Chronic Diseases Journal

DOI: 10.22122/cdj.v13i4.811 Published by Vesnu Publications

Parent-focused group schema coaching program for parents of adolescents with anorexia nervosa: Intervention mapping study

Fatemeh Seifi[1], Javad Molazadeh[1], Abdulaziz Aflakseir[1], Changiz Rahimi-Taghanaki[1], Susan Simpson[2]

1 Department of Clinical Psychology, Shiraz University, Shiraz, Iran
2 Livilands Resource Centre, NHS Forth Valley Eating Disorders Service, Stirling, UK AND Department of Justice and Society, University of South Australia, Adelaide, Australia

Original Article

Abstract

BACKGROUND: Given the pivotal role of parents in the recovery of adolescents with anorexia nervosa (AN), the current study aimed to describe the intervention mapping (IM) approach used to develop and implement a novel parent-focused group schema coaching protocol (online CAREFREE program) for parents of adolescents with AN in Iran, and also to determine its content validity and acceptability.

METHODS: The IM methodology was applied for the systematic development of the online CAREFREE program, consisting of 6 steps: carrying out needs assessment, identifying objectives, intervention design, intervention production, implementation plan, and evaluation plan. The whole procedure took 2 years, from January 2021 to January 2023. The content validity of the protocol was assessed through a panel of experts (n = 6). The acceptability of the intervention was evaluated by the CAREFREE Treatment Satisfaction Rating Scale by the parents (n = 19) in 3 intervention groups.

RESULTS: The results for each IM step were established sequentially in a narrative format. The overall content validity of the modules was high. The mean CVR was 0.99, and the S-CVI was 0.94. The mean scores in each intervention group showed that all the groups reported high satisfaction with the CAREFREE program. Total acceptability mean scores in mid-treatment and post-treatment were 9.31 and 9.63, respectively.

CONCLUSION: The CAREFREE intervention using the IM approach demonstrated high content validity and acceptability. The findings from this study may be particularly useful for other intervention developers in the field of pediatric eating disorders in Iran.

KEYWORDS: Adolescents; Anorexia Nervosa; Parents; Program Development

Date of submission: 05 Jan. 2023, ***Date of acceptance:*** 08 April 2023

Citation: Seifi F, Molazadeh J, Aflakseir A, Rahimi-Taghanaki C, Simpson S. **Parent-focused group schema coaching program for parents of adolescents with anorexia nervosa: Intervention mapping study.** Chron Dis J 2025; 13(4): 190-7.

Introduction

Anorexia nervosa (AN) is increasingly recognized as a serious, highly complex, and potentially life-threatening psychiatric disorder associated with multiple comorbidities, high mortality rates, impaired quality of life (QOL), and suicidal ideation.[1] AN, characterized by severe anxiety and preoccupation with eating, body shape, and weight gain, generally begins to emerge in adolescence, on average at the age of seventeen[2] with a lifetime prevalence reported of more than 1%.[3]

In recent years, the treatment of adolescent AN has received considerable attention. International guidelines recommend family-

Corresponding Author:
Javad Molazadeh: Department of Clinical Psychology, Shiraz University, Shiraz, Iran
Email: molazade@shirazu.ac.ir

based treatment (FBT), commonly recognized as the Maudsley method, as the first-line treatment for AN in adolescents, whereby responsibility for the refeeding process is allocated to parents.[4,5] Up to 27% of families quit this therapy, with greater drop-out percentages most typically in the early phase (i.e., the first 2-3 months) or realize that it does not work for them and may experience relapse after remission.[6] During and after treatment, adolescents in roughly 40% of families experience chronic AN symptomatology and/or psychological distress.[7]

In the proposed adolescent AN treatment models, including FBT, scant attention has been paid to the effects of early childhood experiences and childhood unmet needs, as well as parent-child interaction and relational patterns.[8] In addition, given the prevalence of comorbidity and rigid personality traits in adolescents with AN,[9] deeper-level approaches are needed to assist parents in understanding the complex belief systems underlying the AN presentation to facilitate engagement at a deeper emotional level and enhance the capacity for emotion co-regulation in their relationship with their children.[10] Schema therapy (ST) appears to be ideally suited to fill these gaps due to its strong focus on understanding the influence of early experiences, particularly the role of parenting, attachment, emotional invalidation, and trauma during childhood.[11-14] While the vital role of family dynamics in developing AN has been argued in several studies,[15,16] parents are not to blame for the formation or perpetuation of adolescent AN.[17] Subsequently, in recent years, family therapy treatments for adolescent AN have shown an increased tendency to include establishing a supportive and non-blaming context for parents.[18,19] Additionally, previous research has established that engaging parents in the treatment procedure helps pave the way for recovery.[20] It has been demonstrated that involving carers in the management of AN can be an effective strategy to augment professional help.[21]

Accordingly, the authors of the current study developed an alternative treatment based on the ST mode model and parent schema coaching. The mentioned protocol's theoretical framework and therapeutic interventions benefited to a great extent from the ST model proposed by Simpson and Smith[22] for eating disorders and the recent model proposed by Loose et al.,[23], which combines ST with family therapy assumptions and techniques. The program was named CAREFREE (Carers Program for Fluency in Resonance, and Empowerment in Eating Disorders) and was presented in 12 sessions and an online group format, allowing caregivers to express and address difficult thoughts and feelings openly with other similar parents.[24]

Due to the fact that the CAREFREE intervention was a novel treatment model for supporting the caregivers of adolescents with AN, one powerful evidence-based approach to developing an effective protocol was intervention mapping (IM).[25] is a widely accepted framework that can be used to plan, develop, implement, and evaluate new theory-based and evidence-based health promotion interventions and appropriately modify them to match participants' needs and new intervention contexts.[26] IM takes an ecological approach that encompasses step-by-step decision-making in program development and follows a series of 6 structured steps. Accordingly, the current study aimed to describe the systematic IM process used to develop, implement, and evaluate a novel parent-focused group schema coaching protocol (CAREFREE program) for parents of adolescents with AN in Iran, and also to determine its content validity and acceptability. To the best of our knowledge, this is the first protocol that incorporates the ST mode model into parenting for carers of

adolescents with AN. This study sheds new light on the development of psychological interventions for Iranian families of adolescents with eating disorders who are usually neglected and under-recognized.

Methods

The IM methodology was applied for the systematic development of the CAREFREE program. IM is a descriptive research design, and its procedure comprises 6 steps. These 6 steps and their related tasks are described in the following sections.

Step 1: Needs assessment

In the first step, for creating a logic model of the health problem, a needs assessment was conducted through Public and Patient Involvement (PPI).[27] PPI in research refers to the inclusion and activation of patients or public laypeople as partners in the various stages of the research process. The advisory committee (n = 8) was interviewed and was involved in this step, and collaborated with the authors as a planning group.

Step 2: Identifying objectives

In this step, the planning group described the desired change at both the behavioral and environmental levels, and finally, they specified who and what would change as a result of the CAREFREE intervention.

Step 3: Intervention design

The program designers discussed initial ideas and selected preliminary tools and techniques, and their practical application throughout the program, with the aim of achieving the change objectives. Thereafter, they created theory-based core components and main themes of the protocol with several practical guidelines for parents based on the previous research gaps in similar contexts.

Step 4: Intervention production

The program designers developed and refined the program's structure and the actual intervention modules by integrating and sequencing the methods and applications resulting from step 3. The number of sessions (12 sessions) and their duration (each session: 90 minutes), their methods of delivery (video conferencing), the sequences of modules, and their main headings were determined and finalized through consultation with the PPI advisory committee.

To establish the content validity of the CAREFREE protocol, the Farsi version of the summary of modules and a survey link were sent to 6 Iranian experts (clinical psychologists and psychiatrists) via an email invitation. They evaluated the content validity using the content validity ratio (CVR) and content validity index (CVI). Experts were asked to rate each module in the survey (a total of 36 questions) according to how relevant, clear, and simple it was, using a 4-point CVI scale. Their responses to item-level CVI (I-CVI) scales were coded as not relevant/clear/simple = 1, quite relevant/clear/simple = 2, relevant/clear/simple but need minor revision = 3, and highly relevant/clear/simple = 4. Also, they were asked to rate the modules in terms of their importance in being incorporated into the program, using a 3-item CVR scale (a total of 12 questions): Is this module in the protocol 1. Essential, 2. Useful but not essential, 3. Not necessary. Experts were given 2 weeks to complete the scales, after which time the link was inactivated and data were exported into Microsoft Excel. Literature suggests that a CVR of at least 0.78, a mean CVR of 0.99 with 6 experts' evaluation, I-CVI of at least 0.78, and an Average Scale-CVI of 0.90 are necessary to deem a protocol as valid.[28,29] Additionally, through discussion, experts informed the coordinator about the aspects of the program that seemed culturally inappropriate, and the planning group decided to tailor those aspects to the Iranian culture.

Step 5: Implementation plan

In this step, procedures for the recruitment of participants and sustained contact with them were established, as well as the procedures for

inclusion, screening, randomization, additional patient monitoring, follow-up, and collecting the outcome measure. Also, the informed consent forms were signed by eligible parents prior to their participation.

Step 6: Evaluation plan

In the final step, the acceptability of the intervention was assessed through the CAREFREE Treatment Satisfaction Rating Scale based on a brief 4-item visual analog instrument.[30] It was sent to the caregivers at mid- and post-treatment. This scale measures satisfaction with the following aspects: (1) the relational bond between the therapist and participants, (2) the goals, content, and topics of therapy, (3) the therapist's approach and methods, (4) the participants' view of the sessions and their overall satisfaction.

This step also includes feasibility testing of the intervention and the program effects, which are both outside the scope of this article, as the aim here was to describe the development and design process as well as the content validity report. The actual evaluation of the program on outcomes will be covered in subsequent publications, including a pilot feasibility and effectiveness study, both quantitatively and qualitatively.

This study was approved by the Research Ethics Committees of Shiraz University of Medical Sciences (IR.SUMS.REC.1401.212).

Results

This study used the IM approach following the established steps mentioned in the methods section. The whole procedure took 2 years (from January 2021 to January 2023). The results for each step are described sequentially below, in a narrative format and are presented in tables 1-3.

Table 1. Overview of CAREFREE intervention components

Session	Module's focus	Key purposes
1	Psychoeducation and practical aspects	Clarifying the purpose of the program – guilt and blame vs. recognizing and understanding the complexity of humanness, parenting, and eating disorders, providing psychoeducation about AN
2	Introduction to schema modes	Introducing the concept of modes & Anorexia from a schema mode perspective, Providing practical tools for the refeeding process using experiential techniques
3	Temperament, traits and eating disorders	Introducing anorexia as a biopsychosocial disorder, discussing parents' temperament as well as their family members' temperaments
4	Emotional needs and vitamins	Explaining eating behaviors as attempted solutions for missing emotional vitamins, discussing toxic cultural messages leading to shame and guilt
5	Inner Critic and mode clashes	Describing how the Emotional Self hides because of the inner critic attacking it, discussing how identifying mode clashes can improve parent-child interaction
6	Parenting styles and coping modes	Discussing how eating and body-based behaviors can be used to cope with missing emotional vitamins, Explaining how to bypass coping parts to reconnect with family members
7	Strengthening wise self through empathy	Elaborating on empathy, attunement and co-regulation, discussing what showing up means
8	Modelling healthy self-care	Helping parents to find their own inner parenting compass and learn to model healthy self-care
9	Managing anger and setting limits	Discussing blocks to setting boundaries and the schema modes that block this
10	Negotiating individuation as a missed developmental stage	Negotiating adolescence and the transition from adolescence to adulthood, so that the parents can learn about autonomy, individuation, and risk-taking
11	Introducing intuitive eating as one of the tools of inner wise mode	Coaching parents to model their intuitive eating voice and body connection
12	Self-compassion for parents	Explaining the components of self-compassion and its important role in parenting an adolescent with AN

AN: Anorexia nervosa

Table 2. Content validity ratio (CVR) and content validity index (CVI) of the CAREFREE protocol

Module	Relevancy I-CVI	Clarity I-CVI	Simplicity I-CVI	Importance CVR
1. Psychoeducation and practical aspects	1.00	1.00	1.00	1.00
2. Introduction to schema modes	1.00	0.83	0.83	1.00
3. Temperament, traits & eating disorders	1.00	1.00	0.83	1.00
4. Emotional needs and vitamins	1.00	1.00	1.00	1.00
5. Inner Critic & mode clashes	1.00	0.83	0.83	1.00
6. Parenting styles and coping modes	1.00	0.83	0.83	1.00
7. Strengthening Wise Self through empathy	1.00	1.00	0.83	1.00
8. Modelling healthy self-care	0.83	1.00	1.00	0.83
9. Managing anger and setting limits	1.00	1.00	1.00	1.00
10. Negotiating individuation	1.00	0.83	0.83	1.00
11. Introducing intuitive eating	1.00	1.00	0.83	1.00
12. Self-compassion for parents	1.00	1.00	1.00	1.00
Mean score (Average S-CVI = 0.94)	0.99	0.94	0.90	0.99

CVR: Content validity ratio; CVI: Content validity index

To evaluate and determine the modules' content validity, a quantitative estimate of each module's validity was assessed. This was performed using calculations of CVR and CVI. The results are presented in table 2. The CVR values for all modules were greater than 0.78. Likewise, the expert panel evaluated the relevance, clarity, and simplicity of all modules, and the CVI values for all items were more than 0.78 (all modules at this stage passed the criterion). The mean CVR was 0.99, and the S-CVI was 0.94. Overall, the modules of CAREFREE are rated to be of sufficient importance, relevance, clarity, and simplicity.

In step 5, the intervention was performed using a 3-tiered nonconcurrent multiple baseline (NMBL) across groups methodology,[31] including 3 intervention groups with 3 months of follow-ups. Three possible baseline lengths were selected beforehand (4, 6, & 8 weeks), and parents were randomly and non-concurrently allocated to each group. Initially, each group consisted of 9 recruited parents, but 6 parents remained in group 1 and 2, and 7 parents remained in group 3. The intervention phase began in July 2022 and ended in January 2023.

In step 6, among the types of outcome measures in the implementation stage, acceptability of the protocol was assessed.[32] The acceptability was reported by the participants across 3 groups in mid- and post-treatment. The mean scores in each group (each was rated out of 10) show that all the groups reported high satisfaction with the CAREFREE program, and the results are shown in table 3.

Table 3. Mean scores of acceptability among the three intervention groups

Group	Mid-treatment (6^{th} session)	Post-treatment (12^{th} session)
1	9.25	9.50
2	9.41	9.66
3	9.28	9.71
Total	9.31	9.63

Discussion

The overall aim of this study was to develop a novel treatment protocol for caregivers of adolescents with AN using the IM approach and to evaluate the content validity of the protocol's modules and the program's acceptability. The IM guideline's steps were closely followed to ensure that the intervention was beneficial, parent-friendly, and satisfactory from the perspective of participants. The quantitative estimate of the content validity of each module was measured through calculations of the CVR and CVI. Overall, the results showed that the modules

were valid enough in terms of relevancy, clarity, simplicity, and importance.

Active involvement of the PPI advisory committee throughout the protocol's development stages enabled the specification of the key needs of the participants. This was consistent with the findings of the study by Price et al., demonstrating the health benefits and practical values of PPI.[33] However, one study argues that there is still confusion about the normative underpinnings of PPI, leading to substantial barriers for efforts to assess the success of PPI-based policies.[34]

The protocol's modules were based on the gaps identified in the literature and previous evidence-based AN family-based protocols, and the protocol designers highly profited from the ST for eating disorders' framework, core concepts, and techniques.[22]

Concerning the protocol's content and scopes, the CAREFREE program was expected to empower parents to build a new perspective based on a new schema modes concept in order to enable them to help their children make a satisfactory recovery. Prior studies have shown ST, the schema-mode approach, and related methods to be favorable interventions for complex eating disorders both in individual and group treatment.[35] Also, a great deal of previous research has indicated the important role of parents in adolescent AN recovery.[36,37] However, to the best of our knowledge, this is the first study on the amalgamation of the 2 approaches (ST and parent coaching) in order to design a parent-focused group schema coaching for adolescent AN. Indeed, in this program, parents were instructed to improve their understanding and recognition of the emotional difficulties underlying the eating disorder through the lens of schema modes, and also develop skills to support their children to sufficiently recover from AN via healthy emotional growth. Consequently, parents who participated in the program reported high satisfaction with the implementation of the intervention, meaning that the program was regarded as acceptable from their perspective. These results corroborate the findings of a great deal of previous work on the role of parenting groups in adolescent AN recovery.[38]

A potential limitation of this study was that, in the implementation of the protocol, the authors initially began with a small sample size for each group. This was mostly due to the pilot nature of this study and a lack of official and non-governmental eating disorders specialized centers or services in Iran, indicating that accessing and identifying this population was assumed to be difficult. Future studies should attempt to evaluate the effectiveness of this protocol with a larger sample size and through randomized controlled trials (RCTs) to further provide evidence for the reliability of the CAREFREE protocol. The CAREFREE is the first intervention protocol that adjusts ST to the needs of parenting adolescents with AN in a group format. This study demonstrated the process of developing the CAREFREE protocol while evaluating its content validity and acceptability.

Conclusion

The development of the CAREFREE intervention followed the comprehensive steps of the IM process and was founded on theory and relevant literature. The findings of this study may be particularly useful for other intervention developers who are also planning to design and implement parent-focused interventions targeting other types of eating disorders, particularly in Iranian adolescents.

Conflict of Interests

Authors have no conflict of interests.

Acknowledgments

The authors would like to express their great appreciation to all the parents and colleagues who participated in this research.

Financial support and sponsorship

This research received no specific grant from any funding agency.

References

1. Hambleton A, Pepin G, Le A, Maloney D, Touyz S, Maguire S. Psychiatric and medical comorbidities of eating disorders: findings from a rapid review of the literature. J Eat Disord. 2022; 10(1): 132.
2. Carpine L, Charvin I, Da Fonseca D, Bat-Pitault F. Clinical features of children and adolescents with anorexia nervosa and problematic physical activity. Eat Weight Disord. 2022; 27(1): 119-29.
3. Silén Y, Keski-Rahkonen A. Worldwide prevalence of DSM-5 eating disorders among young people. Curr Opin Psychiatry. 2022; 35(6): 362-71.
4. Lock J, Le Grange D. Family-based treatment: Where are we and where should we be going to improve recovery in child and adolescent eating disorders. Int J Eat Disord. 2019; 52(4): 481-7.
5. Rienecke RD, Le Grange D. The five tenets of family-based treatment for adolescent eating disorders. J Eat Disord. 2022; 10(1): 60.
6. Le Grange D, Pradel M, Pogos D, Yeo M, Hughes EK, Tompson A, et al. Family-based treatment for adolescent anorexia nervosa: Outcomes of a stepped-care model. Int J Eat Disord. 2021; 54(11): 1989-97.
7. Wufong E, Rhodes P, Conti J. "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. J Eat Disord. 2019; 7(1): 5.
8. Jewell T, Herle M, Serpell L, Eivors A, Simic M, Fonagy P, et al. Attachment and mentalization as predictors of outcome in family therapy for adolescent anorexia nervosa. Eur Child Adolesc Psychiatry. 2023; 32(7): 1241-51.
9. Laczkovics C, Czernin K, Carlitscheck J, Zeiler M, Schlund P, Wunram HL, et al. Personality disorder in adolescent patients with anorexia nervosa. Psychopathology. 2023; 56(4): 268-75.
10. Criscuolo M, Marchetto C, Buzzonetti A, Castiglioni MC, Cereser L, Salvo P, et al. Parental emotional availability and family functioning in adolescent anorexia nervosa subtypes. Int J Environ Res Public Health. 2022; 20(1): 68.
11. Flanagan C, Atkinson T, Young J. An introduction to schema therapy. In: Heath G, Startup H, Editors. Creative methods in schema therapy. 1st ed. London, United Kingdom: Routledge; 2020. p. 1-16.
12. Khosravi M, Seyedi Asl ST, Nazari Anamag A, SabzehAra Langaroudi M, Moharami J, Ahmadi S, et al. Parenting styles, maladaptive coping styles, and disturbed eating attitudes and behaviors: a multiple mediation analysis in patients with feeding and eating disorders. PeerJ. 2023; 11: e14880.
13. Basile B, Novello C, Calugi S, Dalle Grave R, Mancini F. Childhood memories in eating disorders: An explorative study using diagnostic imagery. Front Psychol. 2021; 12: 685194.
14. Meneguzzo P, Cazzola C, Castegnaro R, Buscaglia F, Bucci E, Pillan A, et al. Associations between trauma, early maladaptive schemas, personality traits, and clinical severity in eating disorder patients: A clinical presentation and mediation analysis. Front Psychol. 2021; 12: 661924.
15. Erriu M, Cimino S, Cerniglia L. The role of family relationships in eating disorders in adolescents: A narrative review. Behav Sci. 2020; 10(4): 71.
16. Mensi MM, Balottin L, Rogantini C, Orlandi M, Galvani M, Figini S, et al. Focus on family functioning in anorexia nervosa: New perspectives using the lausanne trilogue play. Psychiatry Res. 2020; 288: 112968.
17. le Grange D, Lock J, Loeb K, Nicholls D. Academy for eating disorders position paper: The role of the family in eating disorders. Int J Eat Disord. 2010; 43(1): 1-5.
18. Carpinelli L, Watzlawik M. Anorexia nervosa in adolescence: parental narratives explore causes and responsibilities. Int J Environ Res Public Health. 2023; 20(5): 4075.
19. Baudinet J, Simic M, Eisler I. From treatment models to manuals: Maudsley single- and multi-family therapy for adolescent eating disorders. In: Mariotti M, Saba G, Stratton P, Editors. Handbook of systemic approaches to psychotherapy manuals: Integrating research, practice, and training. Cham, Switzerland: Springer International Publishing; 2021. p. 349-72.
20. Couturier J, Isserlin L, Norris M, Spettigue W, Brouwers M, Kimber M, et al. Canadian practice guidelines for the treatment of children and adolescents with eating disorders. J Eat Disord. 2020; 8: 4.
21. Treasure J, Parker S, Oyeleye O, Harrison A. The value of including families in the treatment of anorexia nervosa. Eur Eat Disord Rev. 2021; 29(3): 393-401.
22. Simpson S, Smith E. Schema therapy for eating disorders: Theory and practice for individual and group settings. 1st ed. London, United Kingdom: Routledge; 2019.
23. Loose C, Graaf P, Zarbock G, Holt RA. Schema therapy for children and adolescents ST-CA: A practitioner's guide. West Sussex, England:

Pavilion Publishing and Media Ltd; 2020.
24. Eshkevari E, Lawrence A, Ferraro I, Wade TD. Group skills training for parents of adolescents with anorexia nervosa: A pilot evaluation. Clin Psychol. 2022; 26(3): 288-95.
25. Fernandez ME, Ten Hoor GA, van Lieshout S, Rodriguez SA, Beidas RS, Parcel G, et al. Implementation mapping: Using intervention mapping to develop implementation strategies. Front Public Health. 2019; 7: 158.
26. Fernandez ME, Ruiter RAC, Markham CM, Kok G. Intervention mapping: Theory- and evidence-based health promotion program planning: perspective and examples. Front Public Health. 2019; 7: 209.
27. Skovlund PC, Nielsen BK, Thaysen HV, Schmidt H, Finset A, Hansen KA, et al. The impact of patient involvement in research: a case study of the planning, conduct and dissemination of a clinical, controlled trial. Res Involv Engagem. 2020; 6: 43.
28. Spoto A, Nucci M, Prunetti E, Vicovaro M. Improving content validity evaluation of assessment instruments through formal content validity analysis. Psychol Methods. 2025; 30(2): 203-22.
29. Yusoff MSB. ABC of content validation and content validity index calculation. Educ Med J. 2019; 11(2): 49-54.
30. Murphy MG, Rakes S, Harris RM. The psychometric properties of the session rating scale: A narrative review. J Evid Based Soc Work (2019). 2020; 17(3): 279-99.
31. Epstein LH, Bickel WK, Czajkowski SM, Paluch RA, Moeyaert M, Davidson KW. Single case designs for early phase behavioral translational research in health psychology. Health Psychol. 2021; 40(12): 858-74.
32. Landsverk J, Proctor EK. From research training to scientific advancement-contributions from the implementation research institute: An introduction to the special issue. Adm Policy Ment Health. 2020; 47(2): 169-75.
33. Price A, Clarke M, Staniszewska S, Chu L, Tembo D, Kirkpatrick M, et al. Patient and public involvement in research: A journey to co-production. Patient Educ Couns. 2022; 105(4): 1041-7.
34. McCoy MS, Warsh J, Rand L, Parker M, Sheehan M. Patient and public involvement: two sides of the same coin or different coins altogether? Bioethics. 2019; 33(6): 708-15.
35. Joshua PR, Lewis V, Kelty SF, Boer DP. Is schema therapy effective for adults with eating disorders? A systematic review into the evidence. Cogn Behav Ther. 2023; 52(3): 213-31.
36. Criscuolo M, Laghi F, Mazzoni S, Castiglioni MC, Vicari S, Zanna V. How do families of adolescents with anorexia nervosa coordinate parenting? J Child Fam Stud. 2020; 29(9): 2542-51.
37. Couturier J, Webb C, Carson N, Doxtdator K, Matheson B, Datta N, et al. Applying online parental guided self-help family-based treatment for adolescent anorexia nervosa: A comparison to family-based treatment delivered by videoconferencing. Clin Child Psychol Psychiatry. 2022; 27(3): 538-48.
38. Rosello R, Gledhill J, Yi I, Watkins B, Harvey L, Hosking A, et al. Early intervention in child and adolescent eating disorders: The role of a parenting group. Eur Eat Disord Rev. 2021; 29(3): 519-26.