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**Clinician adherence to guidelines in the delivery of family-based therapy
for eating disorders**

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Abstract

Objective: Clinicians have been shown to drift away from protocol in their delivery of evidence-based treatments. This study explores this phenomenon in the delivery of family-based therapy (FBT) for eating disorders, and the clinician characteristics that might explain such therapist drift.

Method: The participants were 117 clinicians who reported using FBT for eating disorders. They completed an online survey, which included questions relating to clinician characteristics, caseload, and reported use of FBT manuals and core therapeutic tasks, as well as a measure of anxiety.

Results: The use of core FBT tasks was higher than for other therapies, but there were still noteworthy gaps between recommended and reported practice. Approximately a third of clinicians reported delivering 'FBT' that deviated very substantially from evidence-based protocols, often appearing to be on an individual therapy basis. Using an FBT manual to guide treatment delivery was associated with greater adherence to recommended techniques. Clinician caseload and anxiety were associated with differences in the use of specific FBT tasks.

Discussion: Consistent with previous research regarding clinicians' use of other therapies, the delivery of FBT for the eating disorders is not homogeneous.

Conclusion: Further investigation of this phenomenon is needed in order to determine the impact of deviating from treatment protocols on the effectiveness of FBT for the eating disorders.

Keywords: family-based treatment; evidence-based practice; eating disorders

Clinician adherence to guidelines in the delivery of family-based therapy for eating disorders

Psychological therapies are central to the effective treatment of eating disorders, but only a limited number have empirical support. Those outpatient therapies with the strongest evidence base are cognitive-behavioural therapies (CBT) for adults and family-based therapy (FBT) for younger cases.^{1,2} Each approach is based on the use of manualized protocols.³⁻⁶ Such protocol-based approaches have been shown to be more effective than less structured versions of therapies.⁷ In the case of FBT, this manual-based approach has been shown to be effective in treating anorexia nervosa in children, adolescents and young adults⁸⁻¹¹ and bulimia nervosa in adolescents.¹² However, it does not work for all cases,^{11,13} and cannot be relied upon as the only treatment approach.¹⁴

Evidence-based FBT for eating disorders has well-established principles and protocols.^{4,15} For example, during the first phase of treatment for anorexia nervosa, the clinician focuses on supporting the parents to promote weight gain in their child, interrupting eating disorder symptoms, and normalizing eating behaviours.¹⁵ Within this phase are specific therapeutic tasks, for example, the clinician is to weigh the client at the beginning of every session. Next, the clinician supports the family in returning control over eating to their child, and helps the family to explore previously set-aside issues outside of the illness. Finally, the focus shifts to the development of the child's identity and the family's adjustment to their child's emerging independence. The treatment of bulimia nervosa is similar.⁴ For example, the clinician first focuses on supporting the parents to interrupt their child's eating disorder behaviours (e.g., inappropriate compensatory behaviours), and then the family is supported to explore issues outside of the illness, including those related to the child's development of independence and autonomy. The major differences lie in the degree of involvement of the child in symptom interruption. Given the ego-dystonic nature of bulimia nervosa, evidence-based FBT with such cases involves fostering some collaboration between parents and child in

working together towards overcoming eating disorder symptoms.

While there are clear guidelines about the delivery of evidence-based FBT, it is not clear whether they translate into everyday clinical practice. Recent research has demonstrated that CBT for adults with eating disorders is commonly delivered in ways that deviate substantially from empirically-supported protocols.¹⁶ Fewer than half of self-defined CBT clinicians use core CBT techniques when delivering CBT for such cases.¹⁶ This pattern reflects the more general concept of therapist drift, where clinicians fail to undertake the core tasks of evidence-based psychological therapies for reasons that are more about the clinician than the client's needs.¹⁷ For example, poorer adherence to evidence-based treatment protocols is found where clinicians are more anxious or fail to use treatment manuals.¹⁶ Such failure to use manuals is relatively common in the treatment of eating disorders.^{18,19}

Failure to use evidence-based approaches is known in other disorders²⁰ and therapies.²¹ However, it is not known whether such drift occurs among clinicians delivering FBT for eating disorders. There are some initial indications that this might be the case, such as a qualitative study suggesting that clinicians feel intimidated and anxious about the use of FBT manuals (e.g., not weighing the client; not completing the family meal).²² This failure to use manuals appears to be associated with a greater level of clinical experience and fewer eating disorder cases within a clinician's caseload,²³ possibly because some clinicians report seeing manuals as inflexible and inappropriate for use with more complex cases.²⁴ However, there is no evidence to support any of these patterns of drift from evidence-based methods.

This paper considers whether findings regarding clinicians' use of evidence-based techniques in CBT for adults with eating disorders are paralleled in the delivery of FBT with generally younger cases. The aim is to determine the extent to which clinicians who report using FBT adhere to the specific FBT techniques recommended within evidence-based approaches to treating eating disorders. The study also considers whether the use of such techniques is associated with clinician

characteristics (use of manuals, type of clients, age, experience, anxiety). On the basis of the existing manuals,^{4,15} the treatment techniques considered are divided into those that are recommended and those that are not recommended in the manuals, either explicitly or by their absence.

Method

Participants

The project was approved by Laurentian University's research ethics board. Participants consisted of 117 clinicians who reported using FBT with clients with eating disorders (108 female, 9 male). The mean age of participants was 41.5 years ($SD = 9.72$, range = 26-64), and their mean duration of working with clients with eating disorders was 9.76 years ($SD = 7.58$, range = 1-35). The clinicians were from a range of professions, including psychology ($N = 51$), psychiatry ($N = 12$), nursing ($N = 4$), occupational therapy ($N = 3$), and social work ($N = 34$). The age groups of the identified clients seen were reported to be: aged up to 12 years = 11.0%; aged 13-17 years = 68.2%; aged 18-24 years = 19.5%; and aged 19+ years = 12.1%. In terms of diagnosis, participants reported that 52.9% of their clients met criteria for anorexia nervosa, 19.0% had a diagnosis of bulimia nervosa, and 35.0% had an eating disorder not otherwise specified (EDNOS).¹

Measures and Procedure

As part of a larger study,²⁵ participants were invited to complete an anonymous online survey. There was no overlap of data with other publications. They were recruited via a database of Canadian eating disorder clinicians compiled by the authors ($N = 46$) or the Academy of Eating Disorders listserv ($N = 71$). Clinicians were asked to pass the survey on to eligible colleagues, meaning that it was not possible to determine the completion rate. The FBT portion of the survey was terminated if a participant indicated not practicing FBT with their eating disorder clients. All eligible participants completed questions about their use of specific techniques related to FBT, as

¹ Please note that these two sets of numbers do not total 100% because participants did not always make their numbers balance in that way.

well as a questionnaire measure of their own anxiety.

Survey of use of specific FBT techniques. The survey was developed for clinicians who use FBT when working with eating disorders, and was based on a previous survey of the use of CBT methods,¹⁶ incorporating core techniques described in both the anorexia nervosa and bulimia nervosa FBT treatment manuals.^{4,15} The frequency and proportion of use of each technique (listed below) were rated on a scale ranging from 1-10 (0%–10% to 91%–100%). The items were categorized as follows: techniques recommended by the FBT manuals (weighing the client at beginning of every therapy session; ensuring that all family members attend the first session of treatment; charging parents with the task of refeeding/symptom interruption; the family meal; directing/redirecting therapeutic discussions towards food/eating/symptom interruption until normal), and techniques that are not (providing suggestions and/or solutions in order to help parents achieve the tasks of refeeding/symptom interruption; food diaries; reflecting team family therapy; individual therapy with the client; use of mindfulness).^{4,15} Three additional items were included: whether clinicians prefaced the FBT with sessions dedicated primarily to motivational work; which manuals (if any) they used in directing FBT for these clients; and for how many sessions they would continue to see a client who had declined to be weighed (0, 1, 2, 3, 4, more than 4).

Brief Symptom Inventory-Anxiety Scale (BSI-Anxiety). The BSI-Anxiety Scale is a six-item self-report measure of symptoms of anxiety, drawn from the widely validated 53-item BSI.²⁶ On a five-point scale (*Not at all* to *Extremely*), participants rate their experience of distress about each item within the past seven days. Higher scores indicate higher levels of anxiety. The BSI has been shown to have good reliability and internal validity.

Data analysis

Due to some participants not completing items, the numbers vary across items and tests, as shown in the tables. No missing data were replaced. The use of different core FBT techniques and other methods was detailed using descriptive statistics. Two-step cluster analysis was used to

determine whether the participants fell into distinct clusters, defined by their pattern of use of different therapeutic methods. Chi-squared tests and *t*-tests were used to determine the association of manual use with other clinical variables and correlations (Pearson's *r*) were used to determine the association of dimensional variables (age, clinician anxiety, case distribution) with the use of different FBT techniques.

Results

Frequency of use of manual-recommended FBT techniques

Table 1 shows the frequency of use of individual FBT techniques, separated into those that are recommended in the treatment manuals and those that are not (see above). The manual-recommended methods were those that were used routinely (in 81-100% of cases) by the largest proportion of clinicians. However, even those methods were not used universally (e.g., only 70.5% of clinicians stressed parents' need to take charge of the task of refeeding/symptom interruption in that proportion of cases). Indeed, two FBT techniques (having the whole family attend the first session and the family meal) showed bimodal distributions, being used all the time by approximately a third of the clinicians but rarely by a similar proportion. Among the methods not recommended by the FBT treatment manuals, most were used by relatively few clinicians. However, it is notable that the use of individual therapy and mindfulness were more common than the other methods in this sub-set. On average, clinicians stated that they would see a client between once and twice beyond the point where the client refused to be weighed (mean = 1.47, *SD* = 1.70). While 33% said that they would stop therapy without seeing the client again if they stopped being weighed and a similar proportion would give the client only one more session, it is noteworthy that 16% would maintain contact for three to six sessions (or more).

Insert Table 1 about here

Clusters of clinicians defined by manual-recommended and other techniques

Two-step cluster analysis (using Schwartz's Bayesian Criterion) was used to determine whether the FBT clinicians formed a single group based on their use of different FBT techniques, or whether they fell into different clusters. Two clusters emerged, with a silhouette score = 0.4, indicating a fair level of cluster cohesion and separation. The larger cluster consisted of 66.2% of the clinicians, who were distinguished by a greater use of charging parents' with the task of refeeding/symptom interruption, weighing the client at the beginning of every session, conducting the family meal, directing/redirecting therapeutic discussions to eating/symptom interruption, and having the whole family attend the first session. The second cluster (33.8%) consisted of clinicians who used individual therapy, food diaries, mindfulness techniques, motivational work, and reflective team family therapy more commonly. Given this pattern, the clusters can be described as clinicians using manual-recommend FBT techniques and those using techniques not recommended in the FBT manuals (often seeming to engage in more individual therapy).

Impact of manual use on reported implementation of FBT techniques

Of the 86 clinicians who responded to the relevant item, 77.9% reported using a treatment manual to guide their use of FBT. Considering the two groups of clinicians who had emerged from the cluster analysis (above), those in the larger cluster (manual-recommended FBT) were more likely to use manuals (87.8% of cluster members) than those in the smaller cluster (58.3%) ($\chi^2 = 8.15$, $df = 1$, $P < .004$).

Table 2 shows the mean frequency of reported use of individual FBT methods among those who did or did not use manuals. T-tests were used to compare those groups. The clear pattern that emerged was that the clinicians who used manuals were more likely to use manual-recommended FBT techniques, and less likely to use methods not recommended by the manuals. In those cases where there was a significant difference, the effect sizes (Cohen's d) were all medium ($> .5$) to large

(> .8), indicating substantial differences in clinical practice between those who did and did not use manuals to guide their practice.

Insert Table 2 about here

Association of clinician characteristics with use of specific FBT techniques

Correlation coefficients were used to determine whether clinician age, duration of experience, or anxiety levels were associated with the reported use of FBT techniques. An *alpha* of .01 was adopted, to correct for multiple testing. There were no reliable associations (Pearson's $r < .30$ in all cases) suggesting that temporal and mood variables do not influence the use of specific FBT methods. However, post hoc analyses showed that more anxious clinicians were more likely to state that they weigh clients only 'occasionally' or 'rarely' (respectively, $r = .391$, $P < .002$; $r = .319$, $P < .01$).

Association of clinical practice variables with use of FBT techniques

Correlation coefficients (Pearson's r) were used to determine whether clinicians' practice characteristics (proportion of FBT clients in each age and diagnostic group) are associated with their tendency to use different FBT methods. The acceptable *alpha* was set at .01, to reduce the risk of Type 1 errors. Table 3 shows that there were different patterns for different age and diagnostic groups.

Insert Table 3 about here

Considering the relevance of client age, it is noteworthy that there were different patterns of association for each age group. Clinicians who worked more with children of 12 years and below reported being less likely to weigh their clients at the beginning of every session, but more likely to

use mindfulness techniques. Those who worked primarily with adolescents were more likely to charge the parents with the task of refeeding/symptom interruption and to weigh the client at the beginning of every session. They were also more likely to direct/redirect the discussion back to eating and symptom interruption during sessions. However, those who worked more with transitional-age clients (18-24 years old) showed the reverse pattern, reporting less use of charging the parents with the task of refeeding/symptom interruption, weighing the client at the beginning of every session, and directing/redirecting therapeutic discussions, as well as doing more individual work with this group. Finally, those who worked more with adults were not more or less likely to use any of the specific techniques.

When the proportions of cases in different diagnostic groups were considered, distinct patterns emerged again. Clinicians who worked with a higher number of clients with anorexia nervosa were more likely to focus on charging the parents with the task of refeeding their child. In contrast, those working with a greater proportion of clients with bulimia nervosa were less likely to charge parents with the task of refeeding, to weigh the client at the beginning of every session, and to implement the family meal. The proportion of EDNOS cases on clinicians' caseloads was not related to the likelihood of their using any specific techniques.

Discussion

The present study explored the extent to which clinicians who describe themselves as delivering FBT for eating disorders report using recommended techniques. Although few FBT techniques were used by more than 60% of the sample, the methods that were most commonly reported were those recommended by the manuals. However, many clinicians also reported using techniques that are not recommended either explicitly or by their absence in the manual (e.g., individual therapy; mindfulness techniques). Similarly, there were other patterns of reported clinical practice that differ from evidence-based guidelines. In particular, it is noteworthy that a number of clinicians reported using FBT with clients who were much older than recommended, and others who

reported delivering individual-focused therapy under the label of family-based treatment. Overall, the clinicians fell into two clusters – about two-thirds using manual-recommended FBT techniques, and a third deviating substantially from those recommendations. Perhaps unsurprisingly, those who used FBT manuals were more likely to report using the recommended techniques and used the non-recommended methods less, with medium to large effect sizes indicating substantial differences in the clinical practice of those who used manuals and those who did not.

There were few associations between techniques used and clinician characteristics. Clinician anxiety was associated with being more likely to weigh the client only occasionally or rarely. Caseload pattern was also relevant, as the use of recommended methods was greater where the clinician worked more with adolescents, but lower when working more with transitional-aged clients and bulimia nervosa.

These findings show some similarities and differences relative to the existing literature. For example, clinician anxiety plays a wider role in the implementation of CBT for the eating disorders¹⁶ than it does with this group. The clinicians' relatively common failure to weigh clients on each occasion (43%) is similar to other findings (38%).²² It is possible that some clinicians do not weigh clients themselves because, for example, they obtain weight information from another team member. However, these findings also show that clinicians are more likely to omit weighing due to anxiety and consequent discomfort with this element of FBT. Such an omission is a concern, because: "Weighing the patient does not just serve an instrumental goal, it also strengthens the relationship between the clinician and the patient by helping the patient through a stressful situation (p.48)"¹⁵. It has been suggested that clinicians often need to work experientially to overcome potential emotional blocks in administering therapy,²⁷ and weighing the client within FBT seems to be an area where such work is necessary for a substantial minority of clinicians.

A further contrast with previous findings is in the lack of any impact of clinician age and experience on the use of FBT techniques, given that other authors have demonstrated a greater

level of manual use among more junior clinicians.²³ However, that earlier work examined the use of CBT and interpersonal psychotherapy. Therefore, the lack of such an association in this study might indicate greater uniformity in the uptake of FBT among clinicians from an earlier point in clinical practice, given that it is the only widely recommended treatment in this client age group. This uniformity of uptake might also reflect the fact that some FBT therapists value the exclusive practice of FBT and believe (erroneously) that a failure to do so is “blameworthy and ethically irresponsible”.²⁸

The importance of client age requires further investigation. The previously unreported tendency for FBT clinicians not to weigh younger children but to use mindfulness methods with them is a concern, given the importance of weight monitoring in growing children and the lack of an evidence base for mindfulness with this group. The other age group-related finding was the pattern of correlations with the proportion of adolescent and older clients (though the latter did not achieve significance). While the use of FBT techniques was strong when the clinician worked with a higher number of adolescents, the reverse pattern was true when working with more transitional-aged clients. This shift in practice might reflect the clinician’s desire to respect the adolescent’s transition to adulthood, as reflected in a more family-client collaborative approach,⁸ including more individual sessions. The pattern employed with the transitional-aged group is also similar to that outlined elsewhere, given that clinicians report feeling that families should be encouraged to be supportive of treatment rather than leading it.²⁹ Since bulimia nervosa tends to have a later age of onset than anorexia nervosa, it is possible that the change in practice with older clients explains why recommended FBT techniques were used less frequently among clinicians working with a greater proportion of bulimia nervosa cases. Although it might be very appropriate for clinicians who work with older clients to facilitate more ownership of the tasks of refeeding/symptom interruption by the client (rather than the parents), these changes in practice across age groups are not supported empirically, and there are no systematic studies exploring the effectiveness of the various FBT techniques with transitional-aged clients. As such, the use of FBT with this client group represents a

significant “drift” that is worthy of future study.

The evidence regarding adherence to manualized, protocol-based approaches in everyday clinical practice is relatively clear⁷ - client outcomes are enhanced relative to less structured forms of therapies. Research supporting the efficacy of FBT^{10,12} supports this broader conclusion. However, there is a lack of dismantling studies to demonstrate which elements of FBT are related to therapeutic change across age groups and eating disorders. Therefore, it cannot be concluded that divergence from the use of manuals to guide treatment is always negative. It is possible that such deviations reflect clinical judgement based on a broader grasp of the guiding principles of FBT when treating a wide range of cases and that integrating various therapeutic strategies from other approaches may in fact be effective and appropriate for certain cases. Therefore, it will be necessary to test the validity (in terms of clinical outcomes) of such divergence from the existing evidence-based approaches (e.g., using FBT with adult clients).

This study is not without limitations. The recruitment methods employed and the survey-based methodology used in this study have the potential to bias the results through patterns of participation. Future research based on clinic records, observation and client surveys should also be used to verify and test these findings. The strengths of the conclusions that can be drawn are also limited by the fact that approximately 25% of participants failed to respond to the question regarding FBT manual use. It is also possible that participants' interpretations of the techniques listed could have influenced the results and their interpretation (e.g., clinicians might have suggested different solutions in order to enable families to make decisions about alternative courses of action, rather than suggesting specific solutions to guide the family into particular courses of action). Finally, it is possible that clinician characteristics not examined in the present study, such as intensity of training in FBT, may also relate to the different patterns of FBT use that emerged. It will be important to continue to investigate other clinician variables possibly related to manual-adherence and therapist drift in order to further our understanding of this phenomenon.

Note: The authors have no conflict of interest

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Table 1

Percentage of clinicians using different FBT methods at different levels (0-10% to 91-100%)

		Frequency of use of FBT methods (%)									
Central methods	<i>N</i> ¹	0-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100
All family attend	106	28.3	6.6	1.9	0.9	2.8	2.8	5.7	6.6	9.4	34.9
Parents refeed	105	4.8	6.7	1.9	0	2.9	3.8	2.9	6.7	16.2	54.3
Weigh client	101	13.9	0	2.0	1.0	1.0	1.0	3.0	6.9	13.9	57.4
The family meal	85	36.5	4.7	1.2	0	4.7	3.5	5.9	2.4	7.1	34.1
Direct discussion	87	4.6	0	2.3	1.1	0	4.6	5.7	14.9	26.4	40.2
Other methods											
Food diaries	86	64.0	4.7	8.1	1.2	2.3	1.2	1.2	1.2	8.1	8.1
Motivational work	87	59.8	9.2	6.9	4.6	6.9	3.4	1.1	3.4	1.1	3.4
Reflecting team	87	78.2	4.6	3.4	0	0	1.1	1.1	4.6	4.6	2.3
Individual work	87	31.0	10.3	13.8	5.7	11.5	4.6	5.7	6.9	3.4	6.9
Mindfulness	87	34.5	13.8	9.2	4.6	3.4	9.2	4.6	4.6	6.9	9.2
Suggest solutions	89	3.4	4.5	2.2	5.6	7.9	9.0	6.7	13.5	10.1	37.1

¹ Note – *N* varies according to the number of responses per item

Table 2

Frequency of use of specific FBT techniques (1 = 0-10%; 10 = 91-100%) among clinicians who report using or not using a treatment manual when delivering FBT

	Use manuals		Do not use manuals		<i>t</i> -test		Effect size
	Mean	(<i>SD</i>)	Mean	(<i>SD</i>)	<i>t</i>	<i>P</i>	<i>d</i>
Central methods							
All family attend	7.06	(3.61)	4.89	(4.24)	2.22	.03	0.577
Parents refeed	9.10	(2.05)	6.89	(3.63)	3.40	.001	0.903
Weigh client	9.00	(2.19)	7.32	(3.76)	2.47	.02	0.644
The family meal	6.37	(3.96)	3.39	(3.33)	2.91	.005	0.778
Direct discussion	8.80	(1.60)	7.11	(3.55)	2.94	.004	0.783
Other methods							
Food diaries	2.44	(2.74)	4.26	(4.01)	2.29	.03	0.596
Motivational work	2.40	(2.50)	2.89	(2.45)	0.76	<u>NS</u>	0.198
Reflecting team	2.04	(2.50)	2.53	(2.99)	0.71	<u>NS</u>	0.185
Individual work	3.27	(2.57)	6.26	(3.09)	4.29	.001	1.115
Mindfulness	3.60	(3.11)	5.32	(3.25)	2.10	.04	0.546
Suggest solutions	7.32	(2.70)	8.16	(2.83)	1.18	<u>NS</u>	0.307

Table 3

Association of use of specific FBT techniques with clinical variables

	Proportion of clients in each age group				Proportion of clients per diagnosis		
	Children (≤12 years)	Adolescents (13-17 years)	Transitional (18-24 years)	Adults (≥ 25 years)	Anorexia nervosa	Bulimia nervosa	EDNOS
Core methods							
All family attend	-.18	.12	-.03	-.23	.07	-.09	.02
Parents refeed	-.14	.36**	-.48**	-.23	.30*	-.40**	-.12
Weigh client	-.31*	.32**	-.39**	-.31	.15	-.45**	-.07
The family meal	-.08	.03	-.17	.06	.06	-.30*	.17
Direct discussion	.14	.29*	-.36*	-.06	.15	-.11	-.11
Other methods							
Food diaries	-.06	-.07	-.02	.13	-.05	-.07	.04
Motivational work	-.01	-.05	.09	.01	-.02	.27	-.09
Reflecting team	-.09	.06	-.13	.07	-.08	.10	-.05
Individual work	.04	-.25	.31*	.24	-.04	.16	-.09
Mindfulness	.32*	-.16	-.04	.18	-.05	.18	-.08
Suggest solutions	.14	.09	-.16	-.17	.10	.04	-.08

* $P < .01$; ** $P < .001$