Received: 29 October 2022 | Accepted: 18 July 2024

DOI: 10.1111/1467-6427.12468

ORIGINAL ARTICLE

Adaptation of multi-family therapy for children and adolescents with anorexia nervosa in Japan

Rie Kuge[1,2] | **Kayoko Kojima**[1] | **Ken Shiraishi**[2,3] | **Daimei Sasayama**[2,3] | **Hideo Honda**[1,2] | **Mima Simic**[4] | **Julian Baudinet**[4,5]

[1]Mental Health Clinic for Children, Shinshu University Hospital, Matsumoto, Nagano, Japan

[2]Department of Child and Adolescent Developmental Psychiatry, Shinshu University School of Medicine, Matsumoto, Nagano, Japan

[3]Department of Psychiatry, Shinshu University School of Medicine, Matsumoto, Nagano, Japan

[4]Maudsley Centre for Child and Adolescent Eating Disorders, South London and Maudsley NHS Foundation Trust, London, UK

[5]Institute of Psychiatry, Psychology and Neuroscience, King's College London, London, UK

Correspondence
Rie Kuge, Mental Health Clinic for Children, Shinshu University Hospital, 3-1-1 Asahi, Matsumoto, Nagano 390-8621, Japan.
Email: rkuge@shinshu-u.ac.jp

Funding information
Japan Society for the Promotion of Science

Abstract

Multi-family therapy for children and adolescents with anorexia nervosa (MFT-AN) draws on the same principles as family therapy for AN (FT-AN), but is delivered in a more intensive format to help families overcome a sense of isolation and stigmatisation and to maximise their own resources. In Japan, the main treatment for AN is inpatient care, and family-based treatment that is based on the practice at the Maudsley Hospital in the 1980s has started to be introduced at an inpatient level in Japan. MFT-AN could offer more opportunities to practice managing AN symptoms and reduce the family's anxiety. It may also act as a step-down intervention during transition from inpatient to outpatient care or a step-up in intensity if outpatient treatment is stalling. This article reports on MFT-AN's theoretical underpinnings, the current Japanese eating disorder treatment context, and the way MFT-AN may be adapted for the unique Japanese socio-cultural context.

KEYWORDS
adolescents, anorexia nervosa, multi-family therapy

Practitioner points

- Multi-family therapy for anorexia nervosa adapted for inpatient settings may be a feasible first step in Japan.
- To enhance participant engagement, Japanese therapists may need to adopt a more didactic approach throughout MFT-AN.
- Adopting a more didactic approach could help Japanese participants to feel more supported, comfortable and encouraged to express their opinions, thoughts and feelings.

INTRODUCTION

Anorexia nervosa (AN) is an eating disorder characterised by persistent restriction of calorie intake, a fear of gaining weight and a disturbance in body perception (American Psychiatric Association, 2022). The lifetime prevalence of AN among women is estimated to be as high as 4% (Smink et al., 2013). For children and adolescents who are medically stable, outpatient AN-focused family therapy (FT-AN; Eisler, et al., 2016) is typically the first-line recommended treatment internationally (NICE, 2017). Outcomes from several randomised controlled trials (RCT) have demonstrated its efficacy and have reported improved outcomes compared with individual treatments (Jewell et al., 2016; Solmi et al., 2024).

While FT-AN has undergone several changes in the decades since its initial development, its tenets remain broadly the same. The treatment is phased and moves from engagement and symptom management to addressing lifecycle issues (Table 1). The basic principles include: (1) focussing on working with the family to help their child recover, coupled with a strong message that the family is not seen as the cause of the problem; (2) supporting the parents to take a lead in managing their child's eating in the early stages of treatment; (3) externalising the eating disorder if useful; and (4) shifting the focus of treatment away from symptom management onto adolescent and family developmental life cycle needs in the later stages of treatment (Baudinet, Simic, & Eisler, 2021; Eisler et al., 2016).

MFT: CURRENT MODELS AND THEORETICAL FOUNDATIONS

Multi-family therapy is a therapeutic method that brings several families affected by the same pathology together for treatment. It has become an increasingly popular treatment modality over

TABLE 1 The four phases of family therapy for anorexia nervosa (Eisler et al., 2016).

Phase 1	Engagement and development of the therapeutic alliance with the patient and their family
Phase 2	Helping families to manage the eating disorder and the young person's return to physical health
Phase 3	Helping the young person to re-establish independent eating as well as supporting developmentally appropriate independence and autonomy. Exploring individual and family life cycle needs
Phase 4	Ending treatment and discussion of future plans and discharge

the past 20 years, and there is a growing body of evidence supporting its effectiveness for a range of mental health difficulties (Gelin et al., 2018). Within the field of eating disorders, it is most commonly described in the treatment of adolescent anorexia nervosa (MFT-AN) (Baudinet, Eisler, Dawson, et al., 2021), although preliminary findings of its efficacy and acceptability are also reported for adolescent bulimia nervosa (MFT-BN) (Escoffié et al., 2022; Stewart et al., 2021), as well as adult eating disorders (Skarbø & Balmbra, 2020; Tantillo et al., 2019).

Outpatient MFT-AN enhances FT-AN by delivering treatment in a more intensive group-based format. Outpatient models typically last between 9 and 12 months and offer between 5–21 days of MFT groups alongside treatment as usual (typically FT-AN) (Baudinet, Eisler, Dawson, et al., 2021). However, briefer 1-week (5-day) models have also been described (Baudinet, Eisler, Simic, & Schmidt, 2021; Knatz et al., 2015). Inpatient models are usually briefer, ranging from approximately 2–4 months, with sessions offered weekly or fortnightly (Depestele et al., 2017; Geist et al., 2000). Regardless of the duration and intensity, up to eight families attend MFT-AN and work together in a closed group with the support of two or more multidisciplinary clinicians (Baudinet, Eisler, Simic, & Schmidt, 2021).

Child and adolescent MFT-AN builds upon the same theoretical principles as FT-AN. In addition to those aforementioned, MFT-AN helps participants to: (1) create a sense of solidarity and reduce social isolation and stigmatisation; (2) stimulate new perspectives and provide a context where families learn from each other; (3) strengthen self-reflectiveness through observing others, encouraging mutual support and feedback and experimenting with cross-family exercises; (4) discover and build on competencies, intensifying interactions and experiences and practicing new behaviours in a safe space; and (5) raise expectations and hopes for recovery (Dawson et al., 2018; Eisler, Simic, Hodsoll, et al., 2016; Simic et al., 2021). MFT-AN broadly follows the same four phases of FT-AN (Eisler, Simic, Hodsoll, et al., 2016; Simic & Eisler, 2015), however, a wider range of intervention techniques are used (including group, family, psycho-educational and creative techniques) in MFT-AN (Eisler, Simic, Hodsoll, et al., 2016).

The mechanisms of change in MFT-AN remains relatively understudied (Baudinet, Eisler, et al., 2023; Baudinet, Hodsoll, et al., 2023; Simic et al., 2021). Qualitative investigations and descriptions of the MFT experience indicate MFT is experienced as helpful, intense and challenging (Baudinet, Eisler, Dawson, et al., 2021). Most commonly, participants describe the powerful impact of joining with others struggling with similar difficulties to them and how this helps to reduce isolation and improve understanding (Baudinet, Eisler, et al., 2023; Baumas et al., 2021; Dawson et al., 2018; Wiseman et al., 2019a, 2019b). Similarly, one recent qualitative study found that change was facilitated by the sharing of experiences with other families in a similar situation, role play activities, the increased ability to express emotions and the perceived mutual learning and support (Voriadaki et al., 2015).

MFT: THE CURRENT EVIDENCE BASE

Two RCTs and multiple uncontrolled studies have been conducted on adolescent MFT-AN. The most recent and largest RCT ($N = 167$) compared MFT-AN + FT-AN with FT-AN in an outpatient setting (Eisler, Simic, Hodsoll, et al., 2016). Those in the MFT-AN group gained significantly more weight and had better global outcomes on the Morgan/Russel global outcome scales (Morgan & Russell, 1975) at the end of treatment. A much smaller RCT ($N = 25$) compared eight sessions of single-family therapy with eight sessions of family group psychoeducation (MFT-AN) in an inpatient unit (Geist et al., 2000). In this study, there was no difference in

weight restoration between treatment groups, but MFT-AN was more cost-effective. Other descriptive and open studies have shown that MFT-AN is associated with improvements in eating disorder symptomatology, weight gain and other individual and family factors including comorbidities, self-esteem, quality of life and some aspects of the experience of caregiving (Baudinet & Eisler, 2024; Baudinet, Eisler, Dawson, et al., 2021). Additionally, a high level of satisfaction with treatment and very low dropout rates have been observed (Eisler, Simic, Hodsoll, et al., 2016; Gelin et al., 2018). Furthermore, rates of admission and readmission to inpatient units, as well as length of stay, also tend to be reduced (Gelin et al., 2018). While the majority of research has been conducted on outpatient MFT-AN models (Baudinet & Eisler, 2024; Baudinet, Eisler, Dawson, et al., 2021), a growing body of literature suggests MFT may also be useful on inpatient units (Coopey & Johnson, 2022; Depestele et al., 2017; Geist et al., 2000; Scholz et al., 2005).

EATING DISORDERS IN JAPAN: TREATMENT CONTEXT AND AREAS OF NEED

AN (restrictive subtype) has increased in physical and psychopathological severity over the past 30 years in Japan (Harada et al., 2021). Recent estimates suggest rates of AN are now comparable to those in Western societies (Hotta et al., 2015). However, the number of studies about children and adolescents with AN in Japan remains small, and there is little knowledge on its epidemiology, course, prognosis and treatments in Japan (Iguchi et al., 2021).

Current specialist centres nationwide include the central Centre for Eating Disorder Research and Information in Tokyo and six regional specialist eating disorder services (Miyagi, Chiba, Shizuoka, Fukuoka, Ishikawa and Fukui) across Japan. The main roles of six regional specialist eating disorder services are consultation and support of patients with eating disorders, supervision and training of clinicians and facilitating dissemination and public awareness of eating disorders. Due to a lack of local specialist services at a community level, the capacity for providing specialist treatments is very limited. There is also a significant shortage of medical professionals with expertise in this area, thus creating a situation whereby 5% of the medical facilities in the country end up treating 50–60% of the patients seeking help (National Center of Neurology and Psychiatry, 2020).

If a diagnosis of AN is suspected or established for a child or adolescent in Japan, the typical treatment care pathway would be to refer them to a paediatrician or psychiatrist at a primary or secondary medical facility. Thereafter either outpatient treatment or a hospital admission is offered in the Japanese universal health insurance system. In the outpatient psychiatry department, insurance covers a maximum of one psychiatric session weekly. Regarding specialised psychotherapy for children and adolescents with AN, a number of professionals have received training in family-based treatment (FBT) (Lock & Le Grange, 2012) that is based on the practice at the Maudsley Hospital, London in the 1980s, and the FBT model is starting to be introduced in some inpatient units with promising outcomes (Iguchi et al., 2021). However, due to absence of a sufficient consensus among professionals in Japan, the introduction of FT-AN is slow, with mainly FBT being known in Japan. To date, only one MFT-AN pilot study has been conducted at one centre in Japan (Matsuo et al., 2023). The typical treatment in Japan includes psychoeducation for children and adolescents, behavioural therapy and supportive counselling. If psychoeducation for parents is provided, it typically does not include coaching skills for managing mealtimes. Furthermore, due to high demand, it is typical for most families seen in outpatient treatment to receive a brief (5–30 min) session every few weeks (Iguchi et al., 2021). This is

briefer and less frequent than most first-line recommended treatments internationally (Hilbert et al., 2017), including FT-AN (Eisler, et al., 2016). It is common for children and adolescents not to gain weight within the first few weeks of outpatient treatment, resulting in many being admitted to inpatient units.

There are currently no specialist eating disorder services in Nagano, a prefecture in central Japan with a population of approximately 2 million people. Generally, physical monitoring and behavioural therapy are offered in primary or secondary care facilities. Children and adolescents with AN who are not improving in primary or secondary care facilities and/or those who are severely medically compromised are usually referred to the Mental Health Clinic for Children or Department of Paediatrics at Shinshu University Hospital, a university hospital and tertiary medical facility. Outpatient service at the Mental Health Clinic for Children provides physical monitoring, psychoeducation for children and their parents and dietary advice on the basis of the principles of FT-AN, but these are offered by child psychiatrists rather than members of a multidisciplinary team. Typically, they cannot offer FT-AN sessions as frequently as is recommended in the treatment manual (weekly to begin with) due to resourcing issues. The Mental Health Clinic for Children has four dedicated inpatient beds for children and adolescents with psychiatric disorders, although none are specialist eating disorder beds.

Whilst on the ward, children and adolescents with AN and their families are usually offered a combination of individual sessions, parent sessions and family sessions on the basis of the principles of FT-AN. There is a focus on psychoeducation and increasing understanding of the illness with families, as well as guidance and practical support to manage mealtimes, including live coaching. Once the young person has gained weight above a minimum of 75% of median body mass index (adjusted for sex, age and height) and has managed to complete some meals at home, they are transitioned to outpatient care. This is offered by a member of the multi-disciplinary team, which currently consists of child psychiatry, clinical psychology, dietetics, occupational therapy and nursing. Lastly, a parent psychoeducation group is also offered. It is a mixed group offered to people who are in both the outpatient and inpatient arms of the service. The program content includes the epidemiology of AN, physical and psychological effects of starvation, treatment process, nutrition and supporting families to work effectively together during recovery.

While feedback for the parent psychoeducation group is generally very positive, admissions tend to be quite long. Between April 2018 and March 2021, at the Mental Health Clinic for Children Shinshu University Hospital, the median length of stay for adolescents with AN ($N = 12$, including readmissions) was 127 days (range 55–659 days) and the rate of readmission was 22%. The prolonged length of stay and relatively high readmission rate may be associated, at least partially, with the insufficient availability and intensity of outpatient treatments. Additionally, delays in admission are often caused by the limited number of beds available. Consequently, children and adolescents often present with more severe and entrenched symptoms by the time they are admitted, further lengthening the treatment duration and reducing its effectiveness. This fits with previous research internationally demonstrating that outcomes following hospitalisation are mixed (Gowers et al., 2000; Lay et al., 2002), although they may be improving (Quadflieg et al., 2023).

The most common feedback we received from parents who attend psychoeducation groups while their children were treated on the inpatient unit at Shinshu University Hospital is that they would like to learn more skills to manage mealtimes. Again, this is consistent with previous research indicating that one of the limitations of inpatient care is that parents lack enough opportunity to develop and strengthen their own skills and resources to manage AN symptoms (Scholz et al., 2005).

There is a growing body of evidence that early intervention is key to improved outcomes for young people with eating disorders (Austin et al., 2022; Treasure & Russell, 2011) and that early treatment response is predictive of improved outcomes in outpatient and more intensive day-treatment settings (Baudinet & Simic, 2021; Jewell et al., 2016). There appears to be something important about engaging and identifying symptoms early and helping people make changes as early as possible, something that can be very challenging to do within the current context of the Japanese universal health insurance system. There is an urgent need for more specialist eating disorder clinics, as well as new models of both inpatient and outpatient care that are effective and more cost-effective. Given the cost-effective, early, intensive support offered by MFT-AN, it could address some of these gaps if adapted sensitively to the Japanese cultural context.

ADAPTATIONS OF MFT-AN FOR THE JAPANESE CONTEXT

Adolescents typically attend treatment sessions and appointments with their mothers in Japan. Most often, fathers do not attend due to long working hours. The opinion still exists that raising children is typically the mother's job. Some fathers attend when adolescents are admitted to the inpatient ward. Nevertheless, mothers still usually take most responsibility of caring for their adolescents. It remains rare for fathers to attend treatment in Japan compared with in the West. In fact, Japan has one of the largest gender gaps among developed countries (World Economic Forum, 2022).

Japanese parenting styles are typically less collaborative and more hierarchical than in the West. Japanese parents are more likely to endorse an authoritarian parenting style that involves strictness and parental control compared with parents from the West (Thomas et al., 1992). However, the impact of authoritarian parenting styles in Japan may exert adverse effects on children's development (Hosokawa & Katsura, 2019). Most parents, especially mothers, can feel some anger, disappointment and shame when their adolescents become unwell with AN, and many feel like they are 'bad' parents or have 'failed' in some way.

In the only published pilot study of MFT in Japan to date (Matsuo et al., 2023), two sessions were offered fortnightly followed by two follow-up sessions offered a month apart. Each session lasted for 60 min. All families ($n = 9$) completed four sessions and feedback was mainly positive. However, prior to attending this MFT pilot, all participants had received psychoeducation groups facilitated by the same staff who provided the MFT pilot. Parents attended two sessions (120 min/session) and adolescents attended four sessions (30 min/session), respectively. The authors speculated that these sessions helped build engagement prior to attending MFT and, without them, more sessions may need to be included in the MFT programme to promote engagement and group cohesion (Matsuo et al., 2023). As such, the appropriate number of MFT sessions remains unclear. In the current plan, the number of sessions and treatment length is based on the previous inpatient model that is more intensive than the MFT-AN pilot previously conducted in Japan. The content of MFT session and process have also been adapted to Japanese context.

When adapting MFT-AN to the Japanese context, considerations have been made to ensure the treatment is feasible within the inpatient care model, with an additional aim to encourage fathers to attend the group. Firstly, the number of sessions is set to eight in line with some inpatient models, starting with six weekly sessions followed by monthly meetings for the two subsequent follow-up sessions. The length of each session is 90 min. The aim is to offer MFT-AN sessions during the afternoon or evening to accommodate fathers' schedules, potentially making it easier for them to attend. Furthermore, it might be more culturally acceptable to encourage fathers to

engage in a supportive role in a more indirect manner, such as providing emotional support to their spouses and serving as a buffer when conflict arises between their spouses and adolescents (Iguchi et al., 2021). The attendance of both parents in MFT sessions sends a powerful message to adolescents about their parents' concern and care. It can also foster a broader understanding within the system and increase support for mothers. This, in turn, may alleviate maternal feelings of shame and guilt, helping the family in finding new ways of working together toward recovery.

Regarding personality and social functioning, people in Japan are less emotionally expressive, especially regarding negative emotions. Previous research found that individuals from Japan are more likely to suppress their emotions compared with people in the United States (Matsumoto, 2006). It is known from clinical practice with adolescents who self-harm that they tend to want to hide their self-harm due to fear of parents' overreacting (Matsumoto, 2012). It is also frequently observed in clinical practice that adolescents tend to believe that if they express negative emotion to their parents, this will upset them and leave them heartbroken. Their parents also tend not to open up about the adolescents' illness with friends and relatives (including grandparents), due to the shame associated with others knowing about family difficulties. As a result, parents can feel very isolated. Japanese people also tend not to express their opinions and emotions in groups. Feedback from another group-based intervention for adolescents with AN suggest Japanese people can be more nervous speaking publicly in groups (Kuge et al., 2017).

On the basis of the Japanese tendency to supress emotional expression, including more ice breakers activities throughout MFT sessions is planned, with the purpose of promoting engagement and allowing participants to feel more comfortable in the group-based format. We will start each group with ice breaker exercises, followed by family work, either with all participants together or in separate groups for parents and adolescents. We are planning for facilitators to assume a more didactic style throughout MFT that may help participants feel more relaxed, comfortable and better able to express their opinions and emotions in the group context.

The adapted MFT-AN will be a closed group of two to four families of patients. The smaller group size compared with the previous studies (cf Baudinet, Eisler, Dawson, et al., 2021) has been chosen to create a more comfortable environment for participants. Two facilitators will run each session. The first and second author will be facilitators of MFT-AN and receive supervision from the last author that has extensive experience of both FT-AN and MFT-AN at Maudsley Centre for Child and Adolescent Eating Disorders (MCCAED). The first author is a child psychiatrist who attended the training and several sessions of FT-AN and MFT-AN at MCCAED and has experience of treating children and adolescents with AN in inpatient and outpatient care including psychoeducation groups for parents, children and adolescents and cognitive remediation therapy for adolescents with AN. Additionally, the first author has authored the multi-family group research (Matsuo et al., 2023) in Japan. The second author is a clinical psychologist that has experience of psychotherapy for adults and adolescents with AN and psychoeducation groups for parents in Japan.

The MFT-AN pilot at Shinshu University Hospital will be offered to both inpatients and outpatients in a mixed group in accordance with MFT-AN at MCCAED that is offered to both outpatients and participants of day programme treatment in a mixed group. MFT-AN will function as both a step-down during transition from inpatient care to the community and a step-up in intensity for families who are struggling in the outpatient setting.

Each of the eight sessions will continue to be based on the activities described in the MFT-AN manual (Simic et al., 2021). In line with the phases of FT-AN, activities offered in initial sessions focus on psychoeducation and supporting parents to help their child manage eating disorder symptoms and restore a healthy weight. Later sessions focus more on managing independence

and meeting any lifecycle needs (see Table 2). Given the plan for fewer sessions than the MCCAED model to improve feasibility in the Japanese context, it was considered necessary to carefully select session content that fits the present circumstances in Japan.

To adapt to the Japanese context, an increased emphasis and focus on validation will be included. Introducing validation skill and role play is aimed at helping families acknowledge and express their emotion. Japanese clinicians understand the benefits of active listening and trying to understand each other's emotions while setting boundaries with unacceptable behaviours. Therefore, the concept of validation is well accepted in psychiatric practice in Japan. For example, when an adolescent with AN has difficulty eating and says "I can't eat any more, because I'm too anxious about gaining weight," some parents tend to respond with agreement saying "I feel for you, don't force yourself, eat when you can" in an attempt to quickly alleviate their child's anxiety. Most clinicians in Japan would encourage parents to listen and validate their child's anxiety but not to agree with the child's refusal to eat, given this anxiety likely stems from illness-related cognitions. Ultimately, it will be eating enough and gaining weight that is likely to reduce anxiety in the long run. If parents use validation and warm perseverance in these situations, it can be easier for a child to feel listened to, and for parents to feel that they are responding to their child's distress without reinforcing or colluding with child's anorexic behaviours and symptoms. This links with available qualitative data from non-Japanese studies that persistence and warmth can improve engagement and is considered a key component of affecting change in FT-AN (Baudinet et al., 2024). However, the word "validation" tends to be used primarily in the area of dementia care in Japan. It is not

TABLE 2 Session contents.

Session	Activity	Aim
1	Psychoeducation about anorexia nervosa and information about the MFT-AN programme	Engage all participants to orient them to treatment and to provide psychoeducation about AN
2	Hopes and expectations	Introduce all group members
	Pros and cons of anorexia (for adolescents)	Increase motivation and insight into the illness and promote externalisation
	Preparation for meal (for parents)	Explore symptom management and mealtimes
3	Validation	Introduce the concept of validation, provide skills and help families acknowledge and express their emotion
4	Mealtime role reversal	Assess thinking, attitudes and changes around food and mealtimes
5	Family timelines	Explore future goals and identify coping skills needed to reach them in the future
6	Speed problem-solving	Promote problem-solving skills
7	Brain scans	Help participants mentalise, increase understanding of each other and improve communication
8	Tolerating uncertainty	To target facing uncertainty and explore independence and autonomy
	The final reflection	To allow the group to reflect on the journey of MFT-AN all together

commonly used among eating disorder clinicians in Japan, and there is no direct translation of the word in Japanese to explain this concept outside of this setting. Thus, we propose to introduce the English term "validation" to eating disorder clinicians in Japan.

In line with the most common feedback from the parent psychoeducation group and experiences from inpatient care, we will include coaching on how to manage mealtime difficulties and the MFT mealtime role-reversal activity within the Japanese MFT programme. The MFT activities focussed on tolerating uncertainty will also be included given that, from our clinical observations, adolescents and their parents tend to be anxious about the transition from inpatient to outpatient care.

Lastly, the therapeutic relationship in Japan is also different from one in the West. The main two differences between the therapist stance in FT-AN and Japan are described below through the lens of the FT-AN principles.

Firstly, in FT-AN, parents are given responsibility for their adolescent's eating and weight restoration in the early phases of treatment. Previous data have shown that many parents are concerned treatment can feel too behaviourally focussed due to the emphasis on weight and eating restoration, particularly in the early phases of FT-AN (Wufong et al., 2019). Therapists in Japan tend to adopt a more directive approach when treating adolescents with AN. Rather than supporting parents to lead on these aspects, it is common for therapists to decide on the dietary choices for the adolescents and tell parents what their children should eat. Therapists sometimes instruct parents not to talk about food during treatment to avoid arguments, not to get involved in any aspects of renourishing and only to provide empathetic support between meals (Iguchi et al., 2021). This discrepancy between therapeutic approaches commonly used Japan and those in FT-AN may be confusing for therapists and parents, contributing to the slow adoption of FT-AN in Japan. Recently the meaning of placing the parents in the role of supporting an appropriate level of dietary intake has been reviewed to emphasise its function as care rather than control (Baudinet, Simic, & Eisler, 2021; Eisler et al., 2016), which seems more acceptable to therapists and parents in Japan. This will be emphasised when implementing the MFT-AN pilot in Japan.

Secondly, in FT-AN, therapists are presumed to take a non-authoritarian therapeutic stance and are seen as an expert consultant on AN and its treatment, but not experts in each particular family circumstances (Rienecke & Le Grange, 2022). As such, a collaborative approached is encouraged within FT-AN with all members sharing expertise. As described above, therapists in Japan tend to be more directive in their approach and may struggle with changing their stance. Most therapists in Japan are familiar with psychoeducation and consider it more acceptable to take on a psychoeducational didactic approach in treatment, rather than a collaborative sharing of responsibility. Moreover, as described above, parents also might be more comfortable with therapists who use a didactic, directive and psychoeducational stance, especially in the early stages of MFT.

Furthermore, externalisation of AN, an important part of FT-AN, is familiar to therapists in Japan. Externalisation of AN enables some family members to reduce their frustration and other negative emotion associated with the illness, which enables them to take a more empathetic approach to their child (Rienecke & Le Grange, 2022). Recently the concept of externalisation was broadened to include the role of temperament and neurobiological factors that predispose and maintain the development of AN (Eisler et al., 2016). The broadening the concept of externalisation could be more acceptable for therapists as well as parents and adolescents in Japan. As such, this updated, broader idea of externalisation will be adopted in the Japanese pilot of MFT-AN.

OUTLINE OF SESSIONS

The aim of introducing MFT-AN to Shinshu University Hospital is to reduce the rate of inpatient admissions and readmissions, as well as length of stay. This MFT-AN programme will target families for whom outpatient treatment has not been sufficient or those who need more intensified treatment during the inpatient admission. Participants will be at different stages of recovery, which is seen as a useful component of the treatment as it can promote hope.

Alongside MFT-AN, adolescents and their families will receive treatment as usual; medical monitoring, nutrition therapy, pharmacological treatment as required, psychoeducation, individual sessions and family sessions. The proposed eight sessions of MFT-AN will be offered over 3.5 months. Sessions one to six will be provided weekly and the remaining two sessions offered monthly as follow-up sessions. Each session will last for 90 min. It will be delivered by at least two facilitators (a child psychiatrist and a clinical psychologist). Each session will involve a closed group of two to four families of patients aged between 13 and 19 years old who are suffering from AN.

Each of the eight sessions (see Table 2) will have a similar format: ice breaker, review and question and answer of the previous session (the first session will be self-introduction of the MFT team staff), today's activity and coping skills and mindfulness exercises (Table 3). Sessions one to six fit most closely with phase 1 and phase 2 of FT-AN. Sessions seven and eight are designed to start targeting phase 3 and 4 issues (Eisler et al., 2016). Coping skills and/or mindfulness exercises are included in every session as tools for families to regulate their distress and emotions. The supplementary material shows the detailed content on sessions one to eight.

DISCUSSION

This paper outlines the potential use and adaptations of MFT-AN for the Japanese context. On the basis of previous reports, practical adaptation of MFT-AN for children and adolescents in Japan is feasible by tailoring its contents to the unique Japanese socio-cultural context. The following adaptations may be particularly useful for practicing MFT-AN in Japan: (1) including sessions to promote engagement and group cohesion; (2) devising a schedule that facilitates fathers' participation; (3) incorporating more icebreaker activities throughout the MFT sessions to encourage emotional expression; and (4) reducing the group size to create a comfortable environment for participants.

The session content in the previous pilot of MFT-AN (Matsuo et al., 2023) focussed on communication and did not include skills for managing mealtime. The current proposal extends this pilot by including skills such as validation, how to manage the difficulties during mealtimes

TABLE 3 Session plan.

Time	Task
5 min	Icebreaker
5 min	Review any reflections or homework tasks from the previous session
75 min	Today's activity
5 min	Coping skills and/or mindfulness exercise

and a broader concept of externalisation that includes neurobiology and temperament, as described in FT-AN. This is based on common feedback from the parent psychoeducation groups at Shinshu University Hospital that parents would like help with having more skills and strategies to manage mealtime. These added therapeutic interventions may strengthen the previous findings and increase acceptability for participants in Japan.

The number of studies on the effectiveness of family, children and adolescent-focussed Western therapies in Japan remains limited. There is a need to accumulate reports on the feasibility and acceptability of Western treatments for children and families in Japan and whether modifications based on Japanese culture are necessary.

More broadly, there is an identified need and recent push for greater cultural sensitivity and adaptations within mental health treatments and services (Koslofsky & Domenech Rodríguez, 2017). This is both for diverse groups living within Western societies, as well as people living in non-Western countries and cultures (e.g. Bernal & Domenech Rodríguez, 2009; Koslofsky & Domenech Rodríguez, 2017; Kumpfer et al., 2017). Meta-analytic findings suggest culturally adapted interventions may be more effective for non-white participants in Western countries, and people may engage better in therapy and experience improved outcomes when treatment aligns with their culture (Soto et al., 2018). However, to date, no empirical investigation of cultural adaptations of MFT-AN have been reported to our knowledge.

The next steps will be to pilot the intervention and empirically evaluate the feasibility, acceptability and effectiveness of adapted MFT-AN for the Japanese context.

ACKNOWLEDGEMENTS

This work was supported by JSPS KAKENHI grant no. JP 23K14796.

CONFLICT OF INTEREST STATEMENT

Julian Baudinet and Mima Simic received royalties from Routledge for the publication of a multi-family therapy treatment manual. The other authors have no conflicts of interest to disclose.

ORCID

Rie Kuge https://orcid.org/0000-0002-7727-7361
Daimei Sasayama https://orcid.org/0000-0003-3450-7283
Hideo Honda https://orcid.org/0000-0002-1147-3677
Mima Simic https://orcid.org/0000-0003-4900-1429
Julian Baudinet https://orcid.org/0000-0002-7840-4158

REFERENCES

American Psychiatric Association. (2022) *Diagnostic and statistical manual of mental disorders (DSM-5-TR) (5th edition, text revision)*. Washington: American Psychiatric Association. Available from: https://doi.org/10.1176/appi.books.9780890425787

Austin, A., Flynn, M., Shearer, J., Long, M., Allen, K., Mountford, V.A. et al. (2022) The first episode rapid early intervention for eating disorders – upscaled study: clinical outcomes. *Early Intervention in Psychiatry*, 16, 97–105.

Baudinet, J. & Eisler, I. (2024) Multi-family therapy for eating disorders across the lifespan. *Current Psychiatry Reports*, 26, 323–329. Available from: https://doi.org/10.1007/s11920-024-01504-5

Baudinet, J., Eisler, I., Dawson, L., Simic, M. & Schmidt, U. (2021) Multi-family therapy for eating disorders: a systematic scoping review of the quantitative and qualitative findings. *The International Journal of Eating Disorders*, 54, 2095–2120.

Baudinet, J., Eisler, I., Konstantellou, A., Hunt, T., Kassamali, F., McLaughlin, N. et al. (2023) Perceived change mechanisms in multi-family therapy for anorexia nervosa: A qualitative follow-up study of adolescent and parent experiences. *European eating disorders review*, 31(6), 822–836. Available from: https://doi.org/10.1002/erv.3006

Baudinet, J., Eisler, I., Konstantellou, A., Simic, M. & Schmidt, U. (2024) How young people perceive change to occur in family therapy for anorexia nervosa: a qualitative study. *Journal of Eating Disorders*, 12(1), 11. Available from: https://doi.org/10.1186/s40337-024-00971-8

Baudinet, J., Eisler, I., Simic, M. & Schmidt, U. (2021) Brief early adolescent multi-family therapy (BEAM) trial for anorexia nervosa: a feasibility randomized controlled trial protocol. *Journal of Eating Disorders*, 9, 71.

Baudinet, J., Hodsoll, J., Schmidt, U., Simic, M., Landau, S. & Eisler, I. (2023) Moderators of treatment effect in a randomised controlled trial of single- and multi-family therapy for anorexia nervosa in adolescents and emerging adults. *European Eating Disorders Review*, Available from: https://doi.org/10.1002/erv.3050

Baudinet, J. & Simic, M. (2021) Adolescent eating disorder day Programme treatment models and outcomes: a systematic scoping review. *Frontiers in Psychiatry*, 12, 652604.

Baudinet, J., Simic, M. & Eisler, I. (2021) From treatment models to manuals: Maudsley single- and multi-family therapy for adolescent eating disorders. In: Mariotti, M., Saba, G. & Stratton, P. (Eds.) *Systemic approaches to manuals*, 1st edition. Switzerland: Springer, Cham, pp. 349–372. Available from: https://doi.org/10.1007/978-3-030-73640-8

Baumas, V., Zebdi, R., Julien-Sweerts, S., Carrot, B., Godart, N., Minier, L. et al. (2021) Patients and Parents' experience of multi-family therapy for anorexia nervosa: a pilot study. *Frontiers in Psychology*, 12, 584565.

Bernal, G. & Domenech Rodríguez, M.M. (2009) Advances in Latino family research: cultural adaptations of evidence-based interventions. *Family Process*, 48(2), 169–178. Available from: https://doi.org/10.1111/j.1545-5300.2009.01275.x

Coopey, E. & Johnson, G. (2022) Exploring the experience of young people receiving treatment for an eating disorder: family therapy for anorexia nervosa and multi-family therapy in an inpatient setting. *Journal of Eating Disorders*, 10, 101.

Dawson, L., Baudinet, J., Tay, E. & Wallis, A. (2018) Creating community – the introduction of multi-family therapy for eating disorders in Australia. *Australian and New Zealand Journal of Family Therapy*, 39, 283–293.

Depestele, L., Claes, L., Dierckx, E., Colman, R., Schoevaerts, K. & Lemmens, G.M.D. (2017) An adjunctive multi-family group intervention with or without patient participation during an inpatient treatment for adolescents with an eating disorder: a pilot study. *European Eating Disorders Review*, 25, 570–578.

Eisler, I., Simic, M., Blessitt, E., Dodge, L. & MCCAED Team. (2016) Maudsley service manual for child and adolescent eating disorders. Available from: https://mccaed.slam.nhs.uk/wp-content/uploads/2019/11/Maudsley-Service-Manual-for-Child-and-Adolescent-Eating-Disorders-July-2016.pdf. [Accessed 28th October 2022]

Eisler, I., Simic, M., Hodsoll, J., Asen, E., Berelowitz, M., Connan, F. et al. (2016) A pragmatic randomised multicentre trial of multifamily and single family therapy for adolescent anorexia nervosa. *BMC Psychiatry*, 16, 422.

Escoffié, A., Pretorius, N. & Baudinet, J. (2022) Multi-family therapy for bulimia nervosa: a qualitative pilot study of adolescent and family members' experiences. *Journal of Eating Disorders*, 10, 91.

Geist, R., Heinmaa, M., Stephens, D., Davis, R. & Katzman, D.K. (2000) Comparison of family therapy and family group psychoeducation in adolescents with anorexia nervosa. *Canadian Journal of Psychiatry*, 45, 173–178.

Gelin, Z., Cook-Darzens, S. & Hendrick, S. (2018) The evidence base for multiple family therapy in psychiatric disorders: a review (part 1). *Journal of Family Therapy*, 40, 302–325.

Gowers, S.G., Weetman, J., Shore, A., Hossain, F. & Elvins, R. (2000) Impact of hospitalisation on the outcome of adolescent anorexia nervosa. *The British Journal of Psychiatry*, 176, 138–141.

Harada, T., Yamauchi, T., Miyawaki, D., Miyamoto, S., Yoshida, H., Nishimoto, K. et al. (2021) Anorexia nervosa restricting type has increased in severity over three decades: Japanese clinical samples from 1988 to 2018. *The International Journal of Eating Disorders*, 54, 54–58.

Hilbert, A., Hoek, H.W. & Schmidt, R. (2017) Evidence-based clinical guidelines for eating disorders: international comparison. *Current Opinion in Psychiatry*, 30, 423–437.

Hosokawa, R. & Katsura, T. (2019) Role of parenting style in Children's behavioral problems through the transition from preschool to elementary school according to gender in Japan. *International Journal of Environmental Research and Public Health*, 16, 21.

Hotta, M., Horikawa, R., Mabe, H., Yokoyama, S., Sugiyama, E., Yonekawa, T. et al. (2015) Epidemiology of anorexia nervosa in Japanese adolescents. *BioPsychoSocial Medicine*, 9, 17.

Iguchi, T., Miyawaki, D., Harada, T. & Ogiwara, K. (2021) Introduction of family-based treatment to Japan with adaptations to optimize the cultural acceptability and advance current traditional treatments of adolescent anorexia nervosa. *The International Journal of Eating Disorders*, 54, 117–119.

Jewell, T., Blessitt, E., Stewart, C., Simic, M. & Eisler, I. (2016) Family therapy for child and adolescent eating disorders: a critical review. *Family Process*, 55, 577–594.

Knatz, S., Murray, S.B., Matheson, B., Boutelle, K.N., Rockwell, R., Eisler, I. et al. (2015) A brief, intensive application of multi-family-based treatment for eating disorders. *Eating Disorders*, 23, 315–324.

Koslofsky, S. & Domenech Rodríguez, M.M. (2017) Cultural adaptations to psychotherapy: real-world applications. *Clinical Case Studies*, 16(1), 3–8. Available from: https://doi.org/10.1177/1534650116668273

Kuge, R., Lang, K., Yokota, A., Kodama, S., Morino, Y., Nakazato, M. et al. (2017) Group cognitive remediation therapy for younger adolescents with anorexia nervosa: a feasibility study in a Japanese sample. *BMC Research Notes*, 10, 317.

Kumpfer, K., Magalhães, C. & Xie, J. (2017) Cultural adaptation and implementation of family evidence-based interventions with diverse populations. *Prevention Science*, 18(6), 649–659. Available from: https://doi.org/10.1007/s11121-016-0719-3

Lay, B., Jennen-Steinmetz, C., Reinhard, I. & Schmidt, M.H. (2002) Characteristics of inpatient weight gain in adolescent anorexia nervosa: relation to speed of relapse and re-admission. *European Eating Disorders Review*, 10, 22–40.

Lock, J. & Le Grange, D. (2012) *Treatment manual for anorexia nervosa: a family-based approach*, 2nd edition. New York: Guilford Press.

Mason, B. (2022) Towards positions of safe uncertainty. *Human Systems: Therapy, Culture and Attachments*, 2, 54–63.

Matsumoto, D. (2006) Are cultural differences in emotion regulation mediated by personality traits? *Journal of Cross-Cultural Psychology*, 37, 421–437.

Matsumoto, T. (2012) Understanding and treating self-injury. *Seishin Shinkeigaku Zasshi*, 114, 983–989. (in Japanese).

Matsuo, Y., Morino, Y., Oka, T., Kuge, R., Fujimoto, A., Tominaga, T. et al. (2023) Multiple family therapy for adolescents with anorexia nervosa: a pilot study to investigate its feasibility for use in Japan. *Japanese Journal of Psychiatric Treatment*, 38, 1083–1091. (in Japanese).

Morgan, H.G. & Russell, G.F. (1975) Value of family background and clinical features as predictors of long-term outcome in anorexia nervosa: four-year follow-up study of 41 patients. *Psychological Medicine*, 5, 355–371.

National Center of Neurology and Psychiatry. (2020) *Sesshoku shougai chiryou shien senta secchi unei jigyou houkokusho [Business report on the establishment and operation of the Center for Eating Disorder Research and Information]*. Japanese Ministry of Health, Labour and Welfare. (in Japanese). Available from: https://www.ncnp.go.jp/nimh/shinshin/edcenter/pdf/. [Accessed 28th October 2022]

National Institute for Health and Care Excellence. (2017) National institute for health and care excellence: clinical guidelines. In: *Eating disorders: recognition and treatment, full guideline*. London: National Institute for Health and Care Excellence.

Quadflieg, N., Naab, S., Schlegl, S., Bauman, T. & Voderholzer, U. (2023) Inpatient treatment outcome in a large sample of adolescents with anorexia nervosa. *Nutrients*, 15(19), 4247. Available from: https://doi.org/10.3390/nu15194247

Rienecke, R.D. & Le Grange, D. (2022) The five tenets of family-based treatment for adolescent eating disorders. *Journal of Eating Disorders*, 10, 60.

Scholz, M., Rix, M., Scholz, K., Gantchev, K. & Thömke, V. (2005) Multiple family therapy for anorexia nervosa: concepts, experiences and results. *Journal of Family Therapy*, 27, 132–141.

Simic, M., Baudinet, J., Blessitt, E., Wallis, A. & Eisler, I. (2021a) *Multi-family therapy for anorexia nervosa: a treatment manual*. London: Routledge.

Simic, M. & Eisler, I. (2015) Multi family therapy. In: Loeb, K., Le Grange, D. & Lock, J. (Eds.) *Family therapy for adolescent eating and weight disorders*. New York: Guilford Press, pp. 110–138.

Skarbø, T. & Balmbra, S.M. (2020) Establishment of a multifamily therapy (MFT) service for young adults with a severe eating disorder – experience from 11 MFT groups, and from designing and implementing the model. *Journal of Eating Disorders*, 8, 9.

Smink, F.R., van Hoeken, D. & Hoek, H.W. (2013) Epidemiology, course, and outcome of eating disorders. *Current Opinion in Psychiatry*, 26, 543–548.

Solmi, M., Monaco, F., Højlund, M., Monteleone, A.M., Trott, M., Firth, J. et al. (2024) Outcomes in people with eating disorders: a transdiagnostic and disorder-specific systematic review, meta-analysis and multivariable meta-regression analysis. *World Psychiatry*, 23, 124–138.

Soto, A., Smith, T.B., Griner, D., Domenech Rodríguez, M. & Bernal, G. (2018) Cultural adaptations and therapist multicultural competence: two meta-analytic reviews. *Journal of Clinical Psychology*, 74(11), 1907–1923. Available from: https://doi.org/10.1002/jclp.22679

Stewart, C.S., Baudinet, J., Hall, R., Fiská, M., Pretorius, N., Voulgari, S. et al. (2021) Multi-family therapy for bulimia nervosa in adolescence: a pilot study in a community eating disorder service. *Eating Disorders*, 29, 351–367. Available from: https://doi.org/10.1080/10640266.2019.1656461

Tantillo, M., McGraw, J.S., Lavigne, H.M., Brasch, J. & Le Grange, D. (2019) A pilot study of multifamily therapy group for young adults with anorexia nervosa: reconnecting for recovery. *The International Journal of Eating Disorders*, 52, 950–955.

Thomas, P., Hiroko, K.-W. & Michelle, K. (1992) Childrearing patterns in Japan and the United States: a cluster analytic study. *International Journal of Behavioral Development*, 15, 185–205.

Treasure, J. & Russell, G. (2011) The case for early intervention in anorexia nervosa: theoretical exploration of maintaining factors. *The British Journal of Psychiatry*, 199, 5–7.

Voriadaki, T., Simic, M., Espie, J. & Eisler, I. (2015) Intensive multi-family therapy for adolescent anorexia nervosa: adolescents' and parents' day-to-day experiences. *Journal of Family Therapy*, 37, 5–23.

Wiseman, H., Ensoll, S., Russouw, L. & Butler, C. (2019a) Implementing multi-family therapy within a community eating disorder service for children and young people. *Journal of Systemic Therapies*, 38, 50–66.

Wiseman, H., Ensoll, S., Russouw, L. & Butler, C. (2019b) Multi-family therapy for young people with anorexia nervosa: clinicians' and carers' perspectives on systemic changes. *Journal of Systemic Therapies*, 38, 67–83.

World Economic Forum. (2022) Global gender gap report 2022. Available from: https://www3.weforum.org/docs/WEF_GGGR_2022.pdf. [Accessed 28th October 2022]

Wufong, E., Rhodes, P. & Conti, J. (2019) "We don't really know what else we can do": parent experiences when adolescent distress persists after the Maudsley and family-based therapies for anorexia nervosa. *Journal of Eating Disorders*, 7, 1–18.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

How to cite this article: Kuge, R., Kojima, K., Shiraishi, K., Sasayama, D., Honda, H., Simic, M. et al. (2024) Adaptation of multi-family therapy for children and adolescents with anorexia nervosa in Japan. *Journal of Family Therapy*, 00, 1–14. Available from: https://doi.org/10.1111/1467-6427.12468