

# 7 EMOTION-FOCUSED FAMILY THERAPY FOR EATING DISORDERS

*Managing family life can be difficult enough without the added stress of supporting a child with an eating disorder. Developing the ability to notice and respond appropriately to emotions—hers and my own—has diffused many stressful situations at the dinner table. It's truly making the difference in her recovery.*

—Caregiver

Eating disorders (EDs) are debilitating illnesses that are associated with the highest mortality rate of all mental disorders (Arcelus, Mitchell, Wales, & Nielsen, 2011). In the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; American Psychiatric Association, 2013) and the *International Classification of Diseases* (World Health Organization, 2018), a number of feeding and EDs are listed, including anorexia nervosa (AN), bulimia nervosa (BN), and binge eating disorder (BED). These disorders are characterized by problematic patterns of food intake, low self-esteem and poor or distorted body image (American Psychiatric Association, 2013). EDs are also

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*Emotion-Focused Family Therapy: A Transdiagnostic Model for Caregiver-Focused Interventions*, by A. Lafrance, K. A. Henderson, and S. Mayman

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highly comorbid with mood and anxiety disorders, as well as substance misuse (Hudson, Hiripi, Pope, & Kessler, 2007). The lifetime prevalence of EDs is 0.9% for AN; 1.5% BN; and 2.8% for BED in women and 0.3%, 0.5%, and 0.2%, respectively, in men (Hudson, Hiripi, Pope, & Kessler, 2007).

EDs are known to affect every system of the body (Katzman & Findlay, 2011; Mehler, 2018), and the course of the illness can negatively impact one's emotional, cognitive, and social development (Klump, Bulik, Kaye, Treasure, & Tyson, 2009). Although various interventions have been used to treat adolescent and adult EDs with varied levels of success, many individuals affected do not respond to existing therapies, and relapse rates are high (Halmi, 2009, 2013; Hay, Touyz, & Sud, 2012; Zipfel et al., 2014). For these reasons, novel treatment and adaptations to existing treatments are required (Halmi, 2013). As mentioned in the Introduction to this book, emotion-focused family therapy (EFFT) was developed in response to this need, first as an adjunct to family-based treatment for children and adolescents with EDs (Lafrance Robinson, Dolhanty, & Greenberg, 2015) and later as a stand-alone treatment for EDs across the lifespan (Stillar et al., 2016). As such, the application of EFFT is far more nuanced in this treatment context, and therefore, we dedicate this chapter to highlighting its use in EDs. In addition, readers are encouraged to view the following as a detailed and integrated example of the application of EFFT. The lessons we've learned by treating individuals with eating disorders, such as the importance of caregiver involvement, the role of emotion processing in the development and maintenance of mental illness, and the way in which illness severity can increase the likelihood of emotional blocks, are easily applicable across other mental health disorders. It is what EDs have in common with other mental health disorders, rather than the differences that exist between them, that has allowed for such a rapid expansion of EFFT transdiagnostically.

## **HISTORY OF FAMILY INVOLVEMENT IN EDS**

Historically, family factors have been regarded as causal in the development of EDs. For instance, family enmeshment, an emotional style characterized by a lack of personal and emotional boundaries, was often cited as a problem within families of affected individuals (Haworth-Hoepfner, 2000; Minuchin, 1970). In line with this conceptualization of illness, parental blame was a common practice among professionals and treatment frequently involved increasing ED patients' individuation from their families. At its extreme, parents were excluded from treatment or separated from their

child for extended periods of time (Munn, Smeltzer, Smeltzer, & Westin, 2010). These practices came to be referred to as *parentectomies* (Harper, 1983). Now various lines of research have confirmed that EDs can develop in a wide range of family contexts and that there is no specific family style that predicts their development (Le Grange, Lock, Loeb, & Nicholls, 2010). In fact, some of the problematic patterns of behavior observed within families of an affected child are now understood as reactions to the presence of a life-threatening and often chronic illness (Whitney & Eisler, 2009).

ED treatment that excludes families (parents, spouses, other caregivers) does not reflect the reality of the lives of many of those suffering. Many individuals with EDs are tightly connected to, and often dependent on, their families. Children, adolescents, and adults with chronic EDs are often delayed in their social or emotional development (or both), which results in needs that differ from their peers. Finally, ED families experience considerable strain as a result of their loved one's illness and can benefit from support to disentangle themselves from the effects of the ED. Families also provide an opportunity to extend treatment efforts beyond the office to effect lasting behavioral and emotional change. As such, in contrast to previous practices, and with the support of parent advocate groups such as F.E.A.S.T (Families Empowered and Supporting Treatment of Eating Disorders), contemporary approaches to ED treatment have evolved to include families as active supports in the recovery process. Recent research outcomes have demonstrated the benefits of carer involvement, including improved outcomes for both those with an ED and their family members (Couturier, Kimber, & Szatmari, 2013; Goddard, Macdonald, & Treasure, 2011; Lafrance Robinson, Dolhanty, Stillar, Henderson, & Mayman, 2016). The most well-known of these family-oriented treatment protocols include family-based treatment (Lock & Le Grange, 2015), the New Maudsley method (Treasure, Schmidt, & Macdonald, 2010), and EFFT for EDs (Lafrance Robinson et al., 2016).

## FAMILY INVOLVEMENT IN ED TREATMENT

Family-based treatment (Lock & Le Grange, 2015) is the most widely accepted outpatient family therapy for child and adolescent EDs. It has the most research evidence and has been adapted to more intensive levels of care (e.g., day treatment; Girz, Robinson, Foroughe, Jasper, & Boachie, 2013) and extended beyond childhood and adolescence to support transition age youth (Dimitropoulos et al., 2015, 2018). In its standard form, family-

based treatment is a manualized treatment that involves three phases of treatment. Throughout each phase, clinicians and caregivers work together as a multidisciplinary team (Lock & Le Grange, 2015; Lock, Le Grange, Agras, & Dare, 2000). In the first phase of treatment, clinicians focus on empowering carers to take action against their child's ED through a focus on renourishment and symptom interruption in the home setting (Lock et al., 2000). Following steady weight gain and symptom management, clinicians support caregivers to work toward returning control over eating to their child in a developmentally appropriate manner, while maintaining a focus on their physical health. It is also in this second phase that previously set-aside adolescent issues (e.g., puberty, peers, sexuality) thought to influence symptoms are reintroduced into the therapy. Finally, in the third phase of treatment, the team reviews central issues of adolescence, including the development of age-appropriate autonomy, the development of appropriate parental boundaries, and the need for the parents to refocus their caregiving roles in response to their child's evolving needs.

Although the involvement of caregivers in the treatment of children and adolescents has become standard practice, adult interventions are most often individually focused. The New Maudsley method is a noteworthy exception in that carers are systematically recruited as partners in care across the lifespan (Treasure, Schmidt, & Macdonald, 2010). Rooted in part in the cognitive interpersonal maintenance model (Goddard, Macdonald, Sepulveda, et al., 2011; Schmidt & Treasure, 2006; Treasure & Schmidt, 2013), the New Maudsley method uses psychoeducation to support caregivers to identify and transform potential maintenance patterns or traits. Carers are also taught *collaborative care skills*, including the principles and techniques of motivational interviewing, to support change in their loved one. The New Maudsley method also takes into consideration the developmental stage of the affected individual to determine the specifics of carer involvement.

## **EFFT FOR EDS**

It is in part thanks to the developers of family-based treatment and the New Maudsley method that caregivers are now being recruited as treatment allies, closing the book on parentectomies. These treatment models brought essential and novel approaches to the treatment of EDs and were quickly integrated into clinical programs around the world. EFFT was designed to build on the strengths of these approaches and introduce additional components that could benefit sufferers, caregivers, and clinicians. For example, the spirit of Phase 1 of family-based treatment is integrated within the

behavior-coaching module in that caregivers are empowered to support the normalization of eating patterns and interrupt ED symptoms. The animal metaphors from the New Maudsley method are incorporated to assist caregivers in the identification of problematic patterns of responses to their loved one's symptoms. Throughout treatment, caregivers are also provided with skills training, and the role of emotion is brought to the forefront with a focus on emotion coaching, therapeutic apologies, and the processing of caregiver and clinician emotion blocks. We believe that EFFT's emphasis on core emotional and relational processes and its transdiagnostic application across the lifespan represent important contributions to the developing field of ED treatment. We urge readers to note, however, that, similar to other models of ED treatment, the EFFT clinician or therapist is not meant to act as a sole treatment provider but rather a member of a multidisciplinary team that, at minimum, includes a medical professional and other allied health and mental practitioners such as a psychiatrist, dietitian, occupational therapist, and others, if relevant.

### Caregiver Psychoeducation and Empowerment

Before introducing the modules of EFFT, carers are first provided with psychoeducation on a number of ED-related topics including their causes (e.g., an interplay of risks and stressors, including genetics, temperamental factors, patterns of emotional avoidance, life stressors, sociocultural factors), functions (coping, emotional avoidance), and consequences (physical, psychological, social). Although a full discussion of the psychoeducational content is beyond the scope of this chapter, caregivers should come away with the understanding that although EDs are seemingly about food, weight, and shape, they are complex disorders that serve many functions, one of which is to regulate stress and distress. Our clients with EDs frequently describe the manner in which their symptoms serve to mask and numb their feelings. When they resist the temptation to engage in symptoms, many report experiencing a surge of overwhelming emotion. We therefore encourage caregivers to conceptualize EDs as emotion management disorders, where starving numbs, bingeing soothes, and purging provides relief (Dolhanty & Greenberg, 2007).

We also liken symptoms to *emotion converters*. Whether consciously or not, individuals with EDs convert the experience of emotions such as fear, anger, sadness, and shame to “feeling fat” or to urges to binge, purge, or overexercise. It is as though the narrow focus on weight, shape, and food converts painful emotions into a bodily experience that sufferers can then manage with symptoms. It is for these reasons that we are firm in our belief

that ED recovery should involve equal emphasis on symptom management and support to build capacity in the processing of emotions. As such, caregivers are empowered to take on an active role in their loved one's recovery by increasing their involvement in behavior coaching and emotion coaching, including a therapeutic apology if warranted. Given that each of these modules are explained in detail in previous chapters, special considerations related to the application of these modules in the context of EDs are highlighted, along with clinical illustrations.

### **Behavior Coaching**

The value of behavior coaching in EDs cannot be overemphasized. A basic underlying principle of this module, and one that is borrowed from family-based treatment (Lock & Le Grange, 2015), is that for an individual struggling with an ED, food is medicine. Nutrition is essential to prevent, reduce, or reverse medical complications and to support normal cognitive and emotional functioning. If necessary, carers are informed that ED symptoms can be difficult to give up and can prove fatal over time (Reijonen, Pratt, Patel, & Greydanus, 2003; Von Holle et al., 2008) to help mobilize them to regard food as medicine.<sup>1</sup> The behavior-coaching module of EFFT thus involves equipping caregivers with practical meal-support strategies, as well as specific tools to support the interruption of behaviors such as purging, bingeing, and compulsive exercising. Caregivers engage in this “training” in individual or group settings, as if they were clinical staff newly hired in an ED program. The material is delivered using the same methods and techniques used to train hospital staff around the world.

### **Meal Support**

*Meal support* refers to the act of offering structure, encouragement, and reassurance to an individual completing a snack or meal. It is an incredibly valuable intervention during the renourishment phase of treatment, especially if the affected individual's fear of weight gain is intense, and the temptation to restrict or engage in symptoms is strong. In many cases, meal

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<sup>1</sup>It is important to inform caregivers of loved ones who have eaten very little over a long period of time that there could be a risk of developing *refeeding syndrome*, a potentially fatal condition in medically compromised individuals. If increases in nutrition occur too rapidly, electrolyte levels such as phosphorous, magnesium, and calcium can drop and cause cardiac, respiratory, or circulatory system failures (Boachie & Jasper, 2011). Thus, it is critical that increases occur slowly and incrementally and with the support of a physician in a position to monitor medical stability and needs.

support can also alleviate the guilt that individuals working toward recovery often experience in response to their harsh inner critic or ED voice. In other words, the involvement of others can serve as a distraction from their critic or allow the individual with ED to eat because they “have to.” In its most structured form, carers are involved in preparing and serving meals, including making decisions about the amount and variety of food consumed. That being said, this degree of structure may not be possible for all caregivers or appropriate for all individuals with EDs. As such, in EFFT, the specifics of meal support are developed according to the loved one’s chronological and developmental age, stage of illness, and individual circumstances, as well as the needs of the individual’s caregivers. For example, caregivers of children or adolescents will be supported to take responsibility for supervision and support during all meals, while caregivers of adults who live away may visit for extended periods of time to offer support or provide meal support via video calls. Regardless of the approach, clinicians should work collaboratively with the family to find ways to help make meals go as smoothly as possible, encouraging them to draw on their caregiving instincts to inform implementation. Following is an example of such an exchange between a clinician and carer:

- CLINICIAN:** So, you’re telling me that you’re struggling right now with getting your daughter to complete her meals. What do you think you could change in your approach to help her to eat more?
- CARER:** Well the eating is so slow, and she seems to take forever. It’s like she’s not even there during the meal. She’s so shut down, and I can tell she’s in pain.
- CLINICIAN:** Of course, it would be hard to push when you see her hurting. I’m wondering if there is anything you could do make the meals a bit easier on her without reducing the amount of food she’s expected to eat?
- CARER:** Maybe if she had some distraction . . .
- CLINICIAN:** Distraction can be a great way to reduce distress during meals. Any ideas about what might work best for your daughter?
- CARER:** She used to love documentaries. We used to watch them together all the time. Maybe we can watch TV during meals for a while, to get her mind off the pain.
- CLINICIAN:** That’s a great idea. Anything else that you think might be helpful?

- CARER:** I don't know . . . I guess I keep thinking back to when she was little and felt sick. She always asked me to rub her back, and it made her feel better. But she's a bit old for that, and things have been pretty tense between us.
- CLINICIAN:** So you're thinking this could be soothing for her. But it sounds like your gut is also telling you that you might want to check with her to see if that kind of comfort could be welcome right now.
- CARER:** Yeah, it might be worth asking . . . There are times when she doesn't want to be touched, but not always. Maybe I could invite her to snuggle on the couch as a start, until the worst of it passes.

In this example, the clinician takes care to remind the caregiver of the need for her loved one to increase her caloric intake, while encouraging her to draw on her instincts to individualize the support according to her daughter's unique needs. This collaborative approach instills confidence in the caregivers and serves to recognize the expertise of all members of the treatment team. Should the caregivers struggle to identify possible solutions to the challenges they face, the EFFT clinician offers suggestions from which to choose based on the successes of other families with whom they've worked.

Finally, when supporting a loved one to gain weight, caregivers are encouraged to work on the goals of increasing both the amount and variety of foods consumed. Caregivers must also have a clear understanding of the loved one's "safe" and "scary foods" to work on increasing intake while also reintroducing feared foods. These include those deemed by their loved one as "unhealthy," as research suggests that relapse is more likely when individuals follow a diet limited in variety (Schebendach et al., 2008). To do so, caregivers and their loved ones can work together to develop a fear hierarchy, similar to a process of graduated exposure used to treat specific phobias (Kendall, 1994). Caregivers support the expansion of variety by introducing the least feared foods and moving up to the most feared foods. This allows the affected individual to systematically extinguish fears and develop a more neutral relationship with food. They do the same with respect to eating in front of others, and in different settings, such as at school or in restaurants. Thus, the overarching goal of this phase is to support caregivers to support their loved one to eat without rigid rules about what, when, and how to eat (Satter, 2000).

### **Bingeing**

Episodes of bingeing will naturally decrease in frequency when caregivers encourage the intake of regular meals throughout the day. Eating food at



regular intervals stabilizes blood sugar levels and lessens the urge to eat in a chaotic or uncontrolled way. “Trigger” foods can be identified and removed from the loved one’s home, knowing that these will need to be reintroduced later in treatment so that normalized eating can occur. Caregivers can also decrease opportunities for bingeing via contact and connection during the times of the day when their loved one feels most vulnerable. In these moments, caregivers can support loved ones to use skills such as urge surfing and distraction techniques to manage impulses to binge.

### **Purging**

Individuals with EDs who purge will greatly benefit from the support of others to break the cycle of behavior, whether they purge through vomiting or other methods. The most common form of behavioral support for purging involves supervision postmeals, including supervision of bathroom use for up to 2 hours. Supervision is usually coupled with support around the management of urges, including efforts to distract the loved one from associated distress. This type of support is best offered in person, although many carers have reported great success using telephone or video calls and text messages.

Caregivers should also be made aware that purging through vomiting can occur in other areas (e.g., in showers and garbage bins), and they are encouraged to remain vigilant of these possibilities. When discussing and addressing purging symptoms, caregivers are guided to maintain a neutral yet supportive stance to create an open line of communication. It is also important to note that individuals who have never purged but who are in the process of being renourished can be at higher risk of *symptom shifting*, especially if they are in distress and desperate for relief. (Symptom shifting refers to a process in which individuals shift their pattern of symptoms—for example, from food restriction to bingeing and purging.)

### **Problematic Patterns of Exercise**

Individuals with EDs who overexercise can put themselves at risk for serious medical issues. These complications can include electrolyte imbalances, injuries, and cardiac events (Attia, 2010). Excessive exercise is also associated with longer treatment duration (Solenberger, 2001). As a result, caregivers of individuals who are medically unstable, underweight, or engaged in compulsive patterns of exercise are guided to support their loved one to cease or reduce physical activity for a period of time. Caregivers may need to provide supervision and distraction in places and at times when the urges to exercise are strongest and be aware of other forms of “activity” that may be occurring (e.g., leg shaking, stomach crunches, and any other excessive

movement aimed at burning calories) as these may significantly affect health and weight. Once the return to physical activity has been deemed medically and psychologically safe, caregivers can support their loved one to resume engagement in activities in a way that is separate from the influence of the ED. This might mean that caregivers help their loved ones to participate in new lower risk activities and support them to increase their compensatory nutritional intake, as appropriate.

### **The Role of Intensive Treatment**

Although carers can support their loved one in the home setting as part of outpatient treatment, there are times when their loved one may require a more contained and intensive therapeutic environment due to the severity of the illness or the need for medical monitoring. In these cases, caregivers may need to focus on supporting their loved one to navigate an admission to hospital as a behavioral coaching task. The EFFT clinician may also advocate on behalf of the caregivers to be involved in the partial hospitalization, inpatient, or residential treatment in some way. If this is not possible, EFFT clinicians urge caregivers to recognize the importance of their role leading up to admission and postdischarge. They may also seek the support of an EFFT clinician while their loved one is in treatment to better prepare for the transition to the home environment.

In addition to the techniques already described, several publicly available resources can further inform caregivers' efforts to support their loved one's behavioral recovery from an ED (see Appendix N). Regardless of the strategies employed, caregivers are guided to move flexibly between empathy and encouragement, compassion and firmness, validation and limit-setting when providing meal support and working to interrupt symptoms. To do so, caregivers are also equipped with the skills of emotion coaching to respond to emotions that often arise during the renourishment and symptom interruption phase in a way that is loving and productive. In other words, these modules work together to increase the effectiveness of the behavioral interventions.

### **Emotion Coaching**

There are multiple ways in which emotion coaching can enhance the recovery process for individuals with EDs and their families. As stated in Chapter 2, this volume, this emotion-coaching framework can lead to increases in cognitive flexibility and connection. Therefore, when caregivers attend to their loved one in this way, possible outcomes include a decrease in

resistance to ED interventions (including resistance to having their family involved in structured ways) and an increase in the effectiveness of caregiver-led interventions (meal support and the interruption of symptoms). It can also promote a strengthening of the caregiver-loved one relationship, making it more likely that the loved one will seek out the caregiver for support. Most importantly, however, emotion-coaching serves to facilitate the internalization of emotion-processing skills among those with an ED, making it easier for them to resist the temptation to engage in symptoms when experiencing distress. We next describe some of the more practical uses of emotion coaching in the context of EFFT for EDs.

### **Emotion Coaching and Caregiver Involvement**

When carers can empathize and connect with their loved ones' pain and validate their experiences, including their resistance to intervention and support, loved ones will be more likely to trust and accept the support offered by their caregivers. This style of emotional support can also serve as a powerful buffer against an angry ED voice "warning" sufferers not to believe in those trying to help them in their recovery. Among adult clients, resistance to caregiver involvement may be particularly strong because the level of support required often feels developmentally awkward and generates feelings of shame and resentment. Following is an illustration of the power of emotion coaching based on a real-life example of its use in the context of adult ED treatment.

- LOVED ONE:** I don't want your help, and I don't need it. Please just leave me alone.
- CAREGIVER:** I don't blame you for not wanting my help. You don't want me to see you hurting, and I can only imagine how much shame you must feel that I even know about what's going on.
- LOVED ONE:** Seriously, I'm fine, it's going to be fine, and I can figure this out myself.
- CAREGIVER:** I believe you will be fine. But I also believe that you don't want my help because you're afraid that I will think less of you.
- LOVED ONE:** No—that's not it. I know you love me, but I also know that you're already stressed out with your own life. We both know your health isn't great, and there's no chance I am going to put even more stress on you. I could never live with myself if you had another heart attack.

**CAREGIVER:** Okay, I get it now. I can understand you wouldn't want to be burdened with the guilt if something happened to me. And so I don't blame you for trying to push your mom and me away. I didn't realize why until now, and the truth is, I would probably feel the same way if I were you. That being said, I am your dad and I can't stand on the sidelines knowing you are struggling. That would be far worse. Let me make you a promise. I promise that if I feel stressed or worn down, I will take a break to take care of myself. I will even schedule an extra appointment with the cardiologist to reassure you. Sound like a plan?

**LOVED ONE:** Fine. As long as you keep your promise and we revisit the terms every once in a while.

This exchange illustrates the ways in which the spirit of emotion coaching can serve to decrease resistance to support, even when caregivers' attempts to validate their loved one miss the mark. In fact, inspired attempts, regardless of their accuracy, can convey to loved ones that their caregivers are invested in understanding their perspective, thereby increasing the overall trust between carers and those with an ED. This increased trust and connection often helps loved ones to reveal the fears and motives underlying their treatment refusal or hesitation to involve caregivers in treatment, creating openings for a new path forward.

### **Emotion Coaching for Meal Support and Symptom Interruption**

It is not unusual in the early phases of treatment for loved ones to react to meal support and symptom interruption with uncharacteristic displays of despondence, anxiety, anger, and even violence. We have heard too many reports from parents who described that when they insisted that their child complete a meal, plates went flying. They were not prepared to respond to this level of anger and anguish. As such, it is vital that clinicians teach caregivers emotion coaching strategies so that they can respond effectively to their loved one's reactions that surface before, during, or after meal times. Here is an example of emotion coaching in the context of meal support.

**LOVED ONE:** (points to a slice of cake) There is no way I am eating that.

**CAREGIVER:** I thought you might say that. When I put myself in your shoes, I had the exact same thought. You haven't eaten a pastry in ages, and I can imagine that you'd feel terrified of overdoing it. The fear of bingeing is so strong. It feels too risky to even try one bite.

**LOVED ONE:** I'm serious. There's no chance. I don't ever want to be fat ever again. Don't make me eat this. It's not even healthy.

**CAREGIVER:** I'm sorry, honey. I understand now how scary it was when things were out of control. I don't blame you for feeling nervous. You've been in this pattern for so long. Remember, you have my support. I will be with you for every bite, and I will stay with you until the urges for symptoms pass. Let's start with the first one.

Collectively, we have more than 40 years of experience working on the front line of ED treatment, providing meal support to people in inpatient and partial hospitalization settings, and supervising other clinicians to do the same. We also have years of experience supporting caregivers of children, adolescents, and adults with EDs in the context of family-based treatment and EFFT. Although we acknowledge that emotion coaching does not yield the desired outcomes 100% of the time, we can say with conviction that, in our experience, this technique is by far the most effective strategy to support sufferers to “eat one more bite.” It is a tool we hope will be used more often, and as an alternative to some of the more coercive or punitive practices sometimes employed out of desperation. Although we are in support of firm limits, we believe they must be coupled with the steps of emotion coaching to maximize the effectiveness of meal support and symptom interruption strategies and to minimize distress for all involved.

### **Emotion Coaching for Cognitive Symptoms of EDs**

We have found that for clinicians and carers alike, it can be extremely difficult to resist the urge to reassure, correct with logic, or ignore ED-related comments. Individuals with EDs often express the desire to be sick, to never eat again, or even to die. These statements are incredibly hard to validate for caregivers because they can provoke strong fear reactions. When supporting caregivers to respond to these types of statements, it is important to underline that validation is separate from agreement. Using the structure of emotion coaching, caregivers might respond to their loved one who expresses a wish to remain ill forever in the following way:

Of course you want to be sick. Everything inside you tells you that being sick makes it so that you are deserving of our affection. I can imagine that you'd be terrified to be well again, just in case you lost our love and support.

Although their loved one's pain won't be resolved, the validation efforts will make it so that they are more receptive to support, whether emotional

(e.g., reassurance) or practical (e.g., setting limits regarding the completion of a meal).

Carers can also use the steps of emotion coaching to respond to loved one's expression of body image disturbances, whether the loved one is emaciated, in the normal weight range, overweight, or obese. The following illustrates a possible exchange between a woman struggling with an ED and her husband:

**MICHELLE:** I'm not going out today. I feel so gross. I can't show anyone this fat, disgusting body.

**AHMED:** I can only imagine how hard it is to feel so uncomfortable in your own body. Like you want to climb out of your own skin to escape the feeling. I could see how you might feel like there's something wrong with you or that you might feel scared about how others might see you.

**MICHELLE:** Yes! I don't want to go!

**AHMED:** I get it. The eating disorder is convincing. It must be so heavy to have to carry that burden all day, every day. It sounds exhausting.

**MICHELLE:** It is exhausting. I am exhausted, and I just don't know who to trust.

**AHMED:** No wonder you feel conflicted. I know we can get through this feeling together. I'll tell you what, why don't we snuggle up on the couch and watch a show, and we'll try again in 30 minutes. Let's take some pressure off of you.

**MICHELLE:** Okay. Thanks, love.

Although it takes practice, this type of exchange will be far more effective than typical responses to "I feel/look/am fat," which usually involve reassurance or attempts to correct the individual's experience of her or his self. We remind carers that in EFFT, "fat is a feeling" and a projection of negative affect onto the body. Therefore, the caregiver is guided to attend to the loved one's surface feelings (e.g., feeling fat), followed by the validation of deeper experiences of vulnerability or emotional pain.

### **Therapeutic Apologies**

As discussed in Chapter 4, therapeutic apologies is a module in EFFT that is applicable when self-blame is high in either the sufferer or the caregiver.

Individuals with EDs typically report an extremely strong self-critic making this intervention especially relevant. The ED self-critic often takes the form of a powerful, even abusive, internal voice (Dolhanty & Greenberg, 2007) that convinces sufferers that they are fat, ugly, and unworthy—and, in more extreme cases, that they are better off dead. The intensely negative emotions that result serves to fuel the guilt and shame so many sufferers already experience for the pain “they are causing their family.” Many sufferers blame themselves for having developed the ED in the first place, especially if they recall a turning point in their lives when they “chose” to restrict or purge the first time. In these instances, a therapeutic caregiver-led apology can be used for lifting this self-blame to reduce its impact on help-seeking behaviors and treatment progress.

We also encourage the use of this intervention as a means of strengthening the carer-loved one relationship. Whether or not the relationship is or has been under strain, doing so will maximize the healing power of caregivers’ supportive efforts. As readers will have noted several times throughout this manual, EFFT uses the relationship between carers and their loved ones as a vehicle to effect change. The stronger the relationship, the more impactful caregivers’ efforts will be and the more their loved one will benefit from the carers’ behavioral and emotional support. In light of the extent to which EDs are known to be treatment-resistant, we believe that it is worthwhile to invest in strengthening even the healthiest of relationships to optimize the healing potential of caregiver-led interventions in the various domains of recovery.

Although this module is powerful in the treatment of EDs, we do caution the EFFT clinician to take great care with its implementation. We have observed high levels of self-blame in many parents of children with EDs (Stillar et al., 2016). This propensity for caregiver self-blame is due in part to a long history of parent blaming within the ED field, which may still influence professionals and families today. Additionally, EDs usually develop and flourish in secrecy, often leaving caregivers feeling shame about not having noticed the early signs of illness progression. Others may have encouraged “clean” eating, influenced by a culture flooded with messages about “health,” and therefore feel responsible for their loved one’s obsession with food and weight. This is especially true when caregivers have struggled with disordered eating or an ED themselves. As such, if not sufficiently prepared, caregivers may respond to the proposal of a therapeutic apology with hurt, defensiveness, or even more self-blame. For this reason, and to ensure maximum therapeutic benefit, EFFT clinicians must take great care in conveying the spirit of no blame in which the intervention

is firmly rooted, supporting caregivers to work through any painful feelings that may arise. This process serves to prepare them to deliver the apology, as well as healing the deep roots of their own pain. In fact, and as noted in Chapter 4, only once carers can connect with some level of self-compassion and self-forgiveness for not having been “perfect” can they deliver an effective therapeutic apology delivered from their “good house.” The process of the therapeutic apology can take time, but we’ve found it to be an incredibly worthwhile process to free both the sufferer and the caregiver from the grips of self-blame, among other positive outcomes.

### Caregiver Blocks

Carers are often faced with the very real fear of medical complications and, in more extreme cases, the death of their loved one. Not surprisingly, these and other emotional reactions can lead caregivers to “walk on eggshells” or resist engagement in behavior or emotion coaching in case the distress causes their loved one to withdraw, reject further support, or give up on recovery altogether. Carers can also fall into unhelpful patterns in which they accommodate ED symptoms (e.g., buying low-calorie foods, avoiding the reintroduction of feared foods in their loved one’s diet) so as to avoid these feared consequences (Treasure et al., 2008). These findings highlight a need to identify these and other fears prior to the onset of caregiver-based interventions as they could lead to treatment-interfering behaviors and their transformation could improve outcomes. In response to this need, and in collaboration with parents of children struggling with an ED in a hospital-based program, I (AL) developed the Caregiver Traps Scale for Eating Disorders (CTS–ED) to assess caregiver fears specifically related to their involvement in providing home-based meal support and symptom interruption.<sup>2</sup> One hundred and twenty-four parents of adolescent and adult children with ED participated in a validation study to examine its psychometric properties (Lafrance, Strahan, & Stillar, 2019). Exploratory factor analysis revealed one component, and the scale yielded high internal consistency. The measure was positively correlated with a measure of accommodation and enabling of ED symptoms and negatively correlated with a measure of parental self-efficacy with respect to their helping role. Although it has been used clinically for several years, the results of this study confirm that the CTS–ED can be a valuable tool to target and transform potential fears to improve outcomes. In addition to

<sup>2</sup>The Caregiver Traps Scale, described in Chapter 5, was adapted from this tool.



the CTS–ED, we recommend that ED clinicians consider integrating the other tools and techniques developed to transform emotion blocks outlined in Chapter 5, in particular, caregiver block chair work, as they too were initially developed for use in the context of ED treatment.

### **Clinician Blocks**

It is well established that working as a clinician in the field of EDs can be emotionally challenging (Franko & Rolfe, 1996; Golan, Yeruslavski, & Stein, 2009; Thompson-Brenner, Satir, Franko, & Herzog, 2012; C. S. Warren, Schafer, Crowley, & Olivardia, 2013). Two theoretical models have emerged that explore the influence of clinician factors on the delivery of ED treatment in the context of individual and family-oriented therapies. They include the iatrogenic maintenance model of eating disorders (Treasure, Crane, McKnight, Buchanan, & Wolfe, 2011) and the therapist drift model (Kosmerly, Waller, & Lafrance Robinson, 2015; Tobin, Banker, Weisberg, & Bowers, 2007; Waller, 2009; Waller & Turner, 2016). The developers of these models posit that clinicians, like carers, can find themselves engaging in avoidant or otherwise unhelpful practices when supporting individuals and their families (Treasure et al., 2011; Waller, Stringer, & Meyer, 2012). According to Waller (2009), clinicians may also resist pushing clients for behavioral change when it results in making the client (and, in turn, the clinician) uncomfortable. This can lead the clinician to engage in negotiations around treatment recommendations or to downplay the severity of symptoms to avoid conflict. Positive emotions can also hamper clinical judgment because they may mislead and distract from important clinical information and cues. For instance, clinicians may become enthusiastic about minor changes in a client's course of treatment, which can distract focus away from some of the more serious issues still requiring attention.

In 2015, ED professionals were surveyed with respect to their perception of the influence of emotions on clinical decisions (Lafrance Robinson & Kosmerly, 2015). Clinicians from various disciplines who were engaged in the treatment of child and adolescent EDs were randomly assigned to complete one of two surveys. The first survey assessed clinician perspectives regarding the negative influence of emotions on their own clinical decisions ( $n = 143$ ), and the second survey assessed clinician perspectives of the same with respect to their colleagues ( $n = 145$ ). Both groups endorsed this phenomenon to some degree, although participants were about twice as likely to endorse the negative impact of emotion among their colleagues. The specific treatment decisions thought to be affected fell within three categories: decisions regarding food and weight, decisions regarding the

involvement of the family in treatment, and decisions regarding autonomy and control. Decisions related to the involvement of the family were perceived to be the most emotionally charged—in particular, the involvement of a critical or dismissive parent. Clinicians' responses indicated that certain client states and fears fueled problematic clinical practices on the part of the clinician (Kosmerly, 2014). Specifically, clinicians reported that the client states that were most likely to negatively influence their decision making included expressions of anger, hopelessness, and flat affect. They were most influenced by their own fear of potentially alienating the client (i.e., arousing a hostile or negative emotional reaction, causing the family to disengage from treatment) and feelings of incompetence. Clinicians reported that their most frequent reactions included focusing on another less emotionally arousing topic; overemphasizing minor improvements in the client; and rationalizing, negotiating, or bartering with the client. Follow-up research was conducted among 16 family-based therapists who participated in a semistructured interview (Penney, 2018). Transcripts were analyzed using thematic analysis. Results revealed that the tone of therapist–client interactions and the level of family resistance affected clinical decision-making the most frequently. In fact, every one of the therapists shared that in response to critical or angry parents, they were more likely to deviate from protocol in some way, including advocating for premature discharge. Results also revealed that impact of therapist emotion on clinical decisions could be mitigated via engagement in self-reflective practices and working as part of a treatment team.

### **Common Clinician Blocks in the Treatment of EDs**

We do not believe that the experiences of the clinicians and therapists described in this chapter are unique. In fact, when the stakes are high, as they are in the treatment of EDs, emotions run high as well. The emergence and expression of clinician blocks in these settings are normal, and ED clinicians are supported to increase their awareness of the potential blocks most common to their practice. For example, family therapists may hesitate to enlist caregivers as recovery allies when they present as hostile or in denial or when a caregiver struggles with an ED, substance use disorder, or personality disorder. Similar to the common caregiver blocks in ED treatment, the medical risk associated with ED symptoms can also lead clinicians to be blocked by a tremendous fear of losing a client to death, including being held responsible in some way. These blocks can lead clinicians to avoid working with some clients (or all clients with EDs), blame other health care professionals for lack of treatment progress, or adhere rigidly to treatment protocols.

When a clinician's personal beliefs about food, nutrition, weight, and shape stand in contradiction to the central messages of ED recovery that "all foods fit and variety in nutrition is key" they can also interfere with important aspects of recovery, such as the reintegration of high-calorie foods. There are numerous other blocks that clinicians may experience in the context of ED treatment: They may perceive the individual with the ED as manipulative rather than sick; clinicians may avoid bringing attention to certain ED symptoms, such as laxative use or bingeing or purging (to prevent from shaming the client but also because it can be uncomfortable to discuss the more private features of these symptoms); and they may hesitate to confront their clients about potentially undisclosed symptoms for fear of causing offense and losing their trust. For these reasons, we encourage ED clinicians to maintain a routine of self-reflection and self-care, as well as to engage in regular supervision (peer or otherwise) or personal therapy to identify and work through blocks as they arise.

## SUMMARY

Similar to EFFT for general mental health, there are three main areas of intervention in EFFT for ED. They include supporting carers to (a) increase their involvement in supporting their loved one with meal support and symptom interruption; (b) provide structured emotional support to respond to reactions that arise in response to the behavioral interventions and to attend to the emotional processes fueling ED symptoms; and (c) initiate a therapeutic apology for the healing of family wounds—whether related to relational injuries, the burden of self-blame, or to upgrade the relationship and therefore the impact of caregiver interventions. The associated skills in each of the modules are designed for use in person, over the telephone, or even by text or e-mail. Caregivers are then taught to combine these three sets of skills to increase their effectiveness and are provided with opportunities to practice in session. Should a caregiver struggle to engage in any of the aforementioned tasks, the EFFT clinician supports the caregiver to move through these impasses using the tools and techniques outlined in Chapter 5 on caregiver blocks. Similarly, EFFT clinicians who specialize in EDs are also very aware of the increased vulnerability for the emergence of clinician blocks when working with EDs and integrate within their practice a structure for ongoing processing of potentially problematic attitudes, emotional reactions, or behaviors.

**CLINICIAN'S CORNER**

I spent nearly 10 years working as a psychologist in a hospital-based program treating children and adolescents with eating disorders. We adhered largely to principles of family-based treatment and I thought at the time that I was a clinician who believed in parents and their healing power. I felt as though I addressed emotion with my patients and had taught parents to do the same, but at times, I felt some deeper processes were lacking in my approach. When I first learned about EFFT, it was as though a piece of the puzzle that I didn't even know I was missing finally fit into the picture. I felt that I now had a holistic framework from which to conduct my work. I had practical ways of helping them understand the illness and address both behaviors and emotions. As I deepened my training and practice and went on to become a supervisor and trainer, I continued to experience the benefits and also the challenges of this approach. Working through my own blocks is not something I always look forward to, but I have never engaged in that work without deriving some benefit. When I left the hospital and went into private practice, I extended my focus to include general mental health issues across the lifespan. Tools and techniques from EFFT are now integrated within every case I see in one way or another. I am definitely a better therapist today because of it.

—Psychologist