Parenting skills after participation in skills-based training inspired by the New Maudsley Method

a qualitative study in an outpatient eating disorder setting

Ginnerup Toubøl, Annemarie; Koch-Christensen, Helle; Bruun, Poul; Nielsen, Dorthe Susanne

Published in:
Scandinavian Journal of Caring Sciences

DOI:
10.1111/scs.12694

Publication date:
2019

Document version
Accepted manuscript

Citation for published version (APA):

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Download date: 14. May. 2021
Title:

Parenting skills after participation in skills-based training inspired by the New Maudsley Method: A qualitative study in an outpatient eating disorder setting

Authors:

Annemarie Toubøl, RN, MScN, Senior Lecturer

Helle Koch-Christensen1, RN, MCN, Clinical Nurse Specialist

Poul Bruun, RN, PhD, Head of Research

Dorthe Susanne Nielsen, RN, PhD, Associate Professor

Address:

Health Sciences Research Center, University College Lillebaelt

Vestre Engvej 51 C

DK-7100 Vejle

Direct Phone: +45 26812984

Email: agto@ucl.dk

Abstract:

Background: Eating disorders affect the whole family and it is recommended that parents play an important role in their adolescents’ recovery. Being a parent to an adolescent with an eating disorder is often linked to feelings of guilt and hopelessness and at the same time parents often feel left alone with unmet needs when it comes to handling symptoms in family life. Little is known about parents’ perspectives to skills-based training in adolescent eating disorder treatment. This knowledge is urgently required, since previous

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Child and Adolescent Mental Health Services in the Region of Southern Denmark

Nordbanen 5, DK 7100 Vejle

This is the author manuscript accepted for publication and has undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1111/SCS.12694

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research has focused mainly on adult patients showing positive effects of skills-based training as a promising adjunct in eating disorder treatment.

Objective: To examine parents’ perception of their new skills after having participated in skills-based training inspired by the New Maudsley Method.

Methodology: A qualitative study using deductive dominant content analysis.

Methods: In total 21 parents participated in focus groups.

Findings: Three categories were identified: 1. Standing outside oneself and realise that one has become entangled in the illness, 2. Understanding the daughter’s inner life with the illness offers new opportunities in the relationship, 3. Courage to find new ways of parenting. The parents experienced themselves more calm and confident in their ability to recognize and confront the eating disorder symptoms. They expressed increased communication skills, which improved their relationship with their child and gave access to her inner life.

Conclusion: Skills-based training serves as an important intervention and it may improve parental skills, reduce high expressed emotions and reduce anxiety, guilt and stress. Skills-based training may contribute to reinforcing parents to regain parenting authority and enable parents and adolescents to “be on the same side” in the beating the eating disorder.

Keywords:
Eating disorder, skills-based training, The New Maudsley Method, adolescents, parents’ experiences, focus groups, qualitative content analysis

Running title:
Parental skills after participating in an eating disorder skills-based training course
Parenting skills after participation in skills-based training inspired by the New Maudsley Method: A qualitative study in an outpatient eating disorder setting

Abstract

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Word count for the paper: 5000

(ii) Main text

Introduction
Eating disorders are serious psychiatric disorders (1–3), with a higher prevalence among females (4). On both the national Danish and international level, it is recommended that parents of young people with eating disorders take an active role in treatment, and involvement is considered significant to treatment outcome (5–9). Family-based treatment in different variations and psycho-education are widespread, with the aim of providing parents with knowledge about the illness and skills to deal with the symptoms. Being a parent to a child with an eating disorder can have a significant impact on parents’ mental and physical well-being and a negative impact on quality of life for the whole family (10,11). Therefore, from a treatment point of view, it is relevant to deal with how the family has organised itself around the illness. The role of the family and parents in the treatment of eating disorders has been of clinical interest in recent years and it turns out that family-based treatment (FBT) in its manualized form, is the most evidence-based treatment form so far, from an empirical point of view (12,13). It holds promising effects on young people’s recovery and the family atmosphere (14–16), just as an improved self-efficacy is seen in parents after participation in FBT (17,18). Despite the evidence of the efficacy of FBT, parents are often left with unmet needs and a lack of skills to support their child in the various stages of the illness and in dealing with everyday life (16,19–21). There is a call for the development of FBT, where the active role of parents would be even more prominent (15,22). The insecurity of the parents can have a big impact on the way the family handles the disorder in everyday life; the responses of primary caregivers can, at worst, have the effect of maintaining or aggravating the child’s symptoms (23,24). Skills-based training (SBT) can be a potential way
to bridge the gap between the manualized FBT and parenting a child with an eating disorder as the parents are supported to challenge situations that can arise during the recovery phases (25,26).

International research results show positive results related to parental participation in SBT. For example, participation in SBT gives parents skills for improved communication with their children and strengthening parents’ ability to externalise the illness, which leads to a more positive family atmosphere post-participation. This is attributed to clear boundary setting and to standing firm and being persistent – important competencies acquired during the course (27). Similarly findings show that participation in SBT improved self-esteem and trust in one’s ability to cope with the challenge – based on greater knowledge and understanding of the characteristics of the illness, and better communication with the affected child (28,29). Parents also report that expressed emotions such as overly protectiveness and use of criticism were reduced during and after participation in a SBT workshop sessions, and that this particular reduction is a key factor in breaking the self-sustaining pattern of the disorder (30).

Given the limited amount of knowledge about the specific skills acquired by parents of adolescents with eating disorders through participation in SBT (31) this study aims to investigate parents’ of adolescents perceptions of acquired skills after participation in SBT inspired by the New Maudsley Method (32,33). This method is a theory based intervention for carers of people with eating disorders, with a particular focus on behaviour change skills (32,33).

The term “eating disorder” is meant in its broadest sense in this study and thus includes a wide range of eating disorder diagnoses.

Intervention
The New Maudsley Method inspired SBT address the families’ lack of knowledge and skills in understanding and responding to the maintaining aspects of the eating disorder, and to keeping a relationship and alliance with their affected child throughout the process, with the common goal of coming to grips with the disorder (31,32). Additional treatment in the course included the usual individual FBT and psycho-education, inspired by Lock and Le Grange (34) and translated to fit in the Danish context, and an intensive multi-family therapy over three days, with the focus primarily on handling restrictive eating and meals. In other words, the course allowed for an open forum, where only parents participated, unlike other family based interventions, where the young people participate along with their parents.
The course consists of a total of eight workshops, each of 2.5 hours duration. The course is led by specialist nurses. The first seven are held approximately one week to 14 days apart, over about three months. The final, follow-up workshop takes place about three months later. The course is planned to include parents of eight to 10 adolescents. The purpose of the course is to reduce parental stress and powerlessness by way of enhanced skills and competencies, and thereby knowledge about eating disorders and maintaining factors. Likewise, the purpose is also to train communicative skills to be better able to navigate through conflicts, for example, through externalisation and motivational principles.

As a means of becoming conscious of natural and typical reaction patterns in strained and stressful situations, the New Maudsley Method (31,32) uses animal metaphors which, in an easy and humorous way, mirror the automatic – but not always appropriate – familial reaction patterns that come into play when anxiety controls the handling of eating disorder symptoms. The metaphors of kangaroo, rhinoceros, jellyfish, ostrich and terrier reflect care types, which, in their response to the symptoms, represent emotions that can make it difficult to help the sick child, whereas the metaphors of dolphin and Saint Bernard symbolize care types that have a balanced emotional involvement and a comfortable caring management of symptoms.

Method
Design
This study takes a qualitative approach with focus group interviews. The exchange of views between the participants allows for data that offers greater insight into the topic to be investigated by way of exchanges of opinion, argumentation and reasoning (35,36).

Participants and Recruitment
A total of 21 participants (11 fathers and 10 mothers) were invited and accepted to participate in focus group interviews, see Table 1. The average age of patients was 15, and 14 adolescents girls with an eating disorder were represented. Duration of illness at course start varied from six months to five years with an average on 12 months. The recruitment procedure was purposeful and took place prior to the start of the SBT course and parents were randomly divided into two separate groups (group 1 and group 2) dependent on their enrolment date to the workshop course. The inclusion criterion was: parent of a child with an eating disorder, enrolled on an outpatient course of treatment at the Child and Adolescent Psychiatric Department. There were no exclusion criteria. Dropout between first and second interview were equivalent to the drop out at the follow up workshops.
Focus Group Interviews

Two repeated focus group interviews with two groups of parents were held in the period February - August 2015, all lasted about an hour. The first interviews were held after the seventh workshop and the second after the follow-up workshop. This was done in order to get the parents’ perceptions of the maintenance of the acquired skills. The interviews were conducted in the hospital setting in undisturbed surroundings. The first author (AT), who has no affiliation to the field, acted as moderator and the second author (HKC), who leads the workshop courses and has long experience in the field as a specialist nurse, was an observer and participated with additional questions, in all focus group interviews, as recommended for focus group interviews (37). An interview guide with initial open-ended questions like; ‘Can you describe how your responds to the eating disorder symptoms have changed?’ was used to start up the first interviews. More focussed questions followed in order to address specific skills like: ‘can you give an example of this changed response?’ , ‘How did your daughter react on your changed responds’? ‘How did your changed responds affect the relationship to your daughter?’ and to ensure a dialogue in the group the first and second author encouraged the participants to contribute with their perspectives. The open-ended questions in the second interviews addressed the central points from the first interview.

The interviews were audio-recorded and transcribed verbatim.

Ethical considerations

The study was conducted in accordance with the Ethical Guidelines for Nursing Research in the Nordic Countries (38) and the study was also notified to and approved by the Danish Data Protection Agency (reference 15/28095). Ethical committee approval was not needed in this study according to Danish legislation. All participants were informed verbally and in writing about the purpose of the study by the second author as they were signed up to the workshop course. The participants gave informed written consent that their statements could be used for research purposes and that they could withdraw from the study without explanation and without consequences.

Analysis

The analysis was inspired by the qualitative content analysis as described by Elo and Kyngäs (39). The analytical approach was deductive dominant with a concurrent inductive addition (39,40). As the first step was to develop an analytical matrix (see Table 2) containing concepts that reflect the aim and content of the workshop course, followed by data gathering by content, this part was deductive. The inductive part
consisted of grouping the data to the concepts and the creation of categories in order to accomplish the analysis. The present content analysis process consists of three phases: Preparation phase, organisational phase and dissemination phase and is illustrated in Figure 1, inspired by Elo and Kyngäs (39).

The analytical matrix was applied to the entire text material, in order to ensure rigour and a systematic approach to the ensuing categories. The categories should reflect the aim of the study. First (AT) and second author (HKC) conducted the analysis in common and to ensure trustworthiness a constant reflexive dialogue was performed, where concepts, categories and quotations were compared. The trustworthiness is further strengthened by discussing and agreeing on results and phases in the analysis with the third (PB) and fourth author (DSN). Quotations from the interviews support the results and allow the readers to access the trustworthiness of the analysis (41), see Table 3; From concept to category, examples from the analysis.

Findings
Three categories emerged from the analysis of the empirical data and are presented in the following section supported by citations. The citation codes are explained in Table 1.

Standing outside oneself and realise that one has become entangled in the illness
The focus during the course on reflection of the parents’ automatic reactions had an impact on their future handling of symptoms and cooperation with their daughter. The following quotation reflects the parents’ statements, both at the first and second interview. “It is very good once in a while just to step out of oneself and, like, regard oneself from the outside”, [1.9 (2)]. The animal metaphors, which were intuitive, general and humorous symbols of various more and less appropriate care reaction patterns, had according to the parents a disarming effect on parents, allowing them to face themselves and be less resistant to change. The insights gained from this, expressed by several parents, had formed the basis for new and more reflective ways of dealing with the symptoms. One parent (a mother) referred to the animal metaphors as an inner guide that she used whenever her emotional climate became too hot and she was losing her
temper and raising her voice in frustration and powerlessness. The inner images of the animals helped her correct herself: “Hey, now I’m the terrier again; I’m just going back and being a dolphin”, [1.3 (2)].

Just as the animal metaphors mirrored the nature and degree of expressed emotions, the parents agreed that they were strengthened in their ability to detect illness-maintaining patterns in the family and by that helped to reflect on how they were controlled by and entangled in the eating disorder, and created dysfunction in family life: “We dance around the anorexia along with them (the sufferer) ... we start to eat differently, and then we also have to cook things that will not aggravate this anorexia”, [1.1 (1)].

An important finding in the parents’ statements was that, gradually, through the course, they increased their awareness of how they were important players in the daughter’s illness and healing process. Many parents expressed that it took a long time before they realized that their role was at least as important as the role they attributed to the therapist: “I think we are now very conscious that while the hospital gives a helping hand, but that the main things actually happen in the family”, [1.8 (2)].

**Understanding the daughter’s inner life with the illness offers new opportunities in the relationship**

The parents reported that, through the course, they gained a greater understanding of the illness, its dynamics and its forms of expression, and in doing so they also experienced more communicative ways of action to re-establish or maintain their relationship with their daughter. The parents acknowledged that a trusting and close relationship that can also carry and accommodate the daughter’s ambivalent feelings about the illness and regarding becoming healthy is a prerequisite for accessing her inner life with the illness and thus also a prerequisite to be allowed to help her. The parents also indicated that their ability to listen unconditionally had been strengthened and that this competence was maintained. The improved relationship and increased access to their daughter’s inner life allowed parents to challenge her and experiment regarding her rigidity and deadlocked perspectives.

Especially at the first interview, parents emphasized that they had learned to balance their own emotional involvement and urge to act based on their desire that their daughter would quickly distance herself from the disorder. They experienced that they had become more sensitive in terms of reducing the pressure, and their communication about the current situation and their daughter’s readiness to change. They related that they had become more aware of not only their own communication, but also timing and the child’s reactions. This double consciousness was perceived to be of great importance.

Since the parents were no longer inundated by their own frustrations and feelings of desperation, the family atmosphere was calmer and they entered into a more respectful relationship with the daughter: “So, we don’t end up with screaming and ranting, like in the past” [1.5 (1)].
The parents highlighted at both the first and second interviews that the focus on shifting their attention from predominantly responding to the child's behaviour to going behind it and being more interested in the driving forces behind the child's reactions and actions had helped them understand how the illness controlled the daughter's inner life. One mother told about the consequences of this focus shift: "We've got insight into what is actually happening inside her head ... We have gained a greater understanding of how the illness is actually made up" [2.3 (1)].

The same mother described how, following participation, she saw that this shift and the ensuing greater closeness with her daughter was mirrored directly by her daughter, who said that she did not feel so alone. The girl's father confirmed this: "It's a clear sign that she can talk to us about it. She obviously did not feel that she could before" [2.2 (1)].

The parents agreed that the communication tool "externalisation", where the eating disorder and its consequences are separated from the child and verbalized as something external, had given new opportunities. By externalising the disorder, parents could keep it at arm's length, regard it as a phenomenon apart from the child and distinguish the healthy from the sick. In that way, the daughter's healthy identity could be preserved and amplified and the family shared a common language, which made it possible to gradually regain power over the symptoms.

Courage to find new ways of parenting

The parents stressed that they changed how they dealt with symptoms in everyday life during the course and in the months that followed. The fear of exacerbation was reduced and replaced by a greater courage. The parents developed competencies to understand the mechanisms of the disorder and not get caught up in it, but to dare to disrupt the self-sustaining patterns, make demands and thereby not comply with the premises of the illness. They also found that they could remain consistent and demanding, even at turbulent times, because they now saw that this was what helped the daughter best. A parent put it as follows: "We have got the courage to stand firm in our support during the stormiest times" [1.6 (1)].

The parents saw that one of the benefits of their increased security in their actions and reactions was that they now appeared more credible to their daughter. This credibility was reinforced by the parent’s trust in their own judgement in assessing the conflicts needed to take control of symptoms. At the second interview, the trend was seen to be consistently strengthened and it was clear that the parents found positive effects on their relationship with their daughter. The best support they could give was to appear steadfast in their decisions, leading to increased compliance: "I also sense that when I stand more firm than I did before, it's easier for her and she trusts me more" [2.5 (1)].
The parents had been able to reduce their own stressful feelings by zooming out and gaining an overview and not getting lost in the detail. They could do this because they had gained a more realistic perception of their own part in the daughter’s illness development: “I have had a hard time thinking that it’s not all my fault. I’ve learned little by little that it’s not” [1.6 (1)]. Knowledge and understanding of the forms of expression of the illness, and of their own and the child’s reactions brought calmness – in comparison to the jumble of emotions, chaos and powerlessness that affected parents before the course. It was clear to parents that they had been strengthened to cope with situations: “On the course I feel that I am bolstered to be able to cope with being in it” [2.1 (1)].

At the second interview, the parents said that they had become so confident that they could cope with challenges such as a relapse. They had a stronger belief in themselves and in their parenting role. In talking about dealing with a relapse, one parent said: “Big or small … I’m sure we’ll be able to manage” [2.2 (2)].

**Discussion**

The purpose of the present study was to examine parents’ perceptions of acquired skills after participation in SBT inspired by the New Maudsley Method. In addition, the results add new knowledge about how the skills acquired could be a way of bridging the gap between FBT, as the primary treatment, and dealing with challenges in everyday life.

The parents’ narratives show that, after participating in SBT, they felt competent to perform the role of collaborative carer and seemed to be equipped to meet the challenges. The current findings are supported by previous research that recommends that parents be involved in the treatment and be trained in, for example, communication skills to strengthen their parenting and to stand firm and give clear boundaries (24,26,27). Overall, it appears in the synthesis that parents see it as a prerequisite in helping their daughter that they had learned to respond to the symptoms with a higher degree of reflection on their own reaction patterns. This led to increased courage to engage in and maintain a good relationship with her, with increased security, flexibility and diversity, because the new skills had been practised and internalised. The animal metaphors were considered a tangible and intuitively comprehensible approach to exemplify how a communication style could be ineffective and self-sustaining, which was also found by Pépin & King (28), who reported on the animal metaphors as an aid to improved communication. By way of a thought-through response, parents could establish better contact with the child. The importance of responding more securely and consistently created the basis for a new approach, in which emotions were moderated. This was highlighted as particularly significant by parents in this study. A high degree of expressed emotions is...
known to be a factor that, in the worst case, can sustain the illness (22,23). Comparable to findings in other studies dealing with the effect of SBT (28,30,42), this study also shows that parental emotional involvement can have positive effect in helping the sufferer.

The results in this study show that parents agree that it is easier to dare to get involved when they have a greater understanding of themselves, their own role, the eating disorder and the ambivalence with which their daughter lives in relation to it. They can take stock of their daughter’s stage in the illness so that her readiness for change is considered. This was also found in Pépin & King (28) and Sepulveda et al. (29), who underline the importance of parental insight into the daughter’s readiness for change. In doing so, parents find that they can step in when the child is ready. They learn to observe readiness, in that they know the illness and its mechanisms, and have a better understanding of what the daughter thinks. Thus, the symptoms can be handled more appropriately, which is also found in Goodier et al. (26). This leads to a calmer atmosphere and targeted approach to the symptoms. The parents point out that it is now easier to go along with the daughter in battling the disorder, partly because, through externalisation, the illness is jointly considered as a third party. This is also found by Sepulveda et al. (29) and Goodier et al. (26) who highlight that externalisation is an effective and workable method of approaching the child’s symptoms.

Communication is another, major focal point in the findings in the present study; the parents agree that it has improved and is more open. The parents find that the daughter regards the improved and more direct communication positively, because they are “all on the same side”, so to speak. This can be equated with the findings of MacDonald et al. (27), which describe that it became easier to access the daughter with the right words. The findings show that the parents have been strengthened in their courage to stand firm in their decisions and to set clear limits, as also seen in Goodier et al. (26), who find that parents experience an increased strength of clarity and boundaries, as a direct result of the SBT. Likewise, the findings in the present study show that parents have an increased belief in their ability to cope with challenges. Similar to other studies, the strengthened belief in and confidence that one can overcome the task of parenting a young eating disorder sufferer can be related to participation in SBT (28,29,43).

The parents’ descriptions in this study, therefore, show that SBT can be an effective and promising adjunct to eating disorder treatment in order to prepare parents for the challenges of being a significant player in treatment and living with an adolescent eating disorder sufferer. With reference to existing knowledge, which deals with the views of both experts and parents on the necessary skills to cope with challenges, it seems that the New Maudsley Method meets precisely the needs that the parents feel are not generally covered. Several studies point out that there is a lack of support for parents; for example, Lamarre et al.
(19) investigated blogs written by mothers who participated in FBT and discovered a forum where parents seek support in their parenting role. They ask about guidance for their child while feeling drained of energy and power in everyday life (20), but also seek support in handling and moderating high-expressed emotions. Rienecke et al. (21) and Moskovich et al. (16), for example, recommend that attention should be given to supporting parents with expressed emotions, because this factor is crucial as to whether and in what way parents can support their child, for family functioning and for the outcome of the treatment. The New Maudsley Method SBT is also evaluated by the parents as being particularly effective, because, in addition to communicating knowledge about the illness, it also focuses on reflecting on emotions and exercising appropriate behavioural patterns so that the disorder can be challenged – since conflicts exacerbate the development of the eating disorder. This is supported in findings showing that higher-level caregiving skills, such communication and emotional regulation, lead to better recovery (44). Thus, the optimization of caregiving skills, as an important part of treatment for adolescents with eating disorders, is recommended.

SBT seems to bridge the gap between conventional FBT treatment, and what parents say they are lacking, to deal with the situation. The parents in the present study told us exactly how they return to their everyday lives with new skills and an inherent certainty that they could cope with the challenges they faced. It is exactly this gap that can be filled by SBT, which could be offered as a way to better equip and strengthen parents in their FBT role. Thereby, they can be more actively involved, as requested by Le Grange et al.(15) and in this way recoup some of their previously lost parenting authority.

Methodological considerations

In endeavouring to avoid conformity and polarisation, as well as the risk of an interview developing into therapy, both first and second authors participated in all focus group interviews. This aimed to neutralise the conflict inherent in being at once a therapist and interviewer. It ensured that there was no uncritical over-identification and therapeutic conversation or the opposite, a mechanical, question and answer approach (45). Though, the responses and discussions in the interviews may be influenced by the second author being the facilitator of the workshop course. The saturation of data was ensured by the homogeneity of the participants and further by the replication in data in all interviews (41). The reflexive dialogue among the authors on the analytical process addressed the trustworthiness of the results (39,41). In addition, the categories developed from the analysis were compared to the original data to ensure that the parents’ information was represented in the results (46). The data material gave rich and valuable citations and though many are omitted, the representative citations increases the readers ability to judge the trustworthiness of the results (41). There are some limitations to our study; fewer participants were seen in the second interviews. Therefore, the results of skills maintenance must be interpreted with
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cautions. Similarly, the timespan of three months could be questioned in regard to skills maintenance. Further, only adolescent girls were represented, which correlates with the higher prevalence of eating disorders among girls (4).

Conclusion and implication for practice

This study highlights SBT inspired by the New Maudsley Method as an efficient approach in eating disorder treatment as the parents’ indicates that their participation equipped them with the needed skills regarding adequately responses to the eating disorder symptoms. SBT can be a promising method when parents need to be supported to take an active role in the treatment, because the method can help to limit the devastating effect an eating disorder can have on family relationships. Further SBT can contribute to reinforcing parents to regain parenting authority and enable parents and adolescents to “be on the same side” in beating the eating disorder. In light of their experience and skills in working with patients with eating disorders and their families, specialist nurses can play a key role in supporting and guiding parents in taking on their caring and parenting role in the changed circumstances. The implementation of SBT in eating disorder treatment as an adjunct to convenient treatment may serve as a pivotal part of treatment in order to manage eating disorder symptoms in family life. Further research is required to investigate the longitudinal effect of SBT on the maintenance of parental skills. Additionally the patients’ perspective on their parents’ participation in SBT needs investigation.

(iii) References


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(iv) Table

Table 1: Data of participants

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*participated in interview 1 and 2
** The participant number explains, firstly; the interview number [1.x(x)], secondly the concrete participant [x.1(x)], thirdly in the bracket; the focus group number [x.x (1)]. Participant number follows citations in the text.
Table 2: Analytical matrix

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Table 3: From concept to category, examples from the analysis

<table>
<thead>
<tr>
<th>Concept*</th>
<th>Quotes</th>
<th>Grouping</th>
<th>Category</th>
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<tbody>
<tr>
<td>Consciousness about own reaction patterns</td>
<td>“Several times I have experienced how I have acted inappropriate and then turned back to her (daughter) and we talked about the situation and solved it. I now realize how important that is, not to let the disorder rule”.</td>
<td>The content of the work shop course has been like a mirror – you look at yourself and your way of parenting in a new way</td>
<td>Standing outside oneself and realise that one has become entangled in the illness</td>
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<td>“I think it takes a lot of practice to get rid of this habitual way of acting. It is a tough feature, but it really helped me to take a time-out and consider my reaction”.</td>
<td>The animal metaphors have had a disarming effect and offered a new way of looking at yourself in a humorous way</td>
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<td>“Well, that is the Rhinoceros standing over there trampling in the corner. That is a disarming way of looking at yourself”.</td>
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<tr>
<td>Awareness of significance of own role</td>
<td>“I have learned a lot about my role in my daughters recovering. I am very important and that is a wake-up call to me and it really moves things in the right direction”.</td>
<td>The way of parenting has changed from being a maintaining observer to an actor of crucial importance</td>
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<td>“I think we are now very conscious that while the hospital gives a helping hand, but that the main things actually happen in the family”.</td>
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<td>Awareness of the</td>
<td>“When we listened to all the</td>
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<table>
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<tr>
<th>eating disorder's spin</th>
<th>stories about how other families have organized their lives around the disease, we realized that it (the disease) just slowly entered our life as well&quot;.</th>
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<tbody>
<tr>
<td>&quot;We dance around the anorexia along with them (the sufferer) ... we start to eat differently, and then we also have to cook things that will not aggravate this anorexia&quot;.</td>
<td>The eating disorder has guided the parents' maintaining behavior</td>
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</tbody>
</table>

*equaling the analytical matrix, table 2
Figure 1: The content analysis process

<table>
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<tr>
<th>Preparation phase</th>
<th>Development of research question: How does parents of adolescents with an eating disorder perceive the skills achieved after participation in a skills-based training course?</th>
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<td></td>
<td>The interview guide was developed based on the aims and content of the collaborative care course and existing literature.</td>
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<td>The focus group interviews were held after workshop 7 and after follow-up after approximately three months, for each group.</td>
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<td>The focus group interviews were transcribed.</td>
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<th>Organisation phase</th>
<th>Deductive dominant with an inductive addition</th>
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<td>Each transcribed interview was closely read and then compared with the recording to correct any mistakes and to create an overall impression of the content.</td>
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<td>Development of the analytical matrix: The aim and content of the workshop course were operationalised into concepts.</td>
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<td>Six concepts emerged: Consciousness about own reaction patterns, awareness of significance of own role, awareness of the eating disorder's spin, communicative competencies, parental authority, stress reduction and coping strategies.</td>
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<td>The empirical data was gathered in relation to the six concepts.</td>
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<td>INDUCTIVE: Meaningful units were sought from the content of the concepts by grouping the data under preliminary headings.</td>
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<td>The groups were analysed across concepts and tested conceptually and empirically.</td>
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<td>Three categories emerged that gave an in-depth explanation for the six concepts.</td>
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</table>

| Dissemination phase | In the discussion the findings of the analysis were discussed in light of existing knowledge and the aim of the study was addressed. The contribution to new knowledge was described. |