Title: Family-based inpatient treatment for adolescent anorexia nervosa: A thematic analysis of former patients' post-treatment reflections

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Abstract

This study investigated former patients' experiences with family-based inpatient treatment. Interviews of thirty-seven patients diagnosed with anorexia nervosa during the admissions were conducted to examine their post-treatment perspectives. The accounts were analyzed by utilizing an inductive thematic analytic approach. The analysis yielded 4 main themes, constituted by in all 8 subthemes. The main themes were; 1) *Enabling new ways of understanding and relating*, 2) *Enhancing or maintaining negative power dynamics*, 3) *Vulnerable transitions*, and 4) *Sibling relationships and different ways of involvement*. With its "insider focus," this study contributes to knowledge on how family-based inpatient treatment is perceived from a user perspective. The current study has value for both advancing the development of family-based inpatient treatment, and by adding patient perspectives to the ongoing effort of providing family-based approaches at higher levels of care.

Keywords: anorexia nervosa, adolescent, family-based treatment, inpatient treatment, qualitative research

Introduction

When a child develops anorexia nervosa (AN), the entire family is affected (Fox, Dean, & Whittlesea, 2017). Clinicians and researchers have therefore underscored the importance of working collaboratively with the whole family during treatment, which includes engaging both parents and siblings in treatment (Dimitropoulos, Freeman, Bellai, & Olmsted, 2013; Hughes, Burton, Le Grange, & Sawyer, 2017). Outpatient family-based treatment (FBT) has emerged as the treatment modality with the best evidence base for adolescents with AN (Lock, 2018).

Outpatient FBT is by no means a one-size fits all treatment (Conti et al., 2017; Fink et al., 2017; Le Grange & Lock, 2014; Murray, Anderson, & Cohn, 2017; Strober, 2014). Augmentations and adaptations are needed to enable a better fit to non-responders and different levels of care (Richards, Subar, Touyz, & Rhodes, 2018). Based on promising outcome from outpatient FBT, clinicians and program developers have started to incorporate FBT-principles into higher levels of care, including day hospital programs (Henderson et al., 2014), partial hospitalization programs (Hoste, 2015; Rienecke & Richmond, 2018), and short-term family-based inpatient treatment (Fink et al., 2017; Rockwell, Boutelle, Trunko, Jacobs, & Kaye, 2011; Wallis et al., 2013).

Inpatient treatment is a costly and highly complex enterprise and the long-term effect is uncertain (Anderson et al., 2017; Meads, Gold, & Burls, 2001; Toulany et al., 2015; Vandereycken, 2003). The field needs further research that examines how higher levels of care can be utilized more efficiently (Murray et al., 2015). A recently published study concluded that family-based inpatient treatment, defined as hospitalizations where the adolescent patient is admitted together with family members, may be a promising method of delivering inpatient treatment to young people who fail to respond to outpatient treatment (Halvorsen, Reas, Nilsen, & Ro, 2017). The current study builds upon this work. By applying an inductive thematic analytic approach we aimed to investigate former patients' experiences with family-based inpatient treatment. The incorporation of patient values, experiences, and preferences is considered an essential component in the design and delivery of evidence-based practice for eating disorders (Peterson, Becker, Treasure, Shafran, & Bryant-Waugh, 2016). This study represents an effort to inform ongoing efforts to adapt family-based approaches at higher levels of care for adolescents with AN.

Methods

Participants

The current study is an ancillary study of a research project designed to investigate the naturalistic outcome of inpatient family-based treatment at a tertiary ED unit for adolescents (Halvorsen et al., 2017). Thirty-seven of 58 invited (64%) former inpatients (33 females/4 males) provided written consent to participate in this sub-study. No significant differences between the participants and non-participants were found on demographic or clinical variables during the admission. All participants had a primary admission diagnosis of AN, and all were admitted with their families between May 2008 and June 2014. Prior to the family-based inpatient treatment, all had received outpatient treatment at their local child- and adolescent clinic. Approximately three-quarters had prior to the admission at least one inpatient admission at their local hospital. The duration of ED prior to the admission was on average 2.7 years (range; 0.5 – 6.0, $SD=1.8$), and mean age at admission was 15.8 years (range; 12.4 – 19.5, $SD=1.8$). The majority (33/37) were admitted voluntarily. Mean length of stay was 20.8 weeks (range; 3 – 58, $SD=13.5$), including planned leaves from the ward as part of the treatment program. None of the participants dropped out of treatment. The mean number of years from discharge to the follow-up interview was 4.5 years (range; 1.3 – 7.0, $SD=1.7$). The mean age at follow up was 20.2 years (range; 15.8 – 25.3, $SD=2.6$). Sixty-two percent ($N=23$) reported that they had experienced no hospitalizations post the family-based admission. Thirty-eight percent ($N=14$) had received additional inpatient treatment during the follow-up period. At follow up, the majority (65%) had achieved normal body weight. Twenty two participants did not meet the criteria for any DSM-V ED-diagnosis, 8 met criteria for AN, 2 for BN and 5 for OSFED.

Treatment context

In May of 2008, the adolescent inpatient unit at the Regional Department for Eating Disorders in Oslo restructured the standard treatment program from traditional individually-

based admissions, to provide family-based inpatient treatment. Without adhering to a manualized FBT program, the guiding treatment principles were inspired by outpatient FBT, with its focus on enabling parental authority and responsibility. The predominant treatment focus corresponds to the first phase in outpatient FBT. Staff thus aimed to mirror a non-blaming and non-etiological stance, externalize the ED, and work toward empowering the parents to assume increased responsibility for their child's weight restoration and their wellbeing in a broad sense (Lock & Le Grange, 2013). The enhancement of parental authority during admissions was most clearly expressed via assisting parents to manage the regular meals on the ward, and at home during planned leaves. In addition to helping parents become confident in what their child needed to eat to restore a healthy weight, parents were supported in becoming more efficient in providing emotional support for their child. Contrary to outpatient FBT, the treatment team had the final say on the meal plans during admissions. This decision-making process was done in close collaboration with the parents, and when seen appropriate (i.e., dependent on age and progress), together with the young person during the weekly treatment meetings. During the later phases of hospitalization (i.e., nearer discharge), the focus gradually shifted towards encouraging the adolescent to assume more responsibility for eating, with continued parental supervision. All families had weekly treatment meetings with their multidisciplinary team. Parents were provided with parental counseling, both in structured sessions and, when needed, from the staff working at the ward. Staff working shift had daily scheduled conversations with both parents and the young person, about preparing meals (i.e., addressing roles, responsibilities and providing support) and for the purpose of evaluating the ongoing process. Often these conversations included psychoeducation in situ; by allowing tailored problem-solving of concrete dilemmas (i.e., meal management) under supervision of experienced staff members, and thus enabling learning by doing. The families had on average family therapy sessions twice a week and some of the patients were offered individual sessions.

The provision of supplementary individual sessions was arranged in collaboration with the adolescent and parents. At discharge, all patients and families were referred back to their local outpatient clinic for further therapy and support. Up to five families were admitted at the same time. The patients' siblings were welcomed to take part in the admission, but in most cases the families arranged for siblings to remain at home during most of the stay. Siblings could attend family therapy sessions and family meals, even if only visiting. Besides an occasional group session led by a senior nurse or clinical psychologist, siblings were not offered any specific interventions during the stay. As to contact with fellow patients, there were no restrictions on peer interaction during the stay.

Recruitment and data collection

Ethics approval for this study was obtained from the Regional Committee for Medical Research ethics, South East Norway [REK2014/2223]. All former patients ($N=58$) who had received family-based inpatient treatment between 2008-2014 were invited to participate in the study. Former patients who consented to participate ($N=37$) took part in a semi-structured interview. Qualitative interviews were conducted by either a senior researcher, a clinical psychologist, one psychiatrist or a psychiatric nurse. Twenty-six of the interviews were conducted on-site at the hospital, seven at the participant's home, three by telephone, and one in-person elsewhere. All qualitative interviews (including telephone interviews) were audiotaped and transcribed verbatim, and lasted between approximately 30 and 100 minutes.

Interview guide

A team of experienced clinicians developed a semi-structured interview guide designed specifically for the qualitative study. The interview guide was piloted internally and underwent revision prior to reaching a consensus on the final version. The scope was broad and structured

into three sections: pre-admission, during admission, and post-admission. The interview guide is available upon request.

Qualitative data analysis

Data were analyzed by utilizing the framework of Thematic Analysis (TA) by Braun and Clark (Braun & Clarke, 2006). Main themes were derived from the entire data set; hence all thirty-seven interviews were included to allow as much diversity in views as possible. The analysis was mainly informed by an inductive and semantic approach. Conducting the analysis inductively meant that we aimed at staying with the raw material sufficiently long to truly grasp what the accounts were about. Applying a semantic approach implies that the explicit and surface meanings were considered, rather than inferring beyond the content conveyed in the accounts, as would be the case with an interpretative, implicit approach (Braun & Clarke, 2006). The analysis was guided by the 6 phases outlined in TA: 1) familiarizing yourself with the data, 2) generating initial codes, 3) searching for themes, 4) reviewing themes, 5) defining and naming themes, and 6) producing the report (Braun & Clarke, 2006).

The first author read all the transcripts. Three of the co-authors read interviews selected at random to familiarize with the material. The first author was responsible for initial coding and for developing the main themes and adjacent subthemes, although the analysis was conducted in close collaboration with two of the other authors [HWO/TWH]. This was achieved by repeatedly revisiting the suggested main themes and subthemes; all grounded in the material, to enable corrections and further theme development. Following multiple team discussions, the themes were reviewed and discussed, and the theme structure was changed and modified several times to achieve a final consensus on how the specific labels and structure would best reflect the raw material and the aim of the paper. Before completion, the first author read through all

transcripts once more to ensure that the themes captured the material in a reasonable way. The QSR International's Nvivo11 Software was used for the initial phase of coding (NVIVO-11).

Results

[Insert table 1 here]

The TA yielded 4 main themes and 8 adjacent subthemes (see Table 1). Each main theme is presented alongside its subthemes. Subthemes are illustrated by quotations from participants. The source of each quotation is indicated by the participant's research ID number. Quotes are directly translated from Norwegian to English with only minor revisions to enhance readability.

Enabling new ways of understanding and relating

This main theme captured the accounts that most clearly expressed thoughts of those who experienced the family-based admission as a beneficial treatment approach that enabled both new ways of understanding and relating. The subthemes shed further light on which specific aspects were valued as particularly advantageous, and captured both the importance of togetherness, and the potential of bridging contexts.

Being in it together. Joining forces. Although the majority of participants remembered being initially ambivalent, or even explicitly against, the admission (i.e., subtheme 3B), several reflected upon the advantages of a family-based admission. By being able to join forces, several described the emergence of new ways of understanding and relating to their families. Hence, for the majority, the specific treatment context seemed to present novel opportunities for relationships and communication within the families.

P: We became more strongly attached to each other, because I feel, you kind of slip apart from each other when you get an eating problem and like; "I was in my corner, and she was in hers", but when we were here together, and did all the things together,

and both focusing on the same, then we shared a common ground... and then, the relationship improved too... [...] ... I look back and think it was very, very good, for the both of us... [P13]

Between the ward and home. Bridging contexts. The crucial feature of “bridging contexts” involved the transition and consolidation of efforts between the hospital environment and the home situation. The majority of the participants reflected upon the importance of treatment improving their situation following discharge. Many now appreciated that their parents had become more confident, assumed greater responsibility, and the participants valued the increased parental support at home. By sharing dynamic processes together over time, the potential of bridging contexts between the ward and the home was enhanced.

P: If you don't have your own family present, then I think it would be much easier to just go back to what you did back home and just say; “yes, but they told me that I could do it like this, so that's why I can do it like this...” ... but now, they know in a way, the parents becomes more confident, because they know “this is how it should be done” and they have in different ways experienced the support, from the ward... [P40]

Enhancing or maintaining negative power dynamics

Several of the participants cited problematic or negative aspects with the family-based admission. In hindsight, the treatment context had represented a situation that enhanced or maintained existing negative power dynamics; both within the peer group and within the families.

Negative peer influence. Potentially nurturing the eating disorder. The majority that shared views on being admitted with peers reflected back on the possible negative side effects with observing and interacting with others. Some stated that they learned new eating disordered

behaviors during the admission, and remembered explicitly sharing ideas of how to hide food during meals, and how to manipulate the weight by water loading, or attaching weights to their body. Several shared thoughts on the treatment environment being highly competitive and thus, potentially negatively reinforcing the ED. Others shared stories on how difficult it was to focus on their own recovery process when witnessing others struggling with completing meals and displaying acting out behaviors, that often lead to increased attention by the staff members.

P: I was surrounded by girls, who were... everyone was ill, and we gave each other ideas, and I felt it was kind of a toxic environment, it was really, no, it was no good at all. And it eventually became a struggle between the patients; it was all about who could sneak away most food and it was all this talk about that one should water load as much as possible on the day of weighing, and we gave each other advice on how to attach weights to our clothes and stuff, there were no limits... [P6]

Family-based inpatient treatment should not be the only option. If I could stay here by myself. Some participants emphasized that they probably would have acquired more out of the treatment if admitted alone. These participants questioned the appropriateness of family-based inpatient treatment as the preferred treatment modality. Being admitted with their family was experienced as problematic, and in various ways, provided yet another battleground. In addition to fighting with the ED and the staff members, they found themselves in a situation where they had to struggle with their family as well. Some felt that the admission did not enable them to work on important family issues, and that by intensifying treatment, conflicts intensified too, without being properly resolved during the admission. Others reflected back and thought that it would be sufficient or even better, to receive care and support from the health care professionals, with the family playing a more distant role during admission.

P: I think it would have been easier to fight... with the food, without my parents present. Because when they were present I only wanted to oppose them, in addition to resisting treatment. I didn't want to eat what I was supposed to in the first place. And even less so when they were present and said I had to. If it were only you that stated that, I guess I would have been easier to persuade... [P10]

Vulnerable transitions

This main theme illustrates the participants' various perspectives on the different transitions they faced during the course of the admission. There were diverse views on planned leaves. Moving in and moving out from the ward was often perceived as a high-risk or vulnerable occasion. The majority shared many pre-admission worries and ambivalence at both admission and discharge. Several highlighted the necessity of continued follow-up after discharge, both from the unit and the staff members, as well as from the local outpatient clinic.

Planned leaves can both aid the treatment and enhance the ED. Planned leaves (i.e. weekends, holidays) are a standard component during the admission. These transitions, oscillating between the ward and the home environment, were experienced as a significant part of treatment;

P: It was a bit scary the first times, that it was, but... ehm... it was a very important part of treatment, because this [the ward] was not where I was supposed to get used to being... [P24]

And by others, as a potential escape;

P: It was a pleasant feeling... but I didn't follow the meal plan and things like that... as I was supposed to... I always managed to sneak away things... a lot of food... [P63]

Providing safe transitions (moving in - moving out). The majority of the participants revealed vivid memories of feeling ambivalent or against hospitalization. Several remembered explicit opposition, manifesting as acting-out behaviors, and that the admission ran counter to their preferences and priorities. With a few exceptions, the majority felt their parents were comparatively positive to a family-based admission. Hence, the degree of agreement within the family pre-admission was rarely in balance. The majority spoke of increased levels of anxiety in anticipation of the admission, fears of losing control, and fears of being expected to gain weight.

*P: No... in NO way... I didn't want to go there, I was very much against it, really... [...]
I felt that here, I am supposed to be placed and they [staff] shall decide over me... [...]
They [my parents] had a wish to be admitted, they realized that it didn't work out at
home... [...] So they, I think, felt very much that we needed help... they were exhausted
and couldn't handle it any longer... [P6]*

Upon reflection, the majority advocated for securing carefully planned transfers, and several emphasized the necessity of adequate follow-up after discharge. Others shared views on the duration of the admission and argued that sufficient time was necessary to plan a secure discharge, avoiding a premature discharge immediately upon the establishment of normal weight.

*P: I think it is highly important to make sure to follow up patients with eating disorders
because I know how easy it is... at least on my part, and that I've heard from others
too... how easy it is to relapse... [P11]*

Sibling relationships and different ways of involvement

Participants had a variety of perspectives on sibling involvement. As subtheme 1 revealed, many highlighted the importance of involving siblings in the admission. In contrast, some of the participants demonstrated a more conservative approach, as captured in subtheme 2.

Proving information and enabling taking part. Several expressed the importance of providing sufficient information to siblings and actively including siblings in the treatment process. Information was viewed as crucial to improve siblings' knowledge about various aspects of the treatment, eating disorders, and how the ill sibling was coping during the admission. Some participants stated that they were satisfied with how sibling involvement was organized during the admission; whereas others felt siblings should be given higher priority. Others reflected on the necessity of accommodating siblings' own needs as well.

P: I think that she had needed to have more conversations, yes. About the things she found difficult related to having a sick sister. Because Mom and Dad were very much involved in the treatment and talked a lot with the professionals, but she was very much left out on her own, at least she felt like that, then. I can only state what she said, and what she told me. That she had needed more individual conversations, to maybe hear more about how things went with me, and to be able to talk about what's on her mind, related to having a sick sister... [P20]

Appropriate involvement of siblings. Quite a few emphasized the importance of assessing carefully whether siblings truly wanted to participate in treatment, and that siblings and patients be consulted regarding the extent of sibling involvement. Treatment providers were encouraged to consider factors such as age and the significance of the sibling relationship to assess the appropriateness of sibling involvement, not to simply involve siblings as the default.

Upon reflection, some participants found it beneficial that their siblings did not play an active role during the hospital stay.

P: I don't think young children should be at the unit, I don't see it possible, that it can be of any good... [...] It was a lot of turbulence, you know. It is sufficient that parents... they have a responsibility for their child and that's why it is necessary for them to be present. But I don't think that the siblings need to be part of that, they should be protected against that ... [P60]

Discussion

This qualitative study aimed to investigate patients' experiences with an adolescent family-based inpatient treatment for anorexia nervosa. Interviews were conducted with 37 former patients following discharge and data were analyzed using TA (Braun & Clarke, 2006). Four main themes emerged, representing a diversity of perspectives.

Enabling new ways of understanding and relating

As an inpatient family-admission approach was developed to treat complex cases which had previously received specialized outpatient treatment, it is encouraging that the majority of the participants emphasized family-based inpatient treatment as beneficial. Several reflected that the admission facilitated novel ways of understanding, communication, and relating to family members. In particular, sharing the treatment process time with your family appears to smooth the gap between the inpatient ward and the home environment. It is worth noting, however, that a considerable number of the participants had received further hospitalizations post family-based admission (38%). This is more or less consistent with the literature reporting on the relatively high relapse rates for this population (Khalsa, Portnoff, McCurdy-McKinnon,

& Feusner, 2017), and underscores the importance of post-discharge monitoring and adequate follow-up, in addition to improving available treatments.

Pinpointing the specific change mechanisms in family-based interventions for adolescent AN is difficult (Hoste, 2015; Rienecke & Richmond, 2018), and the same uncertainty pertains to family-based inpatient treatment. Still, there is reason to believe that empowering parents (Byrne, Accurso, Arnow, Lock, & Le Grange, 2015), and reducing within-family criticism may play a pivotal role (Rienecke, Accurso, Lock, & Le Grange, 2016). Without explicitly stating the benefits of perceiving their parents as becoming “less critical”, more “empowered” or “displaying enhanced parental self-efficacy” our findings indicate that such important relational dynamics were enhanced during the admissions. Overall, several participants appreciated that their parents had become more effective caretakers, becoming more supportive, both emotionally and via mutual understanding, and assuming greater responsibility in more supportive ways. A recent study found that a 2-week family admissions program was beneficial in strengthening relationships and providing reunification for the participants (Fink et al., 2017). In line with this, the family-based inpatient approach provides the families with a therapeutic context that both prevents separating significant relationships and offers a new common ground by inviting the family to join forces against the illness. One specific advantage of family-based admissions is thus that the family is offered a more intensified therapeutic context to enhance the likelihood of breaking or restructuring relational patterns that have turned into habitual and powerful maintaining dynamics (Whitney & Eisler, 2005). Overall, the main findings captured in the first theme shed light on the potential promise of admitting the family when the patient is in need of inpatient treatment, and thus adds to the emerging literature on adapting family-based approaches at higher levels of care (Murray et al., 2015).

Enhancing or maintaining negative power dynamics

In contrast, family-based inpatient treatment may also represent a context where negative power dynamics are both enhanced and maintained. According to our findings, these potential negative dynamics can be observed both within the peer group and within the families. The first subtheme suggests the necessity of developing strategies to more effectively promote the potential benefit of the peer group, and emphasizes the importance of preventing negative peer dynamics during admissions. Whereas interacting with fellow patients during the stay can be constructive, harmful strategies may be shared during the stay (Vandereycken, 2011). The findings illustrating iatrogenic effects of being admitted with peers are in line with prior reports, and represent a potential negative side effect with hospitalization in general. Social learning, imitation, negative peer pressure and competition can manifest during admissions, to stimulate and maintain ED-behaviors (Espíndola & Blay, 2009; Offord, Turner, & Cooper, 2006; Tierney & Fox, 2010; Vandereycken, 2011). These findings imply that staff awareness of peer group dynamics is vital. It is also important to not assume that by admitting the patient's together with family members, one automatically protects against such potentially negative dynamics.

The second subtheme clearly portrayed that family-based admissions was not a preferred treatment by all participants. On the contrary, quite a few of the participants stated that they would have preferred to be admitted alone. In retrospect, they reflected that a family-based admission approach should not be the sole treatment option. Beyond the preference to be admitted alone, our findings suggest that from a patient perspective, it may be particularly difficult to accept the increased responsibility which was relegated to parents. This underlines the importance of establishing clear roles and responsibility, both before and during treatment, as suggested in previous studies (Hoste, 2015; Murray et al., 2015; Rienecke & Richmond, 2018). Some former patients reflected that they may have better valued parental support if their

parents had assumed a more distant role in the treatment, especially during mealtimes. Mealtimes are particularly challenging, and our findings suggest the importance of continuing to improve knowledge related to the organization of meals across various phases of treatment. Some expressed that treatment had become yet another battleground, and reflected that by intensifying treatment, conflicts intensified too. Interestingly, these participants expressed the opinion that tailoring treatment and modifications to the treatment program may have resulted in less opposition. We encourage treatment providers to be aware of the potential negative dynamics during family-based admissions and to develop strategies to counteract potential iatrogenic effects. We argue that it is important not to attribute these to the young person or the family per se, but to consider whether there are aspects with treatment delivery that could mitigate or prevent these complex issues from arising.

Vulnerable transitions

Transitions during family-based admissions included the pre-admission phase (from referral to admission), transitions during the stay (planned leaves), and discharge. Several of the participants experienced transitions between services as vulnerable or stressful periods. Interestingly, quite a few underlined that transitions occurring during the stay were also high-risk situations, and the planned leaves could be viewed as a potential escape from treatment. Overall, the findings suggest the significance of being vigilant about transitions across phases of treatment. These findings concur with prior studies documenting potential gaps when transitioning between services (Munoz-Solomando, Townley, & Williams, 2010; Treasure, Schmidt, & Hugo, 2005), and suggest greater attention to proper planning.

Several of the participants reflected upon fears of losing control and fears of change during the pre-admission phase. This is consistent with research suggesting that anxiety in anticipation of an admission is a strong treatment barrier (Griffiths, Rossell, Mitchison, Murray,

& Mond, 2018). The majority recollected skepticism or resistance to admission and described a low degree of within-family agreement regarding hospitalization. Careful preparation involving the family is therefore warranted, as fears and within-family disagreement may negatively influence the treatment if not properly resolved.

Our findings suggest that engaging the young person in treatment preparation is vital at higher levels of care, in which a long duration of illness and prior failed treatment efforts are commonplace. Thus, the findings imply that engaging the adolescent in collaborating in treatment, and young patients' readiness (Bewell & Carter, 2008; DeFife & Hilsenroth, 2011), could be more thoroughly addressed during the preparation phase to maximize therapeutic benefit. Upon discharge, several former patients emphasized the importance of careful planning to secure further outpatient follow-up and prevent relapse. Despite that outpatient family-based treatment is shown beneficial in preventing relapse over the long-term for adolescent AN (Lock et al., 2010), AN is generally associated with high rates of relapse (Khalsa et al., 2017). Ensuring carefully planned transitions between service providers is crucial to minimizing risk of relapse when stepping down to a lower level of care. It is notable that the majority of participants advocated for adequate follow-up post-discharge. Participants' perspectives are reflected in the research literature that both documents the high possibility of relapse and that stepping down from higher levels of care inevitably implies further treatment after admissions (Fink et al., 2017; Hoste, 2015).

Sibling relationships and different ways of involvement

Several of the participants cited the importance of involving siblings, consistent with literature emphasizing the untapped potential of improving sibling involvement (Callio & Gustafsson, 2016; Hughes et al., 2017; van Langenberg et al., 2018; Withers et al., 2014). Appropriate sibling involvement is presumably especially relevant to consider at higher levels

of care, with treatment often occurring farther away from the family's home environment. That said, others stated that involvement not be "default" and that siblings and patients should be consulted in decision-making. Additionally, the siblings' age and importance of the relationship should be considered.

Despite evidence on AN influencing the family as a whole (Eisler, 2005; Loeb, Lock, Greif, & Le Grange, 2010), and that outpatient FBT emphasizes the importance of sibling involvement (Lock & Le Grange, 2013), appropriate sibling involvement can still be thought of as an area that could be accentuated during treatment (Hughes et al., 2017). Yet questions related to the extent of involvement remain, especially how to manage siblings' own needs (Fox et al., 2017; Withers et al., 2014). A relevant question to ask is also whether treatment is truly family-based if important members of the family are absent, as was the case for many of the participants' families in this study. Overall, the findings support the necessity of carefully addressing sibling involvement during treatment.

Strengths and limitations

It is considered a strength that all available participants were included in the analysis ($N=37$). Despite this, a potential selection bias cannot be ruled out, as 58 participants were invited to participate. One obvious limitation is the retrospective nature of interviews. The time between discharge and follow-up interview varied, but considerable in length, and thus subject to recall biases. Nevertheless, a delay between discharge and follow-up may have allowed the participants' time to reflect sufficiently upon their experiences, and hence provide greater nuance and self-reflection less affected by events and emotions immediately upon discharge. Another limitation is that four of the interviewers were previous members of multidisciplinary teams providing treatment, and this represents a source of bias in the collection of data. However, two out of three responsible for analyzing data had no previous work experience at

the unit. The inpatient program and health care setting in Norway enables the opportunity to provide extended family-based treatment within a hospital setting, which may limit generalizability. Despite this, we would argue that the study and the findings posit proper transferability value (Maxwell & Chmiel, 2014). The study makes a contribution by improving our knowledge related to patients' perspectives on family-based inpatient treatment for adolescent AN. Augmenting and adapting family-based approaches to higher levels of care is an important step in improving treatment of adolescent AN (Fink et al., 2017; Hoste, 2015; Murray et al., 2017; Murray et al., 2015; Rienecke, 2017). With its "insider focus", the current study adds to this ongoing effort and is the first study to investigate former patients' experiences with family-based inpatient treatment beyond two weeks (Fink et al., 2017).

Clinical Implications

- With its "insider focus," this study contributes to knowledge on how inpatient family-based treatment for adolescent anorexia nervosa is perceived from a user perspective.
- To our knowledge, this is the first investigation of former anorexia nervosa patients' experiences with being admitted to a family-based inpatient program beyond two weeks.
- The current study has value for both advancing the development of inpatient care and by adding patient perspectives to the ongoing effort of providing family-based approaches at higher levels of care.
- Overall, the findings suggest that providing family-based admissions may be a promising way of delivering inpatient treatment for those in need of treatment at higher levels of care.
- Additionally, the study sheds light on some of the complexities involved in providing inpatient family-based treatment for adolescent anorexia nervosa. We emphasize the

need to individually tailor treatment despite the structured setting, carefully plan transitions and carefully weigh sibling involvement.

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Table 1: Main themes and adjacent sub-themes

1: Enabling new ways of understanding and relating	<p>A: Being in it together. Joining forces (N=24)</p> <p>B: Between the ward and home. Bridging contexts (N=22)</p>
2: Enhancing or maintaining negative power dynamics	<p>A: Negative peer influence. Potentially nurturing the eating disorder (N=15)</p> <p>B: Family-based inpatient treatment should not be the only option. If I could stay here by myself (N=12)</p>
3: Vulnerable transitions	<p>A: Planned leaves can both aid the treatment and enhance the ED (N=22)</p> <p>B: Providing safe transitions (moving in - moving out) (N=32)</p>
4: Sibling relationships and different ways of involvement	<p>A: Providing information and enabling taking part (N=19)</p> <p>B: Appropriate involvement of siblings (N=11)</p>

Numbers in parenthesis equals the number of participants' sharing accounts within each subtheme.