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▶ **To cite this version:**

Solange Cook-darzens, Jeanne Duclos - Lavagne d'Ortigue. Development and implementation of a relationship-focused outpatient multifamily program for adolescent anorexia nervosa. Family Process, 2023, Family Process, 62 (3), p.1055-1074. 10.1111/famp.12826 . hal-04300938

HAL Id: hal-04300938
https://hal.univ-lille.fr/hal-04300938

Submitted on 22 Nov 2023

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Received: 31 March 2022 | Revised: 17 August 2022 | Accepted: 19 August 2022

DOI: 10.1111/famp.12826

ORIGINAL ARTICLE

Development and implementation of a relationship-focused outpatient multifamily program for adolescent anorexia nervosa

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Abstract

Multifamily therapy (MFT) for adolescent eating disorders (ED) is anchored in systemic theory and family therapy, but two conceptual and practical paths have emerged from this common framework. The first one, called ED-focused MFT, is centered on behavioral change and weight gain in the early stages of treatment, while the second, known as relationship-focused MFT, is less directly focused on symptom improvement and more on family changes. Compared to ED-focused MFT, validation of more relationship-focused MFT models has been lagging behind although they are frequently implemented and practiced in Europe. The purpose of this article is to give more visibility to existing relationship-focused MFT models by presenting an integrative, yet predominantly family-oriented MFT program developed for adolescent anorexia nervosa (AN) (12 to 18 years) on the ED unit of a large pediatric hospital in France. After presenting the history and development of this relationship-focused MFT program, including the challenges it encountered and its evaluation, we describe its rationale and objectives, then outline its course and content, giving illustrations of techniques and activities for each of the five phases of the program. Finally, we review the current status of this model, its advantages and limitations, and provide a critical appraisal of existing evidence and recommended future research directions.

KEYWORDS

adolescents, anorexia nervosa, ED-focused MFT, multifamily therapy, relationship-focused MFT, single-family therapy

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INTRODUCTION

Multifamily Therapy (MFT) is a therapeutic method that brings together several families affected by similar difficulties. MFT is generally conceptualized as being linked to family therapy (FT) and group therapy, and is based on the concept that families confronted with similar problems can share experiences, as well as support and learn from one another (Gelin et al., 2018). MFT has become an increasingly popular treatment modality over the past 25 years and there is a growing body of evidence underpinning this intervention, particularly for the treatment of schizophrenia and severe psychoses (McFarlane, 2016), mood disorders (Gelin et al., 2018), eating disorders (ED) (Baudinet et al., 2021), and chronic somatic conditions (Steinglass et al., 2019). Several other problem areas such as couple/family relationship difficulties, as well as school and social exclusion, have also been addressed with this approach (Cook-Darzens et al., 2018).

MFT for adolescent anorexia nervosa (AN) emerged from several conceptual and clinical developments. Firstly, pioneer strategic and structural single-FT models, which were developed in the 1970s around the treatment of ED (Minuchin et al., 1978; Selvini-Palazzoli, 1974), eventually evolved toward the creation of two distinct types of FT models, which, in turn, generated two distinct versions of MFT. The first model includes evidence-based ED-focused FT programs, which were developed in the UK (FT-AN) and the US (Family-Based Treatment or FBT) and centered on behavioral change and weight gain. These "ED-focused" programs, as their designers call them (Baudinet et al., 2021; Eisler et al., 2016), are presently recommended as first-line treatment for adolescent AN (Eisler et al., 2010; Lock & Le Grange, 2012) and became the main foundation for ED-focused MFT. In addition, the Marlborough Family Service, designed in the 1980s for "multiproblem" families (Asen & Scholz, 2010) and entirely organized around MFT principles, inspired the high intensity of some of the later ED-focused MFT programs. The other model comprises single-FT programs that strongly focus on family processes, including family models developed in the late 1980s around severe chronic illness (Rolland, 1994, see below). Relationship-focused MFT, as we call this therapeutic approach, is grounded in this model. More generally, the well-established practice of group therapy, applied separately to ED patients and/or to their parents, also paved the way for the emergence of MFT for adolescent ED (Van Vreckem & Vandereycken, 1989).

Pioneer applications of MFT to adolescent and adult AN and Bulimia Nervosa (BN) started in the late 1980s in Denmark and the US, but remained isolated experiments. In the late 1990s, the Maudsley Institute in London created an intensive MFT model for adolescent AN (MFT-AN), which integrated the theoretical concepts and practices of the FBT/FT-AN (Blessitt et al., 2020) with more general concepts of MFT (Asen & Scholz, 2010; Simic et al., 2022). In its early stages of development, it strongly focused on behavioral change and weight gain and its initial objective was to offer an alternative to inpatient treatment for those who had not responded to FT-AN. Another conceptually very similar MFT model was developed around the same time at the University of Dresden in Germany (Scholz et al., 2005). The Maudsley MFT-AN model has evolved over the last 20 years (Baudinet et al., 2022), notably through the reinforcement of systemic issues of individual and family development, but its overarching goal remains centered on enhancing the speed of change, enabling rapid improvement of AN symptomatology and securing adequate and regular weight gain, considered a necessary prerequisite for recovery from AN. The current program (Simic et al., 2022) offers 10 days of MFT alongside single-FT sessions, as needed, over 6–9 months. Existing evidence suggests that ED-focused MFT models obtain high levels of satisfaction from participating families, can lead to better outcomes than single FT for adolescents treated in outpatient settings, can improve family functioning and tend to be more cost-effective (Eisler et al., 2016; Gabel et al., 2014; Terache et al., 2022).

The success of this ED-focused MFT model for adolescent AN, both in terms of research evidence and dissemination, has rightfully given it high visibility and "legitimacy". In contrast, evidence regarding relationship-focused MFT models (which give priority to issues of family organization and dynamics around the illness rather than to ED behaviors per se) has lagged behind, even though some

of these programs were implemented at the same time as MFT-AN and are currently widely used, at least in Europe and more particularly in French-speaking countries (see below). Indeed, these models (abbreviated by us as RF-MFT) have been and continue to be disseminated through clinical publications, training and supervision of specialized teams. There are several historical, cultural and financial reasons for this delay, some of which will be further examined in the discussion section. Fortunately, both in Europe and the US, research using randomized controlled methodology has started to demonstrate the unique benefits of these Relationship-focused models for single FT, (Agras et al., 2014; Godart et al., 2012, 2022), but no comparable findings have yet been published on RF-MFT. Nevertheless, some initial support in favor of family-oriented MFT has been provided by findings from two preliminary investigations (Depestele et al., 2017; Doyen et al., 2012).

The purpose of this article is to give more visibility to existing RF-MFT models by presenting an integrative family-focused MFT program developed for adolescent AN (12–18 years) in a specialized French ED service. After presenting the history and development of this RF-MFT program, along with the challenges it faced, we describe its rationale and objectives, then outline its course and content, giving several illustrations of techniques and activities designed for each of the five phases of the program. In doing so, we do not intend to challenge the efficacy of other existing models but rather to describe an alternative MFT framework that may be specifically beneficial for some patients and their family members.

DEVELOPMENT OF A FRENCH RF-MFT PROGRAM AND ITS TRANSFORMATIONS OVER TIME

Creation of a family-oriented specialized ED unit

In 1992, we created a specialized ED unit within the child and adolescent psychiatry department of a large French pediatric hospital. This was the first family-oriented ED service in France, which from inception, conferred a key role on the family as a therapeutic partner and agent of change (Cook-Darzens, 2014). Until then, ED inpatients were separated from their families and dispersed in different units for fear they might "pollute" the other patients. In addition, only those families considered to be "dysfunctional" (i.e., responsible for the disorder) were referred for family therapy. In placing the family at the heart of our treatment program, the team drew from more informed theories of ED development and up-to-date evidence regarding the role of the family in the etiology and outcome of ED. It was also strongly inspired by Rolland's Family Systems-Illness Model (1994) and its applications to severe/chronic somatic diseases. This model, which conceptualizes families' experiences of illness as normative, pays particular attention to the adequacy of the family's adjustment to the illness that results from ongoing and evolving family-patient-illness-medical team interactions and their fit over time. Within this developmental framework, family-oriented interventions become relevant for *all* families faced with AN, not just for the most dysfunctional ones. Family belief systems regarding health and illness also become central as they determine the family's sense of control over the illness, influence its coping strategies, and the quality of its participation in the total illness process (including the quality of its working relationship with the healthcare system), and ultimately affect the family's growth and identity.

Overall, various forms of family involvement were developed on the unit, which were highly appreciated by the families who felt supported, guided, and actively engaged in the healing process. But over the following 10 years, the successive development of new contexts of care (partial hospitalization, day treatment programs, home-based care, etc.), in addition to full-time hospitalization and outpatient consultations, encouraged the team to further diversify its family approaches. In addition, a significant minority of families was reluctant to get involved in single FT, or did not seem to benefit from it, or showed critical attitudes toward the patient, which undermined the effectiveness of a single-family approach (Eisler et al., 2007). Still others wanted to meet families confronted with

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similar problems; indeed, we did not yet have parent groups. And finally, there was only one family therapist in the ED service at the time, and her commitment to work with *all* families rapidly became overwhelming. MFT and parent groups have been among the outcomes of this diversity of contexts and experiences (Figure S1).

Creation of our first outpatient MFT program for adolescent AN

Our first MFT program was created in 2000. Given our pediatric context, most of the adolescents (12–18 years) suffered from restricting or purging AN, sometimes from atypical forms of AN, more rarely from BN. In line with our initial theoretical and clinical orientations, and unaware at the time of Maudsley's and Dresden's new MFT programs, our early MFT program drew from existing research on the role of the family in ED, from major schools of FT in the field of ED, and from MFT applications of medical FT to severe and enduring somatic diseases (Steinglass, 1998). In this respect, we were particularly influenced by Gonzalez et al.'s (1989) generic MFT program, a highly structured intervention that includes educational, individual-family, and affective components. We chose a semiclosed, nonintensive yet sustained format (twice a month in 3-h sessions over a period of 9–12 months), in which MFT sessions alternated with separate parent and patient groups, thus giving each generation an opportunity to address specific issues. As in most MFT models, we aimed for a group of 4 to 7 families.

Expanding and reorganizing

Interestingly, descriptions of novel ED-focused MFT interventions (Dare & Eisler, 2000; Scholz & Asen, 2001) were being published at the same time we were implementing our first MFT groups. These and subsequent publications from the Maudsley and Dresden teams (Asen & Scholz, 2010; Simic et al., 2022) eventually helped us expand and reorganize our already well-established multifamily practice. We borrowed an evolving format from their models, with more specific treatment goals and activities associated with each phase. We also started addressing some parental ED management issues, albeit in an indirect way such as through psychoeducation and "behavioral conversations". In our current program, only three activities address symptom-management issues in a direct and focused way: a mealtime psychoeducational video, food collages (borrowed from Maudsley) and a fictitious meal with an adoptive family, also borrowed from Maudsley but simplified for the purpose of identifying and practicing appropriate eating-management strategies (see Table 1; see below, Description and illustrations section, 4th phase). In this process of integration, real multifamily lunch sessions were never introduced as follows: supervised family meals were already part of our comprehensive treatment package and their added value in single- or multifamily settings did not seem to be unequivocally confirmed by the empirical literature (Cook-Darzens, 2016). Simultaneously, we maintained the nonintensive format of our program, as well as our highly interactive approach to psychoeducation. We also added more modules involving general and specific family processes, thus increasing the duration of our programs from 12 to 16 months. We intensified sibling participation, developed activities around gender issues, put greater emphasis on family burden, distress and grief, and more generally spent more time exploring evolving family relationship and identity issues. Finally, our model was progressively enriched by relevant research findings, as well as concepts and practices drawn from motivational theories, cognitive-interpersonal approaches, attachment-mentalization concepts, brief systemic approaches and narrative therapies (see Table S1). Overall, both the Maudsley and RF-MFT models became more integrative, following a mirroring process whereby Maudsley added more family-oriented elements, while the RF-MFT model cautiously added some ED-focused elements. As a result, these two models became less polarized while maintaining their initial specific overarching goals and therapeutic foci.

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TABLE 1 RF-MFT program: Phases, objectives and activities

Phases	Themes/objectives	Possible activities
1rst phase (2 sessions)	1. Affiliation 2. Psychoeducation	1. Cross-parenting Temporary adoption (ice-breaking exercise) Roll-the-ball game 2 Psychoeducational discussions on AN and role of family in recovery[a,b] Brief interactive psychoeducational moments (throughout MFT program)[b] Exploration of health & illness (AN) beliefs
2d phase (2–3 sessions)	1. Externalization of illness 2. Motivation for change 3. Mobilization of family & group resources	1. Drawing the illness (+ externalizing narratives) 2. AN, friend or foe For/Against change Space taken by AN in family & personal life 3 Energy spent by individual family members in fighting AN Semistructured interview on family resources and competencies Health-illness genogram Family shield against the illness[a]
3rd phase (4–7 sessions)	1. Mentalization skills (cognitive and emotional) 2. Problem resolution and symptom (meal) management 3. Exploration of major illness-coping strategies	1. Brain bubble or mind scanning Role reversal exercises (parents-patients…) (throughout MFT program) 2 Learning/improving communication and conflict/problem resolution skills Mealtime psychoeducational video (Leichner, 2004)[b] Food collages[b] Fictitious MFT meals (temporary adoption)[b] 3 Animal genogram[a]
4th phase (4–7 sessions)	1. Explore preillness, current and future family relations, values, identity; improve dysfunctional family dynamics 2. Strong involvement of siblings	1. Family coat of arms Family sculptures (fictitious and real)[a] Family drawings (before/now/after AN) “What if the family were an animal?” Prescription of individual/family tasks 2 Psychoeducation re. impact of illness on siblings Explore sibling experiences of AN, using (i) sibling subgroups & fish in the bowl, (ii) semistructured interview with siblings Letters from patients to siblings…
5th phase (2–3 sessions)	1. Prepare end of MFT and post-MFT: treatment plan, maintain progress, increase autonomy, relapse prevention 2. Goodbye rituals	1. Timeline Back to the future Collage “journey toward recovery” (toolbox, worry box)[a] Organize post-MFT treatment plan Relapse prevention (identify warning signs, role of patient and family, etc.) 2 Ceremonies and diplomas Bring family pictures & other objects Review individual and family strengths

Abbreviations: AN, anorexia nervosa; MFT, multifamily therapy; RF, relationship-focused.

[a]These activities are illustrated in the article.

[b]Behavioral interventions and conversations.

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Further transformations

In addition to the conceptual and practical changes described above, our MFT protocol progressively broadened its applications to different age populations and treatment settings. In 2003, we opened our outpatient program to siblings, devoting entire sessions to them on a regular basis. In 2006, we started running MFT groups specifically for children 8–12 years of age, after an inconclusive attempt at combining children and adolescents in the same MFT groups. In 2007, a new program (combining a parent group with multifamily meetings) was created for families of still younger children (2–6 years) suffering from the typical feeding/eating disorders of this phase of development. And in 2009, we developed an open-recruitment weekly multifamily program specifically designed for inpatients and their families, which included both children and adolescents (8–18 years). Indeed, in this particular context, bringing together families of ED patients from different developmental stages did not seem as challenging as it had been in our outpatient context. The inclusion of siblings was also reinforced in this setting. It is beyond the scope of this article to present our outpatient and inpatient programs for early-onset AN and for feeding/eating difficulties, and they will be addressed separately in another publication. Throughout this process, the outpatient MFT groups, initially intended for patients at risk of relapse and/or chronic course, were opened to patients and their families with less severe profiles, and the frequency of single-FT sessions was decreased accordingly for some families.

Finally, our French RF-MFT model has continued to evolve outside its place of origin, with multiple opportunities for new clinical applications and transformations through training and supervision in French and European institutions.[1] These disseminated models also evolved within their own institutional cultures, producing unique RF-MFT programs. Our model also contributed to the creation of an MFT program and its associated manual (Duclos et al., 2021; Minier et al., 2022), designed for an ongoing randomized controlled trial on the compared effectiveness of distinct single FT and MFT in AN (Carrot et al., 2019). Hopefully, this investigation will stimulate further refinements and adaptations of our own protocol, and perhaps provide additional evidence of its effectiveness.

MFT as a tool for institutional change: Challenges, weaknesses and strengths

All the changes and transformations described above, including our efforts to disseminate our model outside our original institution, were not easy to implement and met with significant challenges, primarily major cultural, conceptual and institutional ones. These were still present in the late 2000s, and their impact continues to be felt to some extent. Indeed, psychiatry and family therapy in French-speaking countries have been shaped and guided by two dominant conceptual frameworks, psychoanalytical/psychodynamic and traditional systemic theories and practices, primarily from the Italian schools of family therapy. These theoretical frameworks have prevailed in the field of ED and pervaded the whole institutional fabric of specialized ED services. Needless to say, their tenets were not readily compatible with the philosophy of our and other MFT programs (see MFT principles and objectives below): 1. Families (mothers?) were considered responsible for the development of ED and needed to be repaired and/or their affected children had to be protected from their negative influence; 2. The ED symptoms were the “tip of the iceberg” and psychotherapy (whichever form it took) was useless unless it targeted the root causes of the disorder; and 3. Evidence-based approaches and clinical research as a whole were not appropriate in the field of psychotherapy, which instead needed to be grounded in creative clinical expertise. If we add to these obstacles the reluctance French mental

[1] After training and supervision, the following ED units of university medical centers and private institutions are currently using the RF-MFT Model: Robert Debré Hospital, A.P. (Paris); Cochin Hospital, A.P. (Paris); Sainte-Anne Hospital, CMME (Paris); Fondation Santé Etudiants de France (Paris); Bellevue Hospital (St-Etienne); Saint Eloi Hospital (Montpellier); Salvator Hospital (Marseille); Saint-Vincent de Paul Hospital (Lille); CHU Rouvray (Rouen); Division Santé des Adolescents (CHU Lausanne, Switzerland). Several other institutions have been trained in France, Belgium and Switzerland, but it is not clear whether they are currently using RF-MFT in a sustained manner.

health professionals showed toward the concept of "therapeutic integration", indeed it took time and patience to get MFT accepted in our own institution and in others as well. Within this context, the reader may better understand the resistance the authors experienced from healthcare providers and therapists regarding the practice of multifamily meals (not to mention institutional issues of hygiene and practicality), and the lack of support for program evaluation. Indeed, the challenges we encountered also explain our own program weaknesses (see below).

On the positive side, these conceptual and cultural differences encouraged us to reflect on our own model, and to carefully identify and operationalize its key principles and objectives. It also sharpened our creativity and taught us the skills of patience and compromise. The progressive integration of our RF-MFT program into the treatment package of several specialized services highlights the acceptability of this model, as well as the teams' ability to question and transform their own institutional culture. Finally, these challenges compelled us to assess our strengths and limits within the framework of our double affiliation, to the French culture on one hand, and to the international clinical and research community on the other hand.

In this context, it was relatively easy to overcome more practical difficulties, such as the instability of our MFT therapeutic team (due to understaffing of care providers), or the challenges of opening and adjusting our program to siblings, to younger patients and to other treatment settings. As it turned out, our lingering sense of insecurity in these new settings was alleviated by the positive feed-back we accumulated from the participating families and from the teams we trained.

Program evaluation

As noted earlier, the evaluative component of our MFT program is preliminary and represents one of its weak points. We systematically encourage the teams we train to include some form of program evaluation in their protocol, but many of them have been hindered by their heavy clinical workload and funding difficulties, and the few that initiated some evaluation of their program have not yet published their results. We will briefly review the existing published and unpublished research literature in this area.

Between 2000 and 2013, approximately 215 families participated in our outpatient MFT program, with a dropout rate of 8% (18 families), most often taking place right after the first MFT session (C. Doyen & S. Cook-Darzens, unpublished material). We have no statistics on the refusal rates prior to entering a new MFT program, but they are likely to be low as well. These low attrition rates were probably influenced by the strong family orientation of our ED service, which made recruitment into MFT a sensible option within the overall treatment program.

Satisfaction surveys conducted between 2005 and 2011 (S. Cook-Darzens & C. Doyen, 2011, unpublished material) also yielded encouraging results. Attendance was generally exemplary, further reinforced by group members who took it upon themselves to encourage absent members to come back to the group. Sixty-seven percent of the parents and 60% of the patients pointed out the following interventions as "most helpful". With regard to group processes, mutual support, comparisons between families, and group/subgroup discussions obtained very high ratings; with regard to content-focused activities, family-oriented ones (communicational exercises, sculptures, family drawings, animal genograms and coat of arms), were highly appreciated. More ED-related interventions were understandably rated as more difficult and anxiety provoking (particularly by the patients), but as necessary. Sibling involvement was highly appreciated after initial reactions of strong parental reluctance, and 85% of the families asked for a higher frequency of "sibling sessions" (Cook-Darzens, 2009). According to the parents, it was the redeployment of family energies on healthy siblings that was considered most useful, while the patients stressed rebuilding sibling relationships that are damaged by the ED; and healthy siblings underscored the experience of being heard and validated. Findings from one of the teams we trained and supervised concur with these results (Fleuret, 2022).

With regard to symptom improvement, our team conducted a naturalistic controlled study (Doyen et al., 2012) involving 43 adolescents (13–17 years) with AN who, following inpatient treatment, were

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placed either in our usual outpatient treatment package (which includes some single-family therapy sessions) or in RF-MFT plus treatment as usual. Compared to the control group, the MFT patients had higher rates of comorbidity (69% vs. 36%) and hospitalizations (54% vs. 14%) prior to outpatient treatment. Weight progression was similar for both groups up to 6 months after discharge, but the MFT group reached a stable healthy weight at 12 months, while the control group showed significant weight deterioration. Parental self-efficacy was also higher in the MFT group and conflicts around meals were reduced. To the extent that MFT patients suffered from more severe AN, with higher risks of chronicity and relapse, these preliminary results are promising but they need to be replicated with a more rigorous methodology.

PRINCIPLES AND OBJECTIVES

Our RF-MFT is guided by the following principles

(a) Whenever possible, priority is given to outpatient care, which preserves young patients' psychosocial development and their family life cycle; (b) All families confronted with AN are potential candidates for a multifamily approach; (c) Both family and group are considered powerful agents of improvement and recovery; (d) Accordingly, therapeutic interventions rely strongly on family/group resources and skills. Families are involved as cotherapists and the group as a whole is guided toward the creation of a contained and secure therapeutic community; (e) Therapists' interventions are supported by existing evidence on the role of the family in ED and on the effectiveness of both FT and MFT.

Resulting objectives are as follows

(a) Overcome feelings of social isolation and stigmatization, and create an atmosphere of security, solidarity and support between families; (b) Get acquainted with the disease: recognize it, understand it and accept it. This involves developing shared knowledge and narratives, facilitating family members' empathy toward the patient and encouraging illness attributions that contribute to feelings of efficiency, mastery and hope; (c) Address families' experiences of the disease as normative processes, promote mutual learning, exchanges of experiences and openness to new and multiple perspectives, all of which facilitate change; (d) Help parents form a strong cohesive parental team, and help the family develop specific skills in communication and problem solving, as well as attitudes and behaviors that create optimal family adjustment to the illness; (e) Reorganize dysfunctional family dynamics (pre-existing or not) that can hinder the recovery process, and help the family maintain or regain a normal developmental trajectory; (f) Stimulate self-reflection in the presence of others and promote self-confidence; (g) Encourage and maintain an attitude of hope and realistic optimism, through the diversity of families' trajectories toward recovery, and the narratives of healing provided by more experienced or "graduate" families; (h) Build and maintain a constructive alliance between the therapeutic team and the families.

STRUCTURE AND CONTENT

RF-MFT program

Our program generally follows 5 phases (18–24 sessions), with distinct objectives and activities for each of them. Most of the activities are presented in three publications, including a manual developed for research purposes (Cook-Darzens, 2007, 2022; Duclos et al., 2021), with detailed descriptions of

their objectives, instructions and possible alternatives. We wish to emphasize that our program does not rely on a therapeutic manual per se, but rather on a fluidly organized toolbox, which preserves flexibility and creativity while maintaining the evolutionary framework deployed in Table 1. It is also important to stress that the techniques and activities described here are intended to support specific therapeutic processes that go beyond the content of the program.

Most MFT programs generally try to balance content- and process-oriented work, as well as verbal and nonverbal approaches. This diversity echoes the conceptual diversity that underlies MFT and the creativity of the therapists, who can decide to invent new exercises to suit group profile, family needs and problem requirements. Three techniques that are unique to the structure of MFT support the activities listed in Table 1: the creation of subgroups (*fish in the bowl* and simultaneous subgroups), the practice of interfamily crossings (including temporary adoption) and the creation of fictitious families in various forms. All three promote listening and empathy, intra- and interfamily exchanges, and the experience of new perspectives and relationships. Other key activities, such as the practice of externalization and the mobilization of family resources, are drawn from the classic repertoire of various schools of single FT (Cook-Darzens, 2014). The clinical vignettes below illustrate some of these techniques and activities.

Bi-weekly session structure

Going around the group

The session generally starts with everyone briefly giving their state of mind (thoughts, feelings, questions) and highlighting progress made and difficulties encountered since the previous session. For 3-h sessions like ours, this moment of temperature-taking must be structured and restricted in time.

Psychoeducation

During the first phase of MFT, structured interactive discussions are organized on topics chosen by the therapists and the families. These generally revolve around specific aspects of EDs (causes, treatments, outcome) and the role of the family in recovery. Families' illness beliefs are systematically explored, with the aim of fostering a sense of mastery and hope, as well as modifying counterproductive coping strategies. As the group evolves, more informal discussions also take place, taking the form of "brief psychoeducational moments" that provide information on issues that arise spontaneously in the group. These moments are appreciated by the families because of their brevity and their relevance at a given time.

A break in the middle of the session

It gives families an opportunity to exchange outside the presence of the therapists and to handle snacks without team supervision, while the therapeutic team discusses specific group issues and if necessary, readjusts its role or the choice of the activity that follows.

The activity itself

In accordance with the objective(s) of the session, the activity must always be followed by a large group discussion. Both activity and group exchanges are meant to facilitate group processes by offering multiple perspectives (between different families, family roles, generations, genders, medical

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status…), and provide opportunities for mutual learning and trying out new patterns of relating and coping.

The closing of the session

It is marked by a summary of the session's salient points, a possible reminder of the tasks prescribed for the following days, an invitation for each participant to give their state of mind in one word, and sometimes a relaxation exercise.

The role of the therapist changes a great deal, both within each session and over the course of the MFT program. This has been well described by Asen and Scholz (2010) who depict MFT therapists as multipositional and *roving*, for example getting close then distancing themselves, being active then observing, being very directive then *gliding* above group processes. Over time, therapists also move from a central and containing role during the first sessions, to being more peripheral during the latter part of the program. Several studies on MFT processes also encourage therapists to reinforce specific types of interactional patterns (notably interfamily *and* intergenerational ones), identified as powerful change mechanisms (Cook-Darzens et al., 2018; Gelin et al., 2018).

DESCRIPTION AND ILLUSTRATIONS

First phase: Affiliation and psychoeducation

Getting to know each other: Techniques of interfamily crossings and cross-parenting

Several techniques help to *break the ice* when starting a new group: the roll-the-ball game, cross-presentations involving two families, cross-fostering or temporary adoption, according to precise instructions, for example *"take twenty minutes to get to know each other without talking about AN"*. Other examples of ice-breaking exercises can be found in Asen and Scholz (2010) and Cook-Darzens (2022).

Getting acquainted with AN

A better understanding of AN is essential for recovery. During the first MFT sessions, psychoeducational guidance, conducted in an interactive and informal manner, is provided on AN, emphasizing circular influences between family and illness, as well as the role of the family in illness outcome. As mentioned above, more subjective factors such as *belief systems* are systematically explored, with the goal of redirecting feelings of powerlessness and hopelessness toward *illness attributions* that promote a feeling of mastery and contribute to maintaining a sense of family identity that integrates the illness without being invaded by it.

RF-MFT Session 2: A paternal model of beliefs regarding AN

One of the goals of this parent group component of the MFT program was to explore the meanings each parent ascribed to their child's illness. Patients were engaged in the same activity in their own group. Various explanations, or illness messages, were initially proposed by the parents and written down on a flipchart. We noted that most of them referred to causes which either could not be changed (e.g., the media, society, genetic vulnerability), or which parents considered modifiable to various

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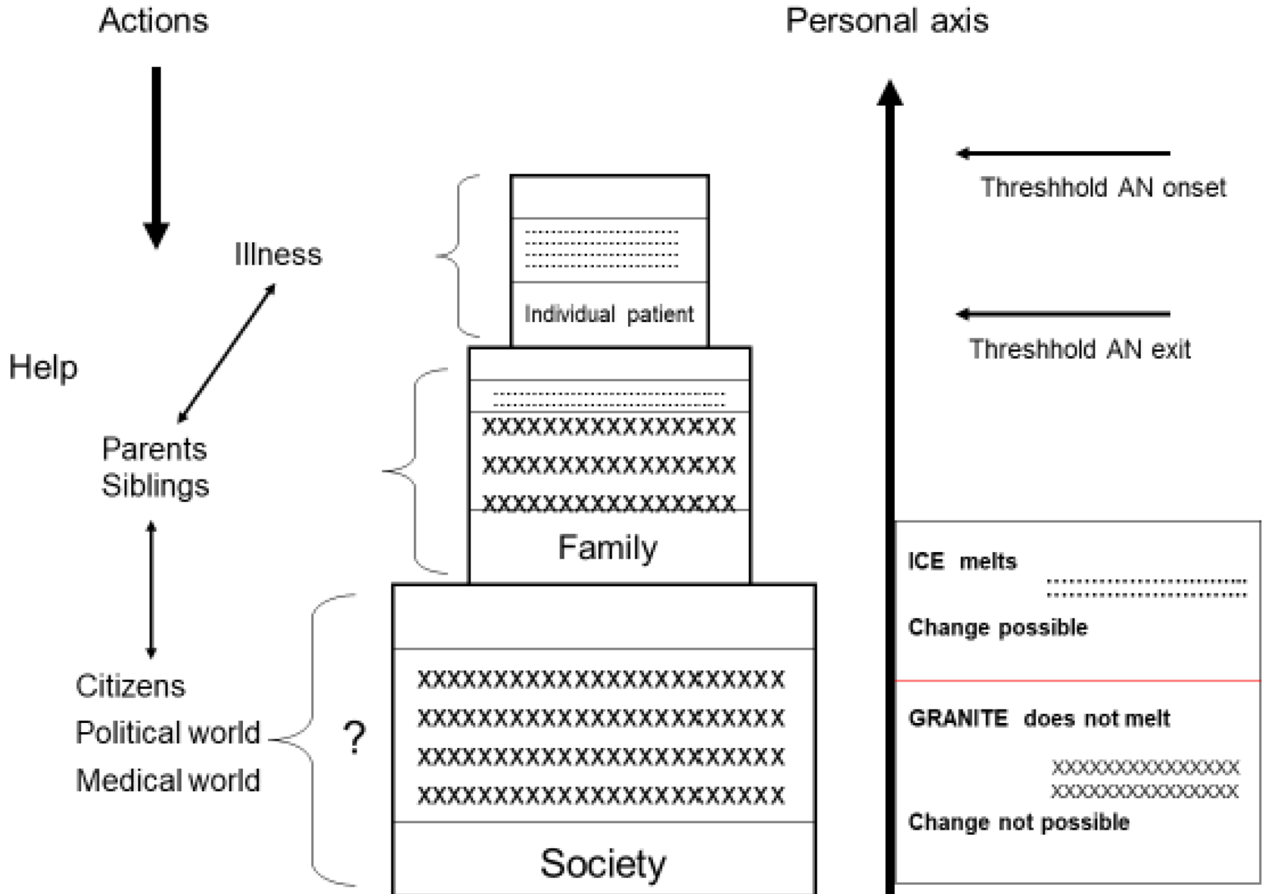
degrees (family functioning, patient behaviors, etc.). This observation inspired one of the fathers, Mr. T. (whose 15.5-year-old daughter suffered from restrictive AN), to conceptualize the following explanatory model of his daughter's illness, which he drew very rapidly on the flipchart (Figure 1).

Mr. T. represented three areas of influence in the development of his daughter's illness, stacked in order of decreasing importance: society, the family and the individual patient. Within each domain, he drew layers either of ice, which could melt and lower the anorexic pyramid toward the threshold for recovery, or of granite, which could not melt and remained unchanged. If enough ice melted in the different domains, the pyramid collapsed and the threshold for leaving AN was reached. According to him, society was mostly made of granite, that is, unchangeable; the family was made of both, but more of granite than ice; and the individual was mostly made of ice. In other words, the individual was more responsible for getting out of AN than the family, although he/she had paradoxically been the least influential factor for getting into AN. This pyramidal model, which Mr. T. thought to be generalizable, sparked heated exchanges within the group, marked by sharp disagreements regarding the relative importance of ice and granite in the family and other areas of influence. The group conclusion was that the family domain did comprise a substantial layer of ice and could also act on the individual patient, on society and on the media. The parents unanimously decided to present this "explanatory diagram" to the MFT group the following week, to get their daughters' reactions.

This welcome initiative generated new feed-back and perspectives, as the adolescents seized this opportunity to identify the nature of the ice in their respective families and in themselves. A *fish in the bowl* with a family helped a young patient verbalize her expectations of support from her family



AN: anorexia nervosa

FIGURE 1 Family beliefs regarding AN: A father's conceptual model. AN, anorexia nervosa.

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and specify the form parental guidance could take. She also took time to reflect on her own possible contributions to melting her layer of ice.

This clinical illustration vividly highlights how MFT group members can intervene in potentially dysfunctional family beliefs and shape them into more empowering and hopeful attributions. The resulting multilevel exchange probably had more psychoeducational impact than the presentation of our own "truths", as it allowed the group to discover and reflect on the advantages and risks of different belief systems.

2nd phase: Motivating for change and mobilizing family resources

Here we draw on all the techniques of externalization and mobilization of family resources that are part of family therapists' repertoires, particularly those with a narrative orientation (Dallos, 2006). We also adapt various motivational exercises from cognitive-behavioral therapies, such as writing letters to *AN friend and foe*, reflecting on the *pros and cons of illness/change*, or *pie charts* (*"how much space does AN take in your family/personal life?"*). Several publications offer a large number of them (Asen & Scholz, 2010; Cook & Doyen, 2008; Cook-Darzens, 2014, 2022; Simic et al., 2022).

Exploring family resources

Two activities, the health-illness genogram (Rolland, 1994) and a semidirective interview on family resources (Cook-Darzens, 2014), explore families' histories of coping with illness, loss and adversity in general. They are useful in highlighting specific family skills in relation to particular types of illnesses (for ex., somatic versus psychological difficulties), and their relevance to the current situation. Another activity, the family protective shield (Simic et al., 2022), is more focused on current family resources in relation to ED. It consists of creating, as an individual family, a shield on which members of the family draw and/or write the strengths, resources, skills, and family qualities – current or inherited from previous generations – that the family can rally in its fight against AN. A family is then placed in the fishbowl and describes its shield. Each family member is encouraged to choose at least one of the family qualities from the drawing and give a specific example of it. This exercise is highly appreciated by the families.

RF-MFT Session 5: Love as a shield

Manon, 18 years old, is an only child who was adopted at the age of 3 months into a cohesive and warm family. She lives with her parents and her maternal grandmother. She has struggled with restrictive AN since the age of 13 and was hospitalized several times. Manon feels very guilty about her illness because of the constant conflicts it creates in the family. Her mother describes herself as the primary caretaker while her father says he tends to overwork to avoid participating in the management of Manon's illness. Both parents acknowledge they have not been able to form a coherent parental team since Manon became ill, and also disclose significant conflicts between the mother and the grandmother, mainly around the handling of mealtimes. Manon's family was placed in the fishbowl. Among the family qualities written on the family shield represented as a radiant sun (Figure S2), Manon chose family festivities and get-togethers with her friends and cousins. She said she was very sociable before she fell ill. Her mother chose perseverance and determination (to help her daughter), efficiency and hope. Her father chose lucidity and self-reflection, qualities that helped him acknowledge the fact that, so far, he had not adequately supported his wife nor helped his daughter overcome her eating difficulties. He was aware that his wife was exhausted but did not know how to join her in the fight

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against AN. The grandmother chose freedom as she thought the illness had paralyzed the family in "all its movements".

After the other families presented their shields, most of the parents expressed the wish to address what they felt to be a shared experience of paternal avoidance and maternal overprotection. Young patients, on the other hand, expressed a specific interest in discussing their social needs and fears. After a group discussion, carried out in the calm and secure context created by our initial exploration of family resources, tasks were proposed to both parents and young people. For instance, Manon was encouraged to join her cousins the following weekend, preferably outside mealtimes or by bringing her own "lunchbox"; other adolescents followed suit; fathers were asked to participate in at least one meal during the following week and then take the time to discuss with their wives common meal management strategies. During this session, strong mutual support was provided along generational lines.

3rd phase: Family-illness interactions, finding optimal adaptation to the illness

New models of family work with EDs emphasize the importance of helping the family find an optimal adaptation to the disorder, an adjustment that is neither accommodating/enabling nor hostile, neither too distant nor too protective, neither avoidant nor overly directive. Using animal metaphors drawn from Treasure's work (Treasure & Alexander, 2013), the animal genogram exercise helps to explore family members' dominant style of adjustment to the illness (over two or three generations), and to identify relational vicious circles that must be interrupted because they may maintain or aggravate the illness in the long run. The objective is to promote a calm, coherent, empathetic, firm and graduated style of coping (dolphin and/or Saint-Bernard) and to move away from styles that are avoidant (ostrich), overprotective (kangaroo), authoritarian and rigid (rhinoceros), aggressive (tiger) or overly emotional (jellyfish). This activity has already been described and illustrated elsewhere (Cook-Darzens, 2014) and proves fruitful in various forms and stages of family work.

RF-MFT Session 8: The « Jellostrich »

Participating families were organized in simultaneous subgroups of fathers, mothers, patients and siblings, each person creating his/her individual family genogram within their subgroup. This diverged from our usual practice of conducting this activity with individual families. Lylia's (16 years old) and Romain's (15 years old) genograms are quite representative of the patient subgroup productions (Figure S3).

The jellyfish (strong emotional reactions) and the ostrich (avoidance) were overwhelmingly selected by the young patients to describe their own dominant style of coping with the illness. Such metaphorical convergences encouraged them to identify and name their dominant emotions, unspoken until then yet very intrusive: guilt, sadness, anxiety, anger and the impulse to harm themselves. The "jellostrich" (*médautruche*), as Lylia called her own mode of adaptation, summarizes well the youngsters' emotional experiences. Discovering common strategies undoubtedly helped them legitimize experiences that had until then been difficult to accept and put into words. Parents and siblings alike were attuned, empathetic and accepting, thus further helping the adolescents feel safe and understood. Before closing the group, families were regrouped to discuss family members' animal genograms, and possibly identify their most counterproductive modes of adaptation to the illness.

4th phase: Working on family relationships and identity

This phase, which involves siblings, is an essential module of our program. It seeks to improve aspects of family functioning (pre-existing or not) that may hinder recovery or contribute to a relapse, and

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to strengthen family competencies that will help them get back on a more normative developmental course. It also seeks to help families reclaim their identity, one that acknowledges illness-related changes yet maintains a sense of shared family values and purpose. Families appreciate this family-oriented module and significant family reorganization often takes place during this period. For this purpose, many techniques from different schools of individual FT can easily be adapted to the MFT context (Cook-Darzens, 2014; Dallos, 2006); MFT manuals or inventories also offer creative family-oriented interventions (Asen & Scholz, 2010; Cook-Darzens, 2022; Duclos et al., 2021; Simic et al., 2022). These facilitate the exploration of a family event, a family trajectory (past or future), a family map, or broader issues of family identity, relationships and emotions, intergenerational transmissions of attachment patterns, etc. The following family sculpture illustrates the unique ramifications of its use in an MFT context.

Family sculptures[2]: Creating real/fictitious families

These favor the body language and provide access to experiences of essential family relationships and underlying family myths. Three moments of family life are generally explored (before, during and after the illness), opening the family to a developmental process that is frequently paralyzed by the illness. In its fictitious version, a participant (most often the patient) silently sculpts their own family relationships with a father, mother, brother, patient, etc. chosen from different families. Externalized AN (personified by a participant or therapist, or symbolized by an object or a puppet) can also be added to the current and future family sculptures. In our experience, this activity always enlists important family/group energies and emotions, positive or negative. It undoubtedly owes its powerful impact to the fact that the sculptor feels freer to sculpt a fictitious family than his/her own. The real family can also observe at a distance (yet with much emotion) its own functioning as it is experienced by their child. Finally, other families (including the fictitious family) echo this experience, thus stimulating multiple perspectives and intensifying new interactions and experiences. In this particular use of family sculpting, exploration of participants' reactions generally starts with the fictitious family, then the real family, finally the wider group.

RF-MFT Session 15: Sculpting past, present and future

Clémence, 13 ½ years old, has recently developed a severe episode of AN. She is the youngest of three siblings, including an 18-year-old brother and a 16-year-old sister. The family is intact, parents are cohesive and warm. The father nevertheless struggles to find his place in a family that is highly organized around the illness. The first fictitious family sculpture created by Clémence depicted marked family closeness *before the illness*: the family was placed in a circle, all members being physically very close. The second sculpture (*during the illness*) mainly expressed isolation, sadness and conflict. The father was noticeably isolated from the rest of the family, while the other members were conflictingly concentrated, not on Clémence but on a personified "Miss Anorexia" (chosen by Clémence among group members). During the third sculpture (*3 years after the illness*), siblings were reunited, parents as well, forming two clearly distinct subsystems turned toward one another. AN was no longer in the picture. The fictitious family's reactions were interesting. The fictitious father expressed deep frustration at being isolated from the rest of the family in the second sculpture, and felt powerless providing support to the rest of the family, particularly to his daughter. Marked externalization of the illness by the rest of the family also left Clémence isolated as an adolescent and made her feel sad and abandoned. Reactions from the "real" family also brought out strong emotions. Watching the second sculpture, parents were very distressed, especially the mother, because they did

[2]A visual and spatial representation of the family by silently positioning each member according to positions, expressions, behaviors and distances (horizontal and vertical) that reflect the usual family interactions.

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not realize their daughter experienced so much loneliness at home. Clémence then proposed to create a new second sculpture, this one of her own family as she would like it to be *now*, still in the presence of AN. In this second scenario, Miss Anorexia firmly held Clémence in her arms, preventing her from moving and participating in family life. Both parents strived together to separate her from Miss Anorexia, while the brother and sister reached out to her, but from far away. This corrective script obviously helped the family define new reachable relational goals, which were ill-defined until then. Throughout the session, the emotional reactions from the rest of the group were strong and several families expressed a wish to reorganize some aspects of their family relationships as well.

Use and limits of externalization

These sculptures are a good illustration of the limits of a systematic use of externalization at a time when adolescent processes are beginning to emerge. Indeed, in the *now* scenario, Clémence's family is busy trying to destroy AN, leaving Clémence voiceless as an adolescent person. In the scenario of an *ideal now*, another aspect of this question is highlighted by the role Clémence attributes to her siblings: her older brother and sister still stand far away from her but try to reach out to her, specifically showing her the path toward adolescence. These two sculptures of family life during the illness allowed Clémence to stage and express essential relational and identity issues she had been experiencing without being able to verbalize them. She was also able to pave the way toward the sculpture of the *future* (healthy but too distant) by introducing an accessible and appropriate intermediate step.

5th phase: Journey toward recovery, relapse prevention, and end of MFT

Metaphorical collage of the family's journey toward recovery

This is a useful exercise at this stage of MFT. Each family is asked to create a family collage that portrays its journey since the beginning of the illness, showing where it currently stands and what the remainder of the journey toward recovery will look like (Cook-Darzens, 2022). Family members also prepare the toolbox they think is needed for their journey and a worry box containing their anticipated difficulties. Themes of crossing an ocean are frequent, depicting drifting rafts caught up in extremis by a medical and/or family boat, or boats rowing with two oars after having rowed with only one. Themes of identity transformation are also often evoked (a chrysalis transformed into a butterfly). This exercise helps families put the illness in perspective and derive pride and reassurance from the changes they have already accomplished. It also helps them identify their strengths and anticipate future challenges. Finally, it sheds light on the diversity of possible journeys toward recovery, and on each person's definition of recovery.

RF-MFT Session 19: Going up and down the volcano

Jade, 14 years old, is an only child from a single father family. She and her father built a three-dimensional volcano and described in great detail both Jade's proud climb to the top of the volcano, her fall into the crater and her inability to get out of it for many months (Figure S4).

Fortunately, says the father, "*hospitalization was like a centrifugal force that expelled her from the crater. Now she is on the edge of the crater and we can put happier things in it: a watch, blue skies and a castle*". Jade continues: "*Now, I have to walk all the way down to a normal life, my friends, my family. I still have quite a ways to go and I don't know if I can make it and which way to go! And you know, lava is hard to walk on and it hurts my feet*". This striking creation helped the patients discuss their own fears regarding the rest of their journey (not having the energy, not having the right tools,

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getting lost) and specify what they needed in order to "make it". It also vividly portrayed differences between parents' and patients' views on the recovery process, a potential source of disconnection in family relationships.

Several goodbye rituals are described in MFT manuals, such as organizing ceremonies, or bringing photos and family heirlooms (Asen & Scholz, 2010; Simic et al., 2022). We prefer to organize these last moments in a spontaneous and collaborative way, and let the families decide on the content of the last session. Of course, this can lead to surprising moments: one group decided to feed the team and the group by bringing their favorite recipes!

DISCUSSION AND CONCLUSION

To our knowledge, the formalized Relationship-focused MFT program described in this article is the first of its kind in France and other French-speaking European countries. Over the past 22 years of its use and dissemination, the model has evolved a great deal, drawing on many different theoretical and clinical sources and being constantly enriched by training, supervision and collegial collaboration. But thus far, this protocol and other derived RF-MFT programs have not gained the same visibility and "legitimacy" as ED-focused programs, which are now well-established thanks to manualization and rigorous clinical research (Baudinet et al., 2021, 2022). Several challenges contribute to this delay. Powerful cultural (philosophical) and institutional factors have already been mentioned in the background section of this article. Other factors pertain to the unique challenges associated with the assessment of systemic processes. Indeed, such processes are likely to be more difficult to identify and operationalize than the more symptom-oriented interventions, which guide ED-focused MFT, and the links that can be hypothesized between RF-MFT and illness outcome are also more ambiguous and indirect. The long recursive process Pote et al. (2003) followed to create a systemic FT manual is a good example of this. In the cultural context we described earlier, these complexities can only be addressed by clinicians who are both expert practitioners and clinical researchers, a condition that will require the resolution of a second obstacle. Indeed, most systemically-oriented family therapists in France are neither trained nor encouraged to use an evidence-based or -supported approach to their practice, and even less to engage in an evaluation of their own programs. Interestingly, their systemic masters and mentors, notably from the Italian schools of FT, only began evaluating their family practice late in their professional lives, and only reluctantly so (L. Onnis, 2011, personal communication). In addition, in France, clinical researchers have a difficult time being integrated into clinical teams, in spite of recent regulations that encourage moving in this direction. This significant and persistent gap between clinical practice and clinical research, aggravated by funding and structural issues, could be addressed in the following ways: make research more "user friendly" for clinicians, systematically include clinical research in the training of family therapists (and of clinical psychologists in general), encourage joint forums through conferences (such as the European Council of Eating Disorders) and publications, and more generally encourage clinicians to formalize their conceptual frameworks and practices (see Cook-Darzens, 2014, for further details on this topic). These goals are ambitious and will take time to implement but they are feasible.

In this somewhat challenging context, it is nevertheless worth stressing that several findings on both ED-focused and Relationship-focused FT and MFT models have produced encouraging results for adolescent ED, including qualitative research and studies on family wellbeing as a factor of symptom improvement (Agras et al., 2014; Depestele et al., 2017; Doyen et al., 2012; Eisler et al., 2016; Gelin, Fuso et al., 2015; Gelin, Simon et al., 2015; Godart et al., 2012, 2022). One ongoing study[3] comparing family-oriented MFT with FT (Carrot et al., 2019) will also add to this growing body of evidence. In addition, direct comparisons between conceptually contrasted MFT

[3]The authors of this article are participating in this multisite study (ThéraFamBest) as researchers, trainers and supervisors.

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programs would usefully inform our understanding of unique change mechanisms in MFT, particularly with regard to format (including duration and intensity of treatment), therapeutic focus (ED- vs. Relationship-focus) and specific content (such as the inclusion of multifamily meal sessions). In doing so, distinct indications for particular forms of FT/MFT may emerge, depending on patient, illness and family characteristics. This type of research, which has been conducted in the field of schizophrenia (cited in McFarlane, 2016), could readily be transposed to ED, contrasting for example a highly relationship-focused MFT program, such as Tantillo's relational-motivational MFT program (Tantillo et al., 2021), with a behavioral ED-focused one such as Simon's FBT-based MFT protocol (Simon et al., 2022). For the same purpose, qualitative research on essential MFT contents and change processes are also needed. Overall, this type of evidence will not only make the case for MFT more compelling, it will also provide therapists and families with a greater diversity of therapeutic choices, based on both evidence and preferences.

In addition to the high acceptability of our RF-MFT model within the French culture, its relatively long-time frame (18–24 sessions) seems to offer an ideal context for working on several family issues, such as gender roles, the long-term impact of externalization, family burden and grief, as well as broader individual and family life cycle issues. In recent years, there has been growing interest in the unique contributions of fathers and mothers to their AN child's recovery, and the impact of the recovery process on parental functioning (Depestele et al., 2017; Duclos et al., 2014, 2018; Maine, 2013). The flexible use of subgroups organized around family and gender roles gives ample and repeated opportunities to explore, amplify or de-emphasize these parental differences. The clinical vignette that illustrates Phase 2 of our program is a good example of this type of work. Likewise, our time frame facilitates careful and modulated use of externalization over time, as illustrated in Phase 4 of our MFT program, as well as an increasingly insight-oriented use of it (Lonergan et al., 2021), which targets specific features of ED (perfectionism, anxiety…) rather than the whole illness. Finally, the duration of our MFT program, as well as the diversity of illness durations and stages of recovery that generally characterize MFT groups, make it more feasible to adopt a longitudinal developmental perspective on those specific life cycle issues and risks that are at play when an illness such as AN exerts an *inward pull* on the family at a time when the *outward pull* of adolescence should prevail (Rolland, 1994).

Overall, the French RF-MFT model was developed within a particular cultural context, which is marked by a long tradition of psychodynamic and pure systemic theories and practices, coupled with great discomfort with illness-focused family practices. Both ED-focused and RF-MFT models are embedded in a systemic perspective, but are also characterized by substantial conceptual differences regarding therapeutic objectives and targets, therapeutic intensity and time frame (see Table S1), whose relative importance still eludes us. As a first step, this issue may be more easily addressed through a research-informed approach guided by the following questions: Are there *common therapeutic processes* that are shared by all MFT applications to ED (unique to the multifamily structure and context)? *How* does a particular MFT program work (what are its distinctive "active ingredients")? *For whom* does it work best (what are its specific indications in terms of patient, family, and illness characteristics)? In what *treatment setting* (outpatient, inpatient, daycare, etc.) is it most efficient, and with *what status within the overall treatment program* (as a stand-alone or adjunctive treatment; as a distinct family treatment or associated with FT)? Answers to these questions will increase our understanding of the impact of various therapeutic foci in MFT, therefore, facilitating its adoption in various treatment settings. There is room for all models of MFT, as long as the model developed is supported by conceptual, institutional, clinical and evaluative considerations.

ACKNOWLEDGMENT

We thank all the families and professionals who helped us design, implement, evaluate and improve this therapeutic protocol over the years. We are particularly grateful to the various teams who adopted the RF-focused MFT model and used it as a tool for institutional change.

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FUNDING INFORMATION

The authors received no specific funding for this work.

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How to cite this article: Cook-Darzens, S., & Duclos, J. (2022). Development and implementation of a relationship-focused outpatient multifamily program for adolescent anorexia nervosa. *Family Process*, *00*, 1–20. https://doi.org/10.1111/famp.12826

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