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Title	Externalisation in family-based treatment of anorexia nervosa: The therapist's experience
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Publication date	2021-12-13
Original Citation	Lonergan, K. Whyte, A. and Ryan, C. (2021) 'Externalisation in family-based treatment of anorexia nervosa: The therapist's experience', Journal of Family Therapy, 44(3), pp.351-369. https://doi.org/10.1111/1467-6427.12380
Type of publication	Article (peer-reviewed)
Link to publisher's version	10.1111/1467-6427.12380
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Externalisation in Family-Based Treatment of Anorexia Nervosa: The Therapist's Experience

Journal:	*Journal of Family Therapy*
Manuscript ID	JFT-2021-0037.R3
Wiley - Manuscript type:	Original Article
Keywords:	Externalisation, Family-Based Treatment, Anorexia Nervosa, Eating Disorder, Clinician Research

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Abstract

Family-Based Treatment is an evidence-based treatment for adolescent eating disorders that incorporates many principles from family therapy. It uses the externalisation of anorexic thoughts and behaviours to separate the person from the anorexia nervosa (AN) through language and metaphor. Little is known about how clinicians understand, conceptualise and support families to externalise. Semi-structured interviews conducted with FBT trained clinicians working in child and adolescent mental health services were analysed using thematic analysis. Three themes emerged: the clinician's use of externalisation, the impact on family functioning, and the barriers to externalisation. Externalisation can support a young person's recovery from AN when used in conjunction with other therapeutic skills. Clinicians should be aware of potential barriers to the implementation of externalisation, such as problem awareness, age, and duration of illness.

Practitioner Points

- Clinicians value externalisation as an important therapeutic technique within the FBT model, while acknowledging that the 'ED-as-illness' metaphor can challenge their own beliefs
- Externalisation can improve family functioning, family communication and reducing conflict within relationships in families with AN
- Lack of insight into the AN can present as a barrier to externalisation for a young person

Keywords: Externalisation; Family-Based Treatment; Anorexia Nervosa; Eating Disorder; Clinician Research

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Introduction

Eating Disorders (ED) such as anorexia nervosa (AN) are serious mental health conditions that cause significant physical and psychological distress for a young person (YP) and their family (Schaumberg et al., 2017; Wufong et al., 2019). The onset of an ED is typically during adolescence (Andrés-Pepiñá et al., 2020) and early intervention leads to better outcomes, including lower relapse rates and hospitalisation (Hay, 2015). The use of family therapy for adolescents with anorexia nervosa has been supported by several RCTs (Geist et al., 2000; Godart et al., 2012; Lock et al., 2010; Whitney et al., 2012) and systematic reviews (Fisher et al., 2019; Watson & Bulik, 2013), and anorexia-nervosa-focused family therapy (FT-AN) is recommended as a first-line treatment in the current NICE guideline (NICE, 2017).

FT-AN developed from a series of studies conducted at the Maudsley Hospital/Institute of Psychiatry in the 1980s (Eisler et al., 2015). Early work drew from ideas in structural family therapy, such as strengthening the parental subsystem to enable the parents to take control of their adolescent's food intake and treating the family as a resource to be mobilised (Dare et al., 1990). FT-AN also built upon the etiological agnosticism of strategic family therapy (Watzlawick, Weakland, & Fisch, 1974), with a view that developed over time that the focus should shift from explanatory models of AN towards maintaining factors (Treasure & Schmidt, 2005). Family functioning may act as one of these maintaining factors in anorexia nervosa, as in many other chronic medical and mental health conditions, through reorganisation around the illness (Steinglass, 1998). Assisting the family to re-examine their relationship and priorities around the illness can be done in a non-pathologizing way, as the focus is no longer on the cause but rather the understandable efforts made by the family to cope with this crisis in their lives (Steinglass, 1998). The later stages of

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FT-AN address these issues of individual and family development, life cycle family issues (Jewell et al., 2016) and aim to increase the adolescent's autonomy.

Family-Based Treatment (FBT) (Lock et al., 2001) is a manualised therapy that was based on the approach to family therapy developed at the Maudsley Hospital, and also drew on wider ideas from family therapy. FBT has demonstrated positive treatment outcomes for adolescents presenting with AN (Agras et al., 2014; Doyle et al., 2010; Le Grange et al., 2012; Lock et al., 2010; Lock et al., 2015; Madden et al., 2015). FBT consists of three phases of treatment: 1) charging the parents with the task of re-nourishing their child to a state of health; 2) return of responsibility for independent eating to the adolescent in an age-appropriate way; and 3) re-establishing healthy independence for the adolescent (Lock & Le Grange, 2013). Underlying these phases of treatment, FBT adopts several core principles from FT-AN, including an agnostic view of the ED; a focus on the symptoms of the ED in the initial phase of treatment; and a non-authoritarian clinical stance. It also includes externalising the ED as an illness or external force impacting the family (Lock & Le Grange, 2001).

Research on FBT effectiveness has identified better outcomes for younger adolescents, those who have a shorter illness duration, those who respond early to treatment through rapid weight gain and those who do not have a comorbid psychiatric condition (Agras et al., 2014; Le Grange et al., 2016; Lock et al., 2006b; Lock et al., 2016). Furthermore, high levels of parental confidence in initial sessions predict positive treatment outcomes (Darcy et al., 2013; Dimitropoulos et al., 2017; Lock et al., 2006a; Lock et al., 2006b). When comparing FBT to individual therapy, no differences were found in full remission at the end of treatment, but FBT was superior at both 6- and 12-month follow-up (Lock et al., 2010).

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In Ireland, the National Clinical Programme for Eating Disorders published a comprehensive Model of Care (MOC), which proposed that all people with eating disorders should be given the opportunity of a trial of first-line evidenced-based treatment. It recommended that clinicians have access to adequate training and supervision to support their provision of treatment with high levels of fidelity to the treatment model. For adolescents with anorexia nervosa, the first-line treatment recommended in the MOC is FBT or FT-AN. In 2015, Professor Lock trained 66 clinicians in FBT in Ireland to ensure that every Child and Adolescent Mental Health team in the country could offer FBT to young people with AN. After they completed the initial FBT training, clinicians were provided with the opportunity to attend an FBT supervision group once monthly to support their delivery of care.

While FT-AN and FBT are now recommended treatments for adolescents with AN, more than half of those undergoing this treatment do not recover to the ideal body weight (IBW) of 95%, one commonly used measure of remission in AN (Agras et al., 2014; Couturier & Lock, 2006; Le Grange et al., 2016). Moreover, dropout rates of 20% have been reported (DeJong et al., 2012; Lock et al., 2010). While much research has focused on the FBT model efficacy and fidelity, less has focused on the core principles and interventions, including externalisation, that constitutes the model (Wufong et al., 2019). Work with transition-aged youths (TAY; 18-21) suggests that clinicians may apply the model in different ways to account for developmental differences across age groups. For example, when using externalisation with TAY, some clinicians reported using insight-oriented externalisations rather than visual representations of the externalised AN used with younger people (Dimitropoulos et al., 2015).

Externalisation is a core family therapy technique that was most clearly articulated within the narrative therapy work of White and Epston (1990), and the process of externalising AN, in particular, began to emerge in the late 1990s, sometimes described

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explicitly as externalisation (Madigan, 1996; Madigan & Grieves, 1997; Dallos, 2001), but at other times appearing implicitly in the wording of therapist case reports, such as "It is the anorexia that makes her hide food... it is the illness that gets your daughter to do all these things" (Le Grange, 1999). Externalisation was given a central role in FBT in the development of the treatment manual (Lock et al., 2001). Some have argued that the process of being labelled with an eating disorder leads to feelings of shame, blame and guilt (White, 2000) and can encourage the person to adopt the identity of the ED (Weber et al., 2006). However, there is also evidence that many young people have a positive identification with AN and experience AN beliefs as ego-syntonic (Griffiths et al., 2015). The primary aim of externalisation is to reduce both the YP and parents' blame and guilt related to the ED. Within FBT, externalisation aims to create a separation between the AN and the YP (Lock et al., 2001), which is primarily achieved using language, metaphor, and visuals. For example, a clinician will initiate conversations with the family, which linguistically separates the YP (their achievements, hopes and goals in life) from the ED (Weber et al., 2006). Viewing the AN as an illness is the most prominent strategy used to externalise in FBT and involves encouraging the family to consider the AN as a disease that has taken control of the YP (Lock et al., 2001). Parents are encouraged to view their child's AN behaviours, emotions and thoughts as resulting from the impact of starvation on the body and as being out of the young person's control (Lock et al., 2001); while YP is supported to view their AN as separate to themselves, and to reflect on the impact of the ED on their lives from this position of separation (Lock et al., 2001). The rationale for externalising the AN is to support the family to view the AN as a "quasi-external force" or "oppressive voice" (Downs & Blow, 2013) rather than an intrinsic part of the young person. This therapeutic shift supports the family to find new meaning in the physical, psychological and behavioural aspects of the AN and

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contributes to parental empowerment, an area identified as essential to recovery by clinicians (Dimitropoulos et al., 2015; Dimitropoulos et al., 2017; Lock & Le Grange, 2013).

While no research has focused solely on the technique of externalisation, client's experiences of FBT have been explored, and externalisation has been highlighted as being an important technique (Lock & Le Grange, 2013; Medway & Rhodes, 2016; Williams et al., 2020; Wufong et al., 2019). YP report that externalising the AN as an illness within FBT facilitates an increase in parental understanding and empathy and leads to improved family relationships, and externalisation can lead to increased insight into the impact of the ED on their lives (Medway & Rhodes, 2016). Parents have reported that externalisation gives them a space to express their emotions without blaming their child and supports them to view the ED as something outside of their child's control (Wufong et al., 2019). Siblings have reported that externalising the illness supports their understanding of the AN and, in turn, functions to maintain the relationship between them and their affected brother or sister (Withers et al., 2014).

While most of this research points to the positive impact of externalisation, adverse effects have been reported (Dimitropoulos et al., 2015; Eisler et al., 2016; Wufong et al., 2019). One study, where the YP did not recover following FBT, found that externalisation led to the YP feeling dismissed, being excluded from therapy and "losing their voice" (Wufong et al., 2019). White (2011) argued that dualistic metaphors, such as those of the ED as an illness or an enemy, can lead to distress in families, particularly if the family do not manage to overcome the ED. Parents echoed this view in the Wufong et al. (2019) study, in which the use of the illness metaphor led to the development of a hostile relationship with the ED and failure to recover being experienced as defeat.

Externalisation has been used successfully as part of a narrative approach with a range of child and adolescent problems, including soiling (Silver et al. 1998), ADHD symptoms

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(Looyeh et al., 2012), conduct problems (Seymour & Epston, 1989), parent-child conflict (Besa, 1994), illness perception and diabetes management (Knight et al., 2003). Externalisation has also been applied to emotional and anxiety difficulties of children with Autism Spectrum Disorder (Cashin et al., 2013; McGuinty et al. 2012) and to eating disorders and depression in adulthood (Vromans & Schweitzer, 2011; Weber et al. 2006). However, there has been a lack of focus in the research on the technique itself (Ramey et al., 2009). Consequently, little is known about how clinicians conceptualise or use externalisation in therapy with families where one child has AN. This study aims to further our understanding of this influential technique through an in-depth analysis of clinicians' experiences of using externalisation in the context of FBT. A deeper understanding of how clinicians conceptualise the technique of externalisation, how they support families to use this technique, and how they manage challenges to its implementation could help improve training in the model and help to close the gap between those who recover after an FBT intervention and those who do not.

Method

Participants

This study received ethical approval from the local university ethics committee. Clinicians met the inclusion criteria if they (a) had received training in the FBT model (both formal training (N = 5) and self-directed training plus supervision (N = 3) were deemed appropriate levels of training); (b) had worked with a minimum of one family using the FBT model; (c) were working in a Child and Adolescent Mental Health Service (CAMHS); and (d) attended regular supervision (either FBT specific or individual supervision). Eligible clinicians in seven FBT supervision groups were invited by email to participate.

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Data collection and analysis

All participants completed a demographic questionnaire and participated in audio-recorded, interviews which lasted between 50 to 80-minutes. A semi-structured interview guide was used, which covered questions about experiences using externalisation in FBT, how it helped or hindered treatment, differences between externalisation by the family and the young person, what techniques were used to support externalisation, therapists own struggles with the externalisation and how the externalisation of ED as an illness fit with the therapist's belief system.

The first author conducted interviews and transcription. Thematic analysis (TA) was used to condense and interpret the interviews, following Braun and Clarke's (2006) guidelines. Overall, an inductive approach was taken to coding; the data were used as the starting point for developing codes, with data used in a "bottom-up" approach (Terry et al., 2017). Data analysis was carried out over six phases, with coding being completed by the first author followed by themes and codes being reviewed by the second and third author. The data analysis process was iterative and recursive, with the researcher moving between phases throughout (Braun & Clarke, 2006). The phases included: familiarisation with the data through interviewing participants, listening to audio-recordings and transcribing the data; making initial notes of patterns throughout the data and beginning to create codes which related to specific data extracts for each transcript; analysing codes and relating them to the whole data set, merging and discarding codes, identifying emerging themes and making visual representations of codes and themes; reviewing themes against entire data set and reviewing the fit between themes, codes and data extracts; defining and naming themes; and reporting on themes and codes.

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Researcher as an instrument

This research paradigm assumes that data analysis is influenced by the researcher's subjective interpretation of the data (Braun & Clark, 2006). Due to the position of the researcher as an instrument, researchers should consider the potential influence of their own personal and professional experiences, knowledge, and views and how these may present as a lens for understanding the data. Throughout the research, a reflective journal was used to document the lead researcher's thoughts, feelings and experiences (Ortlipp, 2008), and if biases emerged, these were explored in supervision. For transparency, the lead researcher is a white, Irish, thirty-year-old female psychologist in clinical training with no direct experience of the FBT model.

Results

Participants Characteristics

The participants consisted of eight clinicians working across six different CAMHS teams in Ireland: six women and two men. All the participants were white and predominantly Irish nationals. Participants' professions included nursing, social work, and clinical psychology. Of note, five of the participants had family therapy training and had worked using externalisation in this context before using the FBT model. Furthermore, all clinicians had training in therapeutic models outside of FBT. Half of the clinicians had worked with ten or more families using the FBT model. A summary of participant characteristics is shown in table 1.

--- Table 1 here ---

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Key themes

Three key themes relating to clinicians' perspectives on externalisation were found through analysis: *clinician factors, family functioning* and *barriers for the YP* (figure 1). Each theme consists of several sub-themes and will be discussed below.

--- Figure 1 here ---

Clinician Factors

When discussing the use of externalisation in FBT, clinicians described therapeutic factors that related to the effective use of this intervention, included the importance of externalisation being used in the context of other clinical skills, the techniques they used to support families to externalise the ED and the struggles that related to viewing the ED as an illness in FBT.

The Importance of Therapeutic Skills. All clinicians reported valuing externalisation as a therapeutic tool in FBT, with clinician 1 noting that it was a "central technique" that supported the clinician to get to the "key issues" a family was experiencing. While clinicians valued this therapeutic tool, many identified the importance of it being used within the context of other therapeutic skills. Both implicitly and explicitly, clinicians described relying on therapeutic skills such as listening, rapport building, knowing how to time interventions, and engaging with a family and understanding the dynamics within the relationships as important factors when trying to implement externalisation.

It sounds on paper like it's quite an easy thing to engage in, but you'd have to also listen and see well how are the family and the YP experiencing it and why is it maybe jarring with them in a way, so when you kind of get an understanding of that you can maybe re-work it in or re-think about how we talk about these things (Clinician 5)

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Furthermore, three participants identified that it takes time and experience to build up this skill and use it effectively with families. Two participants reported that to fully understand and utilise externalisation, it was important for a clinician to read more widely than the FBT manual alone.

Techniques used to Externalise. Participants identified several techniques that they used with families to support them to externalise the ED, including education, language and metaphors, and sculpting exercises. Four clinicians spoke about the importance of providing information and statistics relating to the effect of starvation on the YP's physical and mental health of the family through education in the initial stages of therapy. This process supports parents to begin to view the ED as an illness that has control over their child's decision-making skills, ability to self-regulate, eating pattern and behaviour. Participants also spoke about the importance of their use of language in sessions with families. They described changing their language to reflect a more externalised version of the problem. This included shifting the focus of their questioning from one which viewed the ED as an internal process within the child to questions asking about *"the ED"*

Instead of saying "that made you vulnerable to the problem…" saying "when do you notice the problem the most and what kind of things are happening when the problem is there" (Clinician 5)

All clinicians discussed the role of metaphor in externalising the ED. Most clinicians felt that the illness metaphor was the most effective place to start externalising with the family. However, they also reported using bespoke metaphors that suited the families' interests or areas of knowledge throughout therapy.

…trying to use, even like a sporty kind of analogy for some kids like if the goalie is asleep for 30 seconds, that's going to cause trouble; you know you have to try and stay awake or stay alert to signs of the ED may be getting in again… (Clinician 8)

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Three of the clinicians, all trained as family therapists, discussed sculpting as a technique to support externalisation. These clinicians reported engaging families in sculpting exercises, where the externalised ED would be represented by a person or an object within the room, and the family would then visually explore their relationship with the ED. The clinicians who used this technique reported that sculpting can give the family a sense of the impact of their difficulties and can support families struggling to externalise the ED.

Philosophical Struggle. Implicitly and explicitly reflected throughout interviews were the struggles for clinicians when shifting from viewing an ED with a bio-psycho-social lens to viewing it as a biologically based illness within the FBT model. Participants differed in the views they held on shifting between these perspectives. For one clinician, while externalising a problem fit strongly with their thoughts on mental health, viewing an ED as an illness did not.

The whole kind of illness model…I don't subscribe to. But certainly, externalising a problem, taking it away from the person, that I totally believe in… but where it comes to, like, a disease model, that's the part that I don't (Clinician 6).

Two of the clinicians identified that while they support the families, they work with to view the ED as an illness within sessions, the psychosocial model of the ED, which relates to systemic factors and psychological processes, remains at the forefront of their minds throughout their work with families.

… that was probably his first day where he had a day free of "the ED" from a clinicians perspective, I'm going okay, so that's a day where his internal narrative or his cognitive biases or thoughts, his cognitions around food… weren't bothering him (Clinician 4)

Contrasting this, two clinicians discussed a process of immersing themselves in the externalised view of the ED and engaging with the biological view of the ED as the impact of

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starvation on the body. These clinicians felt that the process of engaging fully with the externalised view of the ED as an illness supported their ability to empathise with the family and improved their use of the externalising technique. Implicitly, throughout the interviews, this position of moving between perspectives was evident. Participants tended to oscillate between discussing the ED as an external entity that existed outside the YP and their family while also formulating about the underlying psychological traits of the YP or systemic factors influencing the family.

Family Functioning

Many of the clinicians interviewed discussed the impact externalisation had on family functioning through supporting communication and reducing conflict between family members.

A Shared Language. Participants consistently reported that externalisation in the context of an ED gives families a new way of communicating with one another inside and outside of therapy sessions. They reported a key advantage of externalisation is that it situates the ED outside of the person experiencing it. This shift in perspective for a family creates space to discuss the ED. It facilitates conversations that focus on how "the problem" impacts their lives individually and at a family-wide level.

So, it's not just about being able to talk to the child with the ED; it's being able to talk to everyone else about "the problem" (Clinician 1)

Clinician 1 went on to suggest that these conversations begin to pull family members together to fight a common enemy. Four clinicians identified ED behaviours (e.g. the YP restricting food; body checking) as leading to heightened emotion within families. They reported that introducing the externalised view of the ED during these times could support family communication and make it easier for parents to effectively intervene with ED behaviours by linking them to the ED rather than seeing them as under the YP's control.

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For instance, if a YP is in front of a mirror… pushing at body parts… they may become distressed. The parent can then go "oh, there's the bully again" or "there's Mr or Ms ED again", so they are able to name it then, and that really helps in the recovery process for the young person and the family as well (Clinician 4).

Clinicians also reported that externalisation supported family subsystems, giving parents a language to communicate between themselves and enabling siblings to find a way to talk about the impact of the ED on their lives.

Family Conflict. All clinicians identified the emergence of difficult emotional responses and interactions in families where one child has an ED. They reported that these experiences can lead to family conflict and that externalisation can play a role in its resolution. Most of the participants discussed clinical experiences where parents had placed the responsibility for the ED on the YP.

… or the family may say it's them [the person with the ED], if they just would eat, we wouldn't have a problem, and we wouldn't be here (Clinician 05).

They reported that parental fear, confusion and lack of information about the ED could lead them to believe that the behaviours they observe in their child (e.g. refusing or hiding food, mood changes, YP being argumentative) relate to internal psychological processes. This internalised view of the ED can lead parents to blame their child for the ED behaviour, and conflict can arise. In these circumstances, clinicians reported that externalising the ED can support parents to view the ED behaviours as out of the child's control, reducing the blame placed on the YP and leading to less antagonistic relational interactions.

I think when you externalise the illness, what it does is the parents are less critical and less hostile because…they are able to step back and go: "my young child… is not eating because they have this illness" (Clinician 2)

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Two clinicians reflected on this experience from the perspective of the YP, reporting that the use of externalisation supports them to feel "personally less blamed and attacked" by their parents.

Barriers for the YP

Clinicians reported that for many of the YP who engage in FBT, externalisation is an important part of therapy that supports them to communicate with their families and treating team and to reflect on the impact of the ED on their lives. Nevertheless, clinicians reported that certain individual factors relating to the YP could make externalisation more difficult. This included the YP's awareness of the ED, their age and the duration of time they had been living with the ED.

ED Awareness. Five out of eight clinicians described working with YP who held a belief that they did not have a problem when beginning therapy, and for some, this belief was maintained throughout. Clinicians differed in how they described this idea. Some clinicians reported that the YP could be so consumed by the ED that they lack awareness of having a problem. Other clinicians felt that the ED was important to the YP and that they valued aspects of it and therefore did not wish to change their relationship with it.

It is a part of them, a part they value even though it's a difficult part and they've had, there's a success with losing weight that they are happy with, so they don't want to lose it (Clinician 8).

Participants agreed that when working with a YP who lacks awareness of the ED or who does not wish to change their relationship with the ED, externalisation can become a difficult task. Externalising the ED in these situations can cause the YP to resist the externalisation, "kick back" at the process, become frustrated or even "rage against" it. Clinicians demonstrated understanding and empathy for the YP they worked with and acknowledged how difficult it is for a YP to separate from an ED that feels like part of their

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identity. Of note, one participant reported that for people who experience a long duration of ED illness, externalisation might not be helpful when engaging with the person. The clinician felt that for these clients, the use of externalisation can reduce the likelihood of engaging therapeutically with the person.

I suppose you never move from that pre-contemplative stage to kind of a recovery orientated model, yeah and … I think… if you want to build a relationship with that person, you need to stay with what they're saying about it (Clinician 5).

Age and duration of the ED. Several clinicians reflected on the impact of age and duration of the ED on a YP's ability to engage with externalisation. Across interviews, five clinicians indicated that younger children engage better with externalisation than adolescents, with two clinicians specifying that children under the age of twelve engage best with the process. Participants reported that externalising the ED for a younger child fits with their developmental level through accessing their imagination and defining a somewhat abstract concept (i.e. the ED) in concrete terms. Furthermore, participants felt that a younger child's dependence on their parents and lack of autonomy further facilitated the process of externalising the ED.

… under twelves, they are amazing. That language just fits with exactly where their imagination and their brain is situated. They can kind of imagine everything being something that they can manipulate or that is outside their thinking, and that makes sense to them (Clinician 5)

Some participants stated that a younger child is likely to have a shorter duration of time with the ED leading to them being less consumed by the ED and more open to changing their relationship with it. Not all clinicians felt that the YP's age had an impact on their ability to externalise, with one reporting that YP across the age range enjoyed engaging with the externalisation process and that it offered relief from the usual focus of talk therapies on

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an individual's thoughts, feelings and behaviours. One interesting finding, discussed by four participants, related to using externalisation with YP who have autism spectrum disorder (ASD). Participants reported that if working with a YP with ASD in the context of an ED, they would reconsider the use of externalisation. For the two clinicians who had previous experience of working within this context, both reported that the YP struggled to understand the concept of externalisation.

Discussion

The current research set out to explore the perspectives and views of clinicians using externalisation as a therapeutic technique in FBT. In line with research within this area, the findings suggest that clinicians value externalisation as a therapeutic tool (Dimitropoulos et al., 2017; Ramey et al., 2009). However, they were unanimous in their view that externalisation requires clinical skill to be used effectively and is a tool that clinicians should try to engage with, understand and practice. Previous research focusing on externalisation in narrative therapy suggested that because the initial stages of externalisation (i.e. naming the problem as external to the person, characterising the problem) can feel intuitive to the clinician, it can lead to it being "ignored or downplayed" (Ramey et al., 2009 p. 264). Clinicians in the current research reported the use of listening skills, tuning in to the emotional tone of families in order to know how to time the interventions, and judging when a family may not benefit from the use of externalisation.

When approaching FBT as a new therapist, the need to read more widely than the FBT manual in order to fully grasp the technique and how it is utilised was identified. In line with the interventions outlined in manualised FBT, education about the impact of starvation on the body, and the use of metaphor, particularly the ED as an illness metaphor, were used most often with families to support them to externalise (Lock & Le Grange, 2013). However, the philosophical tension between externalising AN as an illness and a social constructionist

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approach to externalisation was evident in many of the therapists' reflections. Though some writers have been critical of the degree to which therapy can be a poststructuralist practice (Fish, 1993; Hepworth, 1999), narrative approaches do attempt to highlight the degree to which the presenting problem contains socially negotiated meanings (White & Epston, 1990) and aim to support the family and young person to author new stories about themselves, in part, by creating a space between the problem and the sense of self. One dilemma is where this new story comes from - is it socially negotiated and discovered by the young person and family in the course of the systemic work through identifying unstoried aspects of the lived experience ("unique outcomes" as White & Epston (1990) would put it), or is it prescribed by the FBT manual and the illness metaphor? White and Epson (1990) emphasised that during externalisation, the problem definition needs to be mutually acceptable, while in contrast, Lock and Le Grange (2013) suggest picking a metaphor that most strikes a chord with the parents.

Participants views and engagement with the "ED as an illness" externalisation metaphor were not homogenous. For some clinicians, viewing the ED as an illness did not fit with their view of mental ill-health or ED. Others described supporting families to shift their perspectives to this view while internally translating what they observed in sessions into a psycho-social model of understanding. Others reported a process of trying to genuinely engage with the "ED as an illness" metaphor by focusing on the impact of starvation on the physical and mental health of the YP. It is beyond the scope of this paper, given the diverse sample of clinicians, but further exploration of the tension in the philosophical principles underlying the use of externalisation for family therapists using FBT would be illuminating.

Professionals across mental health teams can be trained in FBT, including those with a background in psychiatry, nursing, social work, family therapy or psychology (Eisler et al., 2016; Lock & Le Grange, 2013). This may have led to a tension in the use of externalisation

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by FBT therapists without a background in family therapy, for whom more familiarity with narrative therapy skills may be useful. A clinician's foundational training, years of experience working in mental health and possibly life experiences may mean that the way they engage with the "ED as an illness" metaphor differ. Moreover, the majority of clinicians in this study had a mixed caseload and worked with clients presenting with a range of mental health difficulties with whom a bio-psycho-social or social constructionist view of mental health was used.

Some obstacles to externalisation within the context of FBT were identified, such as the YP's ED awareness, age, and duration of the ED, all of which could affect their engagement with the technique. The majority of clinicians felt that younger children engaged better with externalisation and developmental factors may influence the ability to engage with externalisation, including their stage of mental development (Inhelder et al. 1976) or theory of mind (Baron-Cohen et al., 1995). These areas may be useful to explore in future research. Clinicians reported that illness duration might impact YP ability to externalise, with a longer timeframe leading to a greater level of internalisation or identification with the ED - a finding which has been reported in other studies (Darcy et al., 2013; Dimitropoulos et al., 2015, Le Grange et al., 2012; Lock et al., 2006). Similar, a YP's age and illness duration negatively impact parental empowerment (Dimitropoulos et al., 2017). Research suggests that problem awareness, low motivation to change and poor therapeutic alliance can present as challenges in this work (Sotero et al., 2016). For some clients, the anorexic voice can be experienced as ego-syntonic, with the individual's self-identity coming to be defined by the AN (Tierney & Fox, 2010) and the young person identifying with their eating disordered beliefs (Griffiths et al., 2015). Research has highlighted how individuals presenting with AN will credit their illness with helping them to achieve structure and control in their daily lives through following rigorous food and exercise regimes; helping them to avoid difficult emotions by

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expending all their energy focusing on their physical body; and helping them to gain mastery over their body through continued weight loss (Gregertsen et al., 2017). Within these circumstances, externalisation of the ED as an illness or a problem can lead to negative interactions between the YP, their family and the clinician. However, emerging work suggested that many clients with AN experience a critical inner voice (Noordenbos et al., 2014, Pugh & Waller, 2017), which can, at times during the illness, be experienced as ego-dystonic or alien to their own identity. This complex and variable relationship with the anorexic voice poses significant potential for interaction with the technique of externalisation, and further research to explore and disentangle this conceptual overlap would be of benefit.

Adaptations to improve the engagement of adolescents in FBT have been suggested, including the use of their greater insight into thoughts, feelings, perceptions and behaviours related to their ED, to facilitate externalisation in a way that improves their understanding of the impact of the ED on all areas of their lives (Dimitropoulos et al., 2015). White (2011) identified how the experience of AN is different for every individual and, therefore, how a person wishes to externalise their ED will also differ. Insight-orientated externalisation, which externalises aspects such as perfectionism, expectations or anxiety, may be more appropriate and hold more meaning for adolescents, allowing the YP to focus on the consequences of these features of their ED and the impact on the relationships in their lives (Eisler et al., 2016; White, 2011).

In addition to the use of the "ED as illness" metaphor, some clinicians reported incorporated sculpting into sessions, particularly with families who struggled to externalise. While not described in the manualised version of FBT, the use of sculpting has been reported in other forms of family therapy for EDs (e.g. multi-family therapy and Maudsley Family Therapy; Eisler, 2005). It makes use of non-verbal modes of expression (Hearn & Lawrence, 1981; Papp et al., 2013), which may be of particular benefit when the family are finding the

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narrative mode of externalising more difficult to engage with. Examples of incorporating the sculpt into the process of externalising AN are given by Atkins and Warner (2000) and Voriadaki et al. (2015).

This study found that some clinicians used nuanced and bespoke externalisation techniques, to overcome difficulties in engagement with the YP. It suggests that clinicians using FBT could benefit from discrete training on externalisation, with a particular focus on how to externalise with YP who are in their adolescent years, lack problem awareness or have a longer ED history. Informed by White and Epston (1990), this could take the form of expanding the methods to externalise to include relative-influence questioning, mapping the effects of the problem on life and relationships and working to develop a mutually acceptable definition of the problem to be externalised. Specific focus could be given to externalisation in FBT supervision to support clinicians to overcome barriers to externalisation and reflect on the impact of a YP's refusal of externalisation on the therapeutic alliance. Future studies on the impact of a lack of problem awareness on the therapeutic alliance are needed. For adolescents, the use of insight-orientated externalisation may be more fruitful, making use of their ability to engage with their experience of the thoughts, feelings and behaviours associated with the ED.

Of the study participants, five had previous training and experience in family therapy, meaning they had prior knowledge and experience of the externalisation technique outside of FBT. Consequently, these clinicians may have had additional methods of externalising and may not have relied as heavily on those set out by the FBT model. It is possible that clinicians who had no previous experience with externalisation may have different perspectives on externalisation in FBT that were not captured by this research, and this could be important in the current service context in which FBT has been disseminated widely to many therapists who are not trained in family therapy. Future research may also

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consider the time since the clinician has completed FBT training and how this may relate to fidelity to the model and the impact on externalisation.

Conclusion

This research highlights that externalisation as a technique is valued by clinicians, regardless of their training or approach. Furthermore, the clinicians in this study used a diverse range of metaphors and techniques with their clients to support them to externalise, often creatively focusing on areas of interest or knowledge with families to facilitate engagement.

Acknowledgements

We wish to thank all the clinicians who took the time to participate in this research. Their knowledge of the field of mental health, and FBT specifically, has greatly supported our understanding of externalisation, an important and dynamic therapeutic technique. Finally, we also wish to thank (x) the family therapist who first highlighted to us the tension between externalisation from a narrative perspective and that of the FBT approach and who offered guidance and advice throughout the research process.

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Table 1

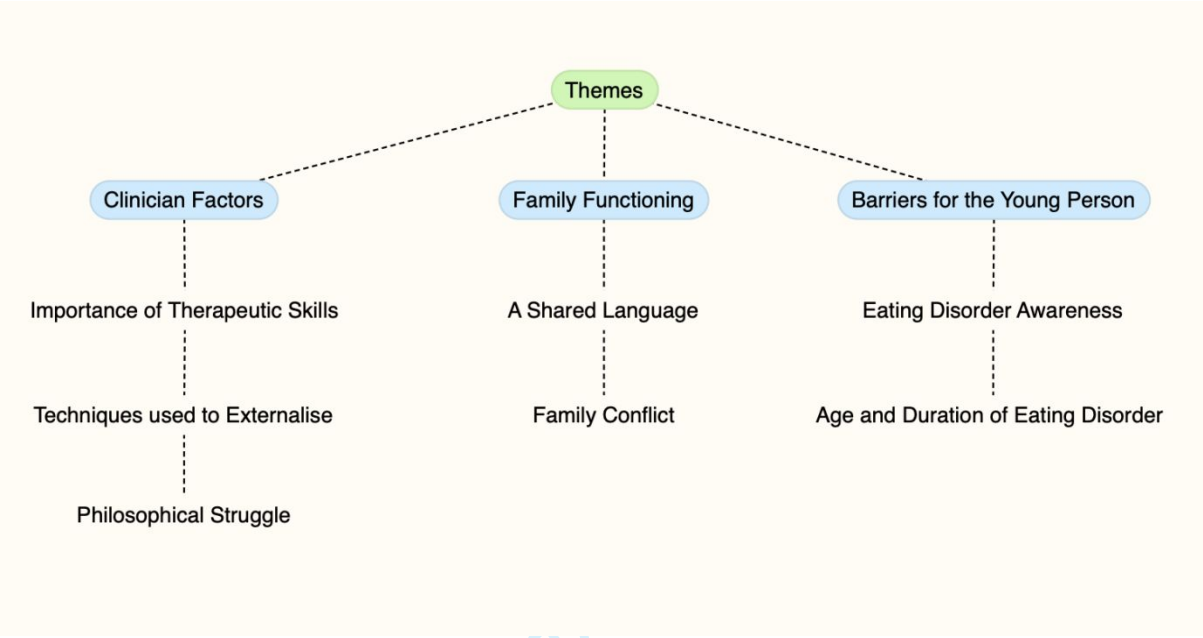
Participant characteristics

	N	*Range*
Gender		
Male	2	
Female	6	
Age		35 – 59
Professional discipline		
Nursing	1	
Social work	4	
Clinical psychology	3	
Years working with adolescent ED		
0 to 1 year	0	
1 to 3 years	2	
3 + years	6	3 - 22
Current caseload of FBT clients		
1 to 3 families	5	
3 to 6 families	1	
6 + families	2	
Presentations using FBT		
AN	8	
BN	2	
Other	2	
Additional training		
Cognitive Behavioural Therapy	3	
Dialectical Behavioral Therapy	3	
Family Therapy	5	
Counselling course	4	
Other	2	

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Figure 1

Themes and subthemes



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