fathers from different demographic groups.

Further research into how fathers manage the transition from the role of provider to carer would lead to a better understanding of the challenges faced and support required. FBT, by requiring the involvement of both parents, presents a unique opportunity to consider this.

The views of young people and clinicians regarding the participation and contribution of fathers in FBT represent an important area of future research.

5.10 Conclusion

In this thesis I have presented and discussed the findings of the first study to focus exclusively on the paternal experience of being involved in FBT, when a son or daughter has anorexia nervosa. This study contributes new knowledge regarding how the paternal role is rescripted when anorexia nervosa first emerges, the paternal experience of engaging with treatment, how participation

shapes the fathers position and role within the family, and how fathers contribute to the treatment process and to supporting the young person.

Implementing a classic Grounded Theory approach to exploring the paternal experience of and contribution to FBT has enabled the development of a theory firmly rooted, or grounded, in the data. While making the transition from clinician to researcher was undoubtedly challenging, I found that by remaining immersed in the Glaserian GT processes supported the development of new and unanticipated insights. Reading about Glaserian GT persuaded me that it was the best methodology to utilise to address my research questions, and a good fit for me as an individual. Implementing this approach in practice has been both challenging and rewarding but, having done so, I am convinced that I made the right choice. The previously hidden narratives that underpin this paternal experience have been made explicit during the study, and, in so doing, the opportunity for a deeper understanding of this important and neglected area has presented itself. I have been changed, by staying with the process, and I have learned how to focus on hearing what the data is telling me. Over the course of this study I have developed as a researcher. I set out as a clinician, interested in the paternal experience of FBT, and became a researcher immersed in understanding participation from the perspective of fathers with direct experience. The fathers I met helped me to see the familiar from a new and different angle. This study demanded balancing the parallel roles of being a clinician and a researcher at the same time. Over the course of the interviews the fathers and I found a space to simultaneously process their experience of FBT. At points it was painful to help them express a less than optimal treatment experience while at others it was a privilege to hear what they gave a voice to for the first time, their hidden struggle. I believe I will be a better clinician for having undertaken this study and I have no doubt that the fathers who participated have supported me to begin my research journey.

The findings presented within this study have the potential to inform developments and improvements within clinical practice. By engaging and including the father in treatment, his contribution can be capitalised on in a way that complements maternal involvement and enhances the efficacy of treatment for the young person. Parental alignment, associated with positive outcomes

within FBT, can only be achieved if both parents are valued as making equal contributions to the treatment process. Priority must be given to considering fathers' needs, if parental alignment is to be improved within treatment and if consistent and sustained paternal attendance is to be achieved. Recognising and addressing the challenges that fathers face during FBT will make it possible to include and involve fathers who otherwise would become lost to treatment. A real opportunity exists to harness paternal energy to improve outcomes for young people with anorexia nervosa.

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Appendix 1- Draft Article for Publication

Draft Submission Original Article International Journal of Eating Disorders

Title - Rescripting – A grounded theory study of the contribution that fathers' make to Family Based Treatment when a young person has anorexia nervosa

Short Title- Rescripting- A Grounded Theory Study

Author Name- Karen McMahon

Institution- University of Stirling¹

Abstract- 246 words

Article- 4444 words

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Abstract

Objective- Family Based Treatment (FBT) is recommended for young people with anorexia nervosa. In FBT parents are expected and required to take on a central role in relation to supporting the young person with recovery. There is a gap in knowledge about the contribution of fathers to FBT. The research reported here examined their experiences and the contribution they make to the treatment process.

Method- A classic Grounded Theory (GT) methodology was employed. A convenience sample of fifteen fathers' who had participated in FBT took part in individual interviews. Data was collected and analysed using the process of constant comparative analysis.

Results- Fathers valued being included in FBT and felt that they had an important contribution to make to treatment. The analysis captures the overall contribution that fathers' make to FBT and the impact on them. Four categories; Being on the Outside, Finding a Way In, Finding a Way To Be and Finding a Way to Let Go and one core category Repositioning were constructed from the data. The substantive theory of Rescripting, generated from categories and core category, describes the way that participating in FBT changes fathers and their role.

Conclusion- Fathers make an important and significant contribution to FBT when a young person has anorexia nervosa. The findings inform clinicians about the importance of including fathers in the treatment of young people with anorexia nervosa and consider the support mechanisms that can be incorporated in to FBT to harness and maximise the paternal contribution.

Keywords- Family Based Treatment, Anorexia Nervosa, Fathers

Introduction

A family therapy approach that directly addresses eating disorder behaviours is recommended for the treatment of young people diagnosed with anorexia nervosa (NICE, 2017). Family Based Treatment (FBT) in manualised form (Lock and Le Grange, 2012) is currently the most extensively researched and best supported intervention for use with the adolescent age range (Couturier et al. 2013; Downs and Blow, 2013; Lock, 2018; Lock and Le Grange 2018). FBT is an outpatient treatment delivered in three phases over approximately 20 sessions or one year that centrally involves parents in supporting the young person particularly in relation to eating and refeeding (Lock and Le Grange, 2012). Phase one of treatment includes a family meal and is focused on supporting parents to take over full responsibility for ensuring that the young person has an adequate intake to support weight gain and the restoration of physical health. The family meal is a clinic based session which involves all family members eating together in the company of the therapist. A key aim is to give both parents an experience of success in supporting the young person to eat. In phase two the responsibility for eating is gradually handed back to the young person and developmental issues that contribute to or maintain anorexia nervosa are explored. In phase three which concludes treatment, adolescent issues are explored and the process of ending treatment is managed by having sessions at less frequent intervals. In clinical practice FBT is seldom a linear process in that some families move forwards and backwards between phases while others become 'stuck' in phase one and struggle to establish sufficient weight gain for the young person to move forward. Full remission from anorexia

nervosa in young people treated with FBT is achieved in approximately 40% of cases (Lock and Le Grange, 2018). Younger patients with a shorter duration of illness have been shown to respond most positively to treatment. Maximising the impact of clinical interventions for this age group has the potential to improve treatment outcomes.

Currently little is understood regarding the actual mechanisms that promote change in FBT (Darcy et al, 2013). Parental self efficacy has been linked to better treatment outcomes (Robinson et al., 2013). Direct parental management of eating, externalisation of the eating disorder and the ability of parents to adopt a non-critical stance are associated with weight gain during FBT (Ellison et al, 2012). In the FBT manual (Lock and Le Grange, 2012) it is expected that both parents are involved in all treatment sessions. However, within routine clinical practice it is unclear how often this ideal is achieved. In the one study looking at the participation of different family members Hughes et al. (2017) found mothers attended 94% of sessions while fathers attended only 72%. The majority of fathers were present at early treatment sessions but only 33% maintained involvement across the entire course of treatment. Early FBT sessions focus on parents committing to the treatment approach by prioritising anorexia nervosa above all other demands and working together as a parental unit to promote weight gain and restore health in the young person. The disengagement of fathers from the treatment process has the potential to interfere with these goals and may undermine or reduce the efficacy of FBT.

By developing an understanding of the factors that promote or hinder paternal involvement in FBT consideration can be given to how best to include and support fathers. Those who have participated in FBT are in the best position to

provide an insight in to the experience of treatment. Despite FBT being predicated on parents as the primary treatment resource there is little research that considers treatment from their perspective.

The aim of this research was to understand fathers' experiences of, and contribution to, FBT. Using a grounded theory approach a substantive theory of the way that fathers contribute to FBT was generated. The theory generated illuminates that the role of the father is changed by engaging, with and remaining involved, in FBT and that this change of role has a significant impact on relationships within the family.

2. Method

2.1 Design

This research used a classic Grounded Theory methodology to explore the experiences of fathers who had participated in FBT. Grounded theory is a valuable methodology where little is known about an area of human experience (Glaser and Strauss 1967). The group of fathers who have participated in FBT in Scotland is relatively small and as such convenience sampling was employed to recruit participants. Theoretical saturation (no new data emerging from participants accounts) was achieved within the study indicating that the sample recruited was sufficient to be representative of the experiences of this particular group.

2.2 Ethics

Ethical approval for this study was granted by the University of Stirling and West of Scotland Research Ethics Service. Informed consented was established verbally and in writing prior to individual interviews being

undertaken (Creswell, 2009; Denscombe, 2010; Holloway and Galvin, 2017). Participants were made aware that all data collected would be anonymised and securely stored and that findings would be discussed in a doctoral thesis and articles for publication. Mechanisms of support were put in place prior to interviews commencing.

2.3 Participants

Fifteen fathers of young people with anorexia nervosa who had participated in FBT were recruited. Twelve were identified by clinicians working in generic Child and Adolescent Mental Health Services (CAMHS) and three responded to an advert posted on an online eating disorder support forum.

2.4 Data Collection & Analysis

Fourteen fathers took part in face to face interviews and one father participated in a telephone interview. Data was collected and analysed simultaneously using the process of constant comparative analysis (Glaser 1992). Using this process, interviews were conducted, transcribed and compared in order to ensure that a substantive theory grounded in and informed by the data would emerge. Fourteen substantive codes and four categories were constructed, and these led to the discovery of one core category. From this core category the substantive theory was generated.

A semi structured interview schedule acted as a guide for early interviews and thereafter theoretical sampling informed the direction of future questioning. Theoretical sampling employs coded data to guide and inform the data that is collected next in order to support and enhance the development of a substantive theory (Glaser and Strauss, 1967).

3 Results

Category 1: Being on the Outside

Recognition was the first challenge that fathers encountered in relation to anorexia nervosa. Generally the first signs were not recognised as cause for concern. One father, who had previous experience of the disorder, did recognise the early warning signs. Having a sister who developed anorexia nervosa as a teenager made him more vigilant, enabled him to spot early warning signs and informed early help seeking behaviour. In contrast the majority of fathers confused the first signs with healthy or normal development.

Altered eating patterns and exercise routines were perceived as the young person becoming more interested in and motivated to take care of their health.

“Now I have always been athletic and taking exercise... She started to look after her diet particularly and going to the gym more frequently which we thought yeah keeping healthy fantastic... a positive step, keeping healthy.” (Arran)

And fathers found it difficult to distinguish cause for concern from normal adolescent development

“... because teenagers, young women always discuss their weight, talk about their weight...we weren't concerned at first.” (James)

Overall fathers were confused by anorexia nervosa as it first emerged and to some extent this feeling persisted across the course of FBT.

“I had no idea what anorexia was, what the implications were for [...], the health implications, why she wouldn't eat, what I was going to do to make her eat. To be honest all this it still feels like a daze.” (Michael)

Recognition that changes represented cause for concern rather than healthy development initially led to denial. Fathers found it difficult to believe that their previously well functioning daughter or son could be developing an eating disorder. Denial of the disorder emerged as inextricably linked to feelings of failure and blame

“The first signs were there in July 2014 ...never in a million years could you foresee what was coming... it is very hard to accept and admit, because you feel as if as a parent you have failed... that was I remember really hard to take in and then of course you start blaming yourself.”
(Anthony)

Not recognising the initial signs of anorexia nervosa or denying the seriousness of what was happening to the young person placed most fathers on the outside of the help seeking process. They continued to be fully emerged in the world of work while the young person's mother took responsibility for arranging a GP consultation. It was once engaged with CAMHS, for assessment and treatment, that fathers' started to realise the seriousness of the situation they were facing. Their initial response was to feel more confused and completely overwhelmed. It is significant that fathers feel overwhelmed at the point of making decisions about which treatment approach to take. In every case FBT was presented as the only treatment choice and all fathers deferred to and accepted professional advice that this was the best treatment option. Where the young person made good progress during treatment progressed fathers did not question their

decision to participate in FBT. However if the young person failed to gain weight and the situation became 'stuck' fathers became increasingly critical of the lack of consideration given to additional or different treatment approaches at the outset. Fathers in this group drew attention to what they saw as the limitations of FBT.

"I think it needed a combination of counselling for [...] and help for my wife and I in terms of guidance on what we needed to do in order to support her whereas there wasn't any counselling for [...] at all. The only time she was seeing professionals was with us present and it all being about the eating" (Gordon)

At the beginning of treatment all fathers felt overwhelmed and powerless. FBT requires fathers to take on an active role from the outset of treatment in relation to supporting the young person at home. In order to be involved in treatment and support fathers required to find a way in; that is to move from a peripheral to a more central position.

Category 2: Finding a Way In

In order to find a way in fathers utilised information seeking as a psychological and emotional strategy to counteract feelings of being overwhelmed. Acquiring knowledge and developing some understanding of anorexia nervosa decreased feelings of powerlessness and gave fathers some sense of control over the situation. However good quality information was not always provided by FBT clinicians and this left fathers trying to negotiate the information maze on their own.

“I mean perhaps we weren’t looking in the right place; the information for parents is not always necessarily easy to come by. So you kind of feel a bit in a vacuum.” (Graham)

When good quality information was provided early in treatment it made a significant impact on the fathers overall experience of treatment.

“The thing I would say is to give them that information sheet. I would say that is probably one of the most important things because half the families probably don’t even know what is involved...if you don’t have that then you haven’t a clue what’s happening... if you can give it out early doors it would make a big difference.” (Curtis)

A fundamental task given to both parents within FBT is to halt weight loss and promote weight restoration by supporting the young person to eat an adequate dietary intake. Fathers said it was made clear to them that this was a parental responsibility but that they had no idea how to make it happen in practice. Initially fathers had little or no idea how all consuming the process of refeeding would become.

In relation to finding a way to support eating most fathers did not experience the family meal session as particularly useful. The artificiality of the situation, feeling observed and potentially scrutinised or judged by professionals often made it difficult for fathers to fully engage with the process. When therapists were active in providing direct coaching to fathers in relation to eating strategies learning was more likely to be transferred from the clinic to the home environment.

“...you know sitting holding his hand trying to encourage him to eat this yoghurt it was just horrible. ...I think because of that happening sitting down at the family meal I totally understood why that had to happen... I do remember being very sceptical... thinking how is this going to help and then sitting in it very emotional and felt drained coming out of it but I totally got why it had to happen.” (Anthony)

Less active therapists left fathers questioning the purpose of the session and no link was established between the family meal and challenges being faced in the home environment.

“So there wasn’t much interjection by the therapists, they just took notes, and they never said a lot to us...and we thought we would maybe get a bit more feedback at the next appointment and I honestly can’t remember if we did or not. I mean the family meal as far as I am concerned was just an event that was kind of non-descript.” (Kevin)

Category 3: Finding A Way To Be

As FBT progressed and fathers were more involved in supporting the young person and the role they adopted became increasingly all consuming on both an emotional and practical level. At this stage fathers reassessed their priorities and work moved in to a secondary position in their lives. Prior to the onset of anorexia nervosa all fathers identified as being professionally successful and being moved in to a new and different position as FBT challenged and altered their worldview. FBT changed the way that fathers viewed themselves and their relationships with others in and beyond the family.

Although fathers often reduced the time they were physically spending at work in order to be at home to support the young person, on an emotional level they highly valued the attitude of their employer to supporting flexible working arrangements or a leave of absence. A sound attachment to the world of work provided a base from which fathers felt able to rebalance and reassess their priorities for a period of time in the knowledge that they would return to it in the future.

“... to me my family comes first...I work in manufacturing. I have been there for a long, long time about 30 years so they kind of understand ... it is very family orientated as well so time off was never an issue.” (Curtis)

In relation to supporting the young person at home, I found that anorexia nervosa had the potential to either unite or undermine the marital relationship.

“...it [anorexia nervosa] definitely drove a bit of a wedge between us”
(Gordon)

Regardless of the impact that managing the disorder had on the marital relationship all fathers identified that finding ways to work together as a parental unit as important.

“...my experience is that as a disease it exploits any chink in the armour and if you haven't got a united front it's no good it's not going to work.”
(Graham).

Separated fathers valued the opportunity to become more involved in the life of the young person for a period of time and appreciated the inclusivity of FBT in this regard.

“...in some ways being kind of separated from the family I think I had been kept at arm’s length for a while and it actually helped me greatly to actually be pushed right in...” (Harry)

In this context fathers had to find ways to deal with and manage their own emotional reaction to the situation.

“So there were times she would just refuse to eat, leave the room and storm away that kind of thing... So okay don’t lose your temper, no point in losing your temper... It was trying to split it in to that not to lose your temper...” (James)

Blame and stigma had an affect how able fathers felt to access external support.

“You know, if it was cancer, I think the reaction would be different, you know, it is the stigma around mental health that gets in the way. But, you know, I think the reaction would be different for cancer patients.” (Andrew)

While perseverance, meal by meal, and hopefulness over the course of treatment were important personal attribute that fathers relied upon.

“It’s not easy. It’s not easy. And when you are hitting the brick wall ... Just go away sit up the stairs for 10 minutes, have a cup of tea and then come back... You can’t give up...And even the next months and years to come I don’t know what is going to happen. So hopefully she will be fine.” (Michael)

The way that fathers viewed the eating disorder and their relationship with the young person had an important influence on the contribution they felt able to

make during FBT. Fathers had to balance their pre existing relationship with the 'well' young person and their need to develop a new relationship with the young person in the grip of anorexia nervosa. Separating or externalising anorexia nervosa sometimes supported fathers with this transition but at times left them feeling that the young persons individuality was under threat and in danger of being lost.

Category 4: Finding a Way to Let Go

Fathers focused much less on phase three of FBT during the individual interviews. Although FBT had drawn to a close some fathers were not convinced that their encounter with anorexia nervosa was over.

"It will always be there. I cannot see a time in my life when I am not going to be thinking ... I do have a fear about it. I don't think it will be as large a fear as when we first found out, if it comes back. Which I don't know, but it may, and, we will, do our, go through it all again if we have to." (John)

Despite these fears fathers on the whole were optimistic about the future and felt that at the end of treatment their young people were in a stronger position.

"She has goals and objectives and I can't see Clare failing on any of them. But to do that she has got to keep eating and that's what I am happy about. I will be on the sidelines, watching, cheering her on hopefully." (Michael)

These four categories informed the generation of the core category of repositioning that applies across the course of treatment.

Core category: Repositioning

The core category of repositioning emerged in relation to the challenge fathers face in holding on to who their young person is at the same time as coping with the effects of anorexia nervosa upon them. In the course of treatment fathers “find a way to be” by holding their young person in mind at the same time as taking action to deal with the effects of anorexia nervosa upon them. In order to achieve this fathers must first move in to a close enough position in relation to anorexia nervosa to appreciate that they have a contribution to make. A family based treatment approach asks fathers to become closely involved in treatment. By engaging with the approach fathers move from a peripheral to a central position.

Discussion: Rescripting

The way that developing a chronic illness affects the life of an individual has been previously studied. Bury (1982) developed the theory of biographical disruption to describe the way that personal narratives are revised and rewritten when an individual becomes chronically unwell. Chronic illness profoundly impacts on an individuals’ sense of identity and fundamentally alters the way that they view themselves and how they engage with the world. This theory has been applied to men living with prostate cancer (Cayless et al., 2010), mothers living with HIV (Wilson, 2007) and the experience of chronic illness in the home setting (Corbin and Strauss, 1985). However to date less attention has been paid to the impact of illness in the family on the lives of other members of the family. The narratives of fathers actively involved in supporting a young person with anorexia nervosa extend the theory of biographical disruption. They highlight that experiencing a potentially chronic disorder, in a daughter or son,

changes the way that fathers view themselves and how they engage with others both within and out with the family.

Being repositioned by FBT places the father in the role of taking an active part in the provision of direct care to the young person. Young people with anorexia nervosa present with a range of needs that are out of keeping with their age and stage of development. Repositioning draws fathers close to the young person and their needs. Fathers respond by rescripting the role they are prepared to play within the family in order to cope with the demands upon them. Unlike other treatments FBT, not only requires parents to be involved in treatment sessions, but also necessitates them taking twenty four hour responsibility for meeting the young person's physical and psychological needs. Fathers placed in this position find themselves providing care that would be delivered by nurses if the young person were in an inpatient setting but without the support structure and supervision that would be in place if they were a professional rather than a parent.

Fathers were moved in to this position from being immersed in the world of work where they had established a secure professional identity. As they adopted this new role they felt removed and cut off from previous sources of validation and support. They described the family as 'closing down' for the duration of FBT in order to both manage the demands of supporting the young person and to maintain a degree of privacy. Family members and friends, perceived as not understanding eating disorders, were viewed as compounding an already stressful situation and as such were kept at a physical and emotional distance and there was considerably less engagement with a world beyond the family.

Fathers did not feel able to talk openly out with the family about the situation they were experiencing. In general, males tend to be reluctant to seek psychological support for their own personal problems (Berger et al., 2013, Corrigan, 2004, Corrigan et al., 2009, Corrigan and Rao, 2012, Levant et al., 2013 and Corrigan et al., 2014). This coupled with fears about how society views mental illness in general and eating disorders in particular precluded fathers from sharing their experience and accessing external support for themselves. They would have felt more comfortable being open with others who had had similar experiences but for many this was not an opportunity that was available.

From this isolated position fathers questioned their own competence and blamed themselves for the emergence of anorexia nervosa. At the same time as trying to take on responsibility for supporting the young person fathers' were also struggling with the complex emotions that the presence of the disorder aroused in them. The demand within treatment to take responsibility for managing the illness led fathers to adopt an external persona of coping that belied the confusion and sense of being overwhelm they felt inside. Sessions involving all family members precluded fathers from talking openly about their own emotions or expressing their need for support. A desire to be seen as supportive and non critical of the young person frequently inhibited fathers from verbalising concerns about behaviours they were observing in an open and honest way. This meant that many areas of paternal concern associated with caring for and supporting the young person were never fully discussed within the treatment designed to provide support. While FBT is effective at involving fathers at the outset, it is not always so effective at adequately supporting them during treatment.

Being invited to participate in a Family Based Treatment approach was welcomed by the fathers who took part in this study and they all remained actively engaged for the duration of treatment. While some fathers contemplated exploring alternative interventions or disengaging from treatment none of them actually did so.

A strong therapeutic alliance between fathers and therapists was most evident when early weight gain was secured, and in these circumstances, fathers tended to stick most closely to the FBT script of taking a firm stand in relation to anorexia nervosa. Therapeutic alliance has been found to significantly influence outcomes in FBT (Isserlin and Courturier, 2011; Zaitsoff, 2015 Pereira et al., 2016). Where weight gain was not secured and young people resisted paternal attempts to support them, fathers were more likely to rescript their own role and to move towards a more collaborative stance alongside the young person. In these circumstances fathers engaged in more compromising and negotiating with the young person. Such accommodating behaviours in caregivers have been found to be most evident in those with the longest duration of illness (Anastasiadou et al., 2014 and Treasure et al., 2014). It is of interest that a shift towards this way of managing was evident in families where young people had a short duration of illness but were resistant to weight gain during FBT.

A key challenge for fathers during FBT was trying to find ways to manage their own emotional reaction to the eating disorder. Components of FBT designed to support parents to develop strategies for coping were not always successful at capitalising on paternal involvement. Most fathers experienced the family meal session as inhibiting and challenging. Fathers were most positive about therapists who were active in coaching and directly supporting them to manage

the challenges associated with eating this session and they reported being able to generalise advice to the home setting. In contrast where therapists were perceived as passively observing the fathers struggle to support the young person to eat feelings of being scrutinised and judged were intensified. For these fathers not being involved in planning the family meal session or agreeing goals in advance acted as a barrier to full engagement and participation. In these circumstances fathers protected themselves by not fully engaging with the process and adopting a coping persona. Consequentially an opportunity for them to explore or develop new strategies and skills was missed.

Fathers felt strongly that FBT by virtue of its nature and design required their involvement and they welcomed being included. Having participated they were able to identify aspects of anorexia nervosa and FBT that hindered their involvement and those that maximised and harnessed their contribution.

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Appendix 2- Letter of Ethical Approval

WoSRES
West of Scotland Research Ethics Service



West of Scotland REC 3
Ground Floor – The Tennent Institute
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www.nhsgcc.org.uk

Mrs Karen McMahon
Research Student/ Specialist in Family Based
Treatment
Connect-ED, First Floor
Templeton Business Centre
G40 1DW

Date
Your Ref
Our Ref
Direct line 0141 211 2123
Fax 0141 211 1847
E-mail Liz.Jamieson@ggc.scot.nhs.uk

Dear Mrs McMahon

Study title: **What contribution does the participation of fathers in Family Based Treatment for child and adolescent anorexia nervosa make?**
REC reference: **13/WS/0303**
IRAS project ID: **115990**

Thank you for your letter of 17 December 2013, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC. A list of the sub-committee members is attached.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Mrs Liz Jamieson, Liz.Jamieson@ggc.scot.nhs.uk.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation, as revised subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering Letter		12 November 2013
Evidence of insurance or indemnity		07 November 2013
Interview Schedules/Topic Guides - Fathers	1	25 August 2013
Interview Schedules/Topic Guides – Young People	1	25 August 2013

Investigator CV		
Letter from Sponsor		07 November 2013
Letter of invitation to participant	3 - Young Person	12 December 2013
Other: CV Supervisor Dr K Stoddart		
Other: Contact Sheet - Fathers	2	12 December 2013
Other: Contact Sheet - Young People	2	12 December 2013
Participant Consent Form: Fathers	3	12 December 2013
Participant Consent Form: Young People	2	12 December 2013
Participant Information Sheet: Fathers	2	12 December 2013
Participant Information Sheet: Young People	2	12 December 2013
Protocol	3	12 December 2013
REC application		12 November 2013
Response to Request for Further Information	Email	17 December 2013

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

13/WS/0303	Please quote this number on all correspondence
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We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



Liz Jamieson
Committee Co-ordinator
On behalf of Eoin MacGillivray, Vice Chair

Enclosures List of names and professions of members involved in the review
"After Ethical Review" – Guidance for Researchers

Copy to: Carol Johnstone, University of Stirling
Dr Erica Packard, NHS Greater Glasgow and Clyde R&D

West of Scotland REC 3

Sub-Committee of the REC meeting in correspondence - 23 December 2013

Committee Members:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Mrs Monica Ann Dickson	Retired - Lay Plus Member	Yes	
Ms Susan Fleming	Public Health Researcher	Yes	
Mr Eoin MacGillivray	Retired Dentist - Vice Chair	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs Liz Jamieson	Committee Co-ordinator

Appendix 3- Substantial Amendment Letter

WoSRES
West of Scotland Research Ethics Service

NHS
Greater Glasgow
and Clyde

West of Scotland REC 3
Ground Floor – The Tennent Institute
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Mrs Karen McMahon
Research Student/ Specialist in Family Based
Treatment
Connect-ED, First Floor
Templeton Business Centre
Templeton Street, Glasgow
G40 1DW

Date 1st October 2015
Your Ref
Our Ref
Direct line 0141 211 2123
Fax 0141 211 1847
E-mail WOSREC3@ggc.scot.nhs.uk

Dear Mrs McMahon

Study title: What contribution does the participation of fathers in Family Based Treatment for child and adolescent anorexia nervosa make?
REC reference: 13/WS/0303
Amendment number: AM01
Amendment date: 11 September 2015
IRAS project ID: 115990

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Summary of Amendment

- 1) Changes to the timing of recruitment
- 2) Clinicians/Case Manager will provide Fathers/Adolescents at the end of phase 2 or in phase 3 of FBT with an information pack about the study. This change will allow Fathers/Young people who are willing to participate in the study to complete a contact sheet and give to the clinician/case manager who will pass to the researcher. This is instead of relying on fathers/young people filling in a contact sheet at home and then posting back.
- 3) An extension to the study until 4th August 2016. The study would therefore run for 4 years and 8 months.

Approved documents

The documents reviewed and approved at the meeting were:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Covering letter on headed paper [Ethics]		18 September 2015
Covering letter on headed paper [Fathers]	4	12 June 2015
Covering letter on headed paper [Young People]	4	12 June 2015
Notice of Substantial Amendment (non-CTIMP)	AM01	11 September 2015
Other [Contact Sheet Fathers]	4	12 June 2015
Other [Contact Sheet Young People]	4	12 June 2015
Other [Letter from Stirling University REC]		09 June 2015
Participant information sheet (PIS) [Fathers]	4	12 June 2015
Participant information sheet (PIS) [Young People]	4	12 June 2015
Research protocol or project proposal	4	12 June 2015

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

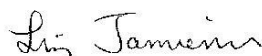
Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

13/WS/0303: Please quote this number on all correspondence

Yours sincerely



Liz Jamieson
REC Manager
On behalf of Dr Adam Burnel, Chair

Enclosures: List of names and professions of members who took part in the review

Copy to: Dr Erica Packard, NHS Greater Glasgow and Clyde
Carol Johnstone, University of Stirling

West of Scotland REC 3

Sub-Committee of the REC meeting held in correspondence between 29th September 2015 and 09 October 2015

Committee Members involved in the review:

<i>Name</i>	<i>Profession</i>	<i>Present</i>	<i>Notes</i>
Dr Adam Burnel	Consultant Psychiatrist - Chair	Yes	
Mrs Monica Ann Dickson	Retired - Lay Plus Member	Yes	
Ms Susan Fleming	Public Health Researcher	Yes	
Mr Eoin MacGillivray	Retired Dentist - Vice Chair	Yes	
Mrs Rosie Rutherford	Volunteer - Lay Plus Member and Alternate Vice Chair	Yes	

Also in attendance:

<i>Name</i>	<i>Position (or reason for attending)</i>
Mrs Liz Jamieson	REC Manager

Appendix 4- Covering Letter

Appendix A
Version 4 29/05/2015

UNIVERSITY of
STIRLING 

School of Health Sciences
University of Stirling
Stirling FK9 4LA

Tel: +44 (0) 1786 466395
Fax: +44 (0) 1786 466333
Email: karen.mcmahon@stir.ac.uk

Dear Sir,

My name is Karen McMahon and I am a Clinical Doctorate student at the University of Stirling. I am interested in learning more about fathers' experiences of treatment when their child/adolescent has had Anorexia Nervosa.

This pack has been given to you because you have been involved in treatment and in the hope that you might be interested in talking to me.

In the enclosed pack you will find an information sheet about the study I am undertaking, a contact sheet and a stamped addressed envelope.

I would be much obliged if you would read the information sheet and consider taking part.

If you have any questions I would be happy to answer these. I can be contacted on the email address or telephone number below.

If you would like to take part then please fill in the contact sheet and return it to the clinician who will return it to me. I will then get in touch with you to arrange a convenient date and time to meet.

Many thanks for your interest in this study.

Yours Sincerely
Karen McMahon
karen.mcmahon@stir.ac.uk
0141 277 7407

Appendix 5- Information Sheet

Appendix C
Version 4 29/05/2015

Talking to Fathers about Family Based Treatment

UNIVERSITY of
STIRLING 

School of Health Sciences
University of Stirling
Stirling FK9 4LA

Tel: +44 (0) 1786 466395
Fax: +44 (0) 1786 466333
Email: karen.mcmahon@stir.ac.uk

Participant Information Sheet- Fathers

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Who is conducting the research?

The research is being carried out by Ms Karen McMahon who is a research student at the University of Stirling.

What is the purpose of the study?

The purpose of the study is to talk to fathers about their experience of the treatment their child received for an eating disorder. In this study I would like to include any men who have been involved in a parental role in Family Based Treatment, this would include biological fathers, adoptive fathers and step fathers. The study is being undertaken as part of a Clinical Doctorate in Nursing.

Why have I been invited?

I am recruiting fathers who have children who have received treatment for an eating disorder within Child and Adolescent Mental Health Services.

Do I have to take part?

No. It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care or any future treatment that your son/daughter receives.

What does taking part involve?

You are invited to read this information sheet and decide if you would like to take part in this research. If you decide to take part you will be invited to participate in a face to face interview with the researcher (Ms Karen McMahon). This interview will last approximately one hour. The interview will be tape recorded in order to ensure that what you say is accurately reported. You do not have to answer any questions that you do not wish to answer. Given that we will be talking about your experience of Family

Based Treatment it is possible that this might feel difficult and that you become upset. If this happens it will be your decision if you wish to carry on or not. The researcher will ensure that support is available to you should this be required.

If I agree to take part, what do I have to do?

Please read the participant information sheet and if you would like to participate in this study please sign and return the contact sheet to the clinician who will return it to the researcher. The researcher will then contact you to organise a convenient time and place to meet to carry out the face to face interview.

What happens to the information?

Your identity and personal information will be completely confidential and known only to the researcher. The information obtained will remain confidential and stored within a locked filing cabinet. All data is held in accordance with the Data Protection Act. In the event of information being disclosed to the researcher which raises a concern in relation to professional practice or about the welfare of a young person this would require to be reported in accordance with NHS policy and procedure

What are the possible benefits of taking part?

There are no direct benefits of taking part in this study. However understanding fathers' experiences may help us to provide better services in the future.

What happens when the research study stops?

The research student (Karen McMahan) will write up the results of the study and discuss the implications of the findings with academic supervisors at University of Stirling. The data will be analysed and presented in writing as a thesis for the qualification of Clinical Doctorate in Nursing. The findings will be presented at research/clinical conferences and two peer reviewed academic articles will be published.

Who has reviewed the study?

The study has been reviewed by the School of Nursing, Midwifery and Health Ethics Committee and the West of Scotland Research Ethics Committee 3.

If you have any further questions?

We will give you a copy of the information sheet and signed consent form to keep. If you would like more information about the study please contact Karen McMahan (details below). If you wish to speak to someone not closely linked to the study please contact your case manager.

External support

If you require support this can be accessed via www.supportinmindscotland.org.uk .

If you are unhappy about any aspect of the study

Please contact Professor Jayne Donaldson, Head of School, School of Health Sciences, University of Stirling, Stirling, FK9 4LA jayne.donaldson@stir.ac.uk Tel:- 01786 4666345

If you have a complaint about any aspect of the study?

If you are unhappy about any aspect of the study and wish to make a complaint then you should follow the normal NHS complaint mechanisms. Advice on how to make a complaint can be obtained on NHS Greater Glasgow and Clyde website www.nhsggc.org.uk . Alternatively you can email complaints@ggc.scot.nhs.uk or telephone 0141 201 4500.

Thank you for taking the time to read this information sheet.

Karen McMahon
Email karen.mcmahon@stir.ac.uk
Tel 0141 277 7407

Appendix 6- Contact Sheet

Appendix E
Version 4 29/05/2015

Contact Sheet

I have read the information sheet about
Talking to Fathers about Family Based Treatment

I would like to hear more about the study.

If you are happy for the researcher to contact you please fill in the details below and then initial the boxes on the right hand side of the page.

Name-	<input type="checkbox"/>
Email-	<input type="checkbox"/>
Mobile Telephone number-	<input type="checkbox"/>
Landline Number-	<input type="checkbox"/>
Work Telephone Number-	<input type="checkbox"/>

Signature

Date

Please return the contact sheet to the clinician. The clinician will post it to Karen McMahon, the researcher, in the stamped addressed envelope provided. Karen will then contact you about a week later to discuss the study.

Karen McMahon
karen.mcmahon@stir.ac.uk
Tel 0141 277 7407

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STIRLING

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Appendix 7- Consent Form

Appendix G
Version 3 12/12/2013



UNIVERSITY OF STIRLING

PARTICIPANT CONSENT FORM

Title of Project – Talking to Fathers about Family Based Treatment

Researcher: Karen McMahon

SCHOOL OF
NURSING, MIDWIFERY
AND HEALTH

School of Nursing, Midwifery
and Health (Room 3S6)
University of Stirling
Stirling FK9 4LA

Tel: +44 (0) 1786 466395
Fax: +44 (0) 1786 466333
Email: k.m.stoddart@stir.ac.uk

1. I confirm that I have read and understand the information sheet dated _____ for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that it is my choice to take part in the study and that I can stop taking part at any time.

3. I understand that my participation in this study will be anonymous and data will be stored on a password protected computer.

4. I understand that if some of my views are quoted in a report or published papers; this will be done in a way that ensures that I cannot be identified.

5. I understand that my views will be audio recorded for the purpose of the study and that any recordings will be destroyed at the end of the study. Anonymised transcripts of the recordings will be kept for a period of 10 years to ensure accurate reporting in any future publications.

6. I agree to take part in the above study.

7. I would like to receive summary results of the above study.

8. I understand that relevant sections of my childs' care record and data collected during the study may be looked at by responsible individuals from the sponsor or host organisation or from regulatory authorities where it is relevant to taking part in this research.

Name

Date

Signature

Name of Researcher
taking consent

Date

Signature

Appendix 8- Interview Schedule

Interview Schedule

I am interested in learning more about the contribution that fathers make to Family Based Treatment.

1. Can you tell me a bit about the makeup of your family?
2. What age were your son/ daughter when they developed an eating disorder?
3. How were they referred in to CAMHS?
4. As a father were you involved in seeking this referral?
5. When you were seeking information about eating disorders where did you look?
6. Did you go to the first CAMHS appointment? What was it like?
7. When did you first hear about Family Based Treatment?
8. When you were doing FBT what was a typical day like? Can you talk me through it?
9. As a dad how did you find the beginning stage of treatment (Phase 1)? And the family meal?
10. From your point of view as a father what was it like moving on to phase 2 and phase 3 of treatment?
11. As a dad were there things that felt particularly helpful or unhelpful about FBT?
12. When your child was referred for help as a dad did you expect to be asked to take an active part in treatment?
What were your views on this at the start of treatment?
Have your views changed over time?

13. From a fathers point of view what was ending FBT like for you?

14. What contribution do you think you made to FBT as a father?
What would you say to other fathers whose child/adolescent is diagnosed with an eating disorder who are deciding whether or not to take part in FBT?

15. As a father was there any particular challenges you faced in relation to taking part in FBT?

16. From the point of view of a father is there anything else about your thoughts on or taking part in FBT that you think is important for me to know about ?

Thank You

Appendix 9- End of Study Declaration



Health Research Authority

DECLARATION OF THE END OF A STUDY

(For all studies except clinical trials of investigational medicinal products)

To be completed in typescript by the Chief Investigator and submitted to the Research Ethics Committee that gave a favourable opinion of the research ("the main REC") within 90 days of the conclusion of the study or within 15 days of early termination. For questions with Yes/No options please indicate answer in bold type.

1. Details of Chief Investigator

Name:	Karen McMahon
Address:	10 Auchentiber Place Kilmarnock Ayrshire KA3 6BG
Telephone:	07585333413
Email:	karen.mcmahon@stir.ac.uk
Fax:	

2. Details of study

Full title of study:	What contribution does the participation of fathers in family Based treatment for child and adolescent anorexia nervosa make?
Research sponsor:	Carole Johnstone, University of Stirling
Name of main REC:	West of Scotland REC3
Main REC reference number:	13/WS/0303

3. Study duration

Date study commenced:	4/12/2013
Date study ended:	12/04/2017
Did this study terminate prematurely?	Yes <i>If yes please complete sections 4, 5 & 6, if no please go direct to section 7.</i>

4. Circumstances of early termination

What is the justification for this early termination?	Because of extreme difficulties in recruitment encountered in the study when making amendments to the recruitment protocol (11/09/2015) I sought to continue the study until August 2018. However following the amendments to recruitment protocol and by extending recruitment sites I have recruited all required fathers to the study.
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5. Temporary halt

Is this a temporary halt to the study?	No
If yes, what is the justification for temporarily halting the study? When do you expect the study to re-start?	<i>e.g. Safety, difficulties recruiting participants, trial has not commenced, other reasons.</i>

6. Potential implications for research participants

Are there any potential implications for research participants as a result of terminating/halting the study prematurely? Please describe the steps taken to address them.	No
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7. Final report on the research

Is a summary of the final report on the research enclosed with this form?	No <i>If no, please forward within 12 months of the end of the study.</i>
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8. Declaration

Signature of Chief Investigator:	Karen McMahon
Print name:	KAREN McMAHON
Date of submission:	12/04/2017