

Emotion-Focused Family Therapy for Eating Disorders Across the Lifespan: A Pilot Study of a 2-Day Transdiagnostic Intervention for Parents

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Emotion-focused family therapy is a transdiagnostic approach that affords parents and caregivers a significant role in their loved one's recovery from an eating disorder. A 2-day intervention was developed on the basis of emotion-focused family therapy principles and delivered to 33 parents of adolescent and adult children. Data were collected pre- and post-intervention. Through education and skills practice, parents were taught strategies with respect to meal support and symptom interruption as well as emotion coaching. Parents were also supported to identify and work through their own emotional blocks that could interfere with their supportive efforts. Analyses revealed a significant increase in parental self-efficacy, a positive shift in parents' attitudes regarding their role as emotion coach and a reduction in the fears associated with their involvement in treatment, including a decrease in self-blame. Overall, this broad-based, low-cost intervention shows promise, and future research is warranted. Copyright © 2014 John Wiley & Sons, Ltd.

Key Practitioner Message:

- A low-cost, intensive emotion-focused family therapy intervention shows promise for parents of individuals with an eating disorder, regardless of their loved one's age, symptom profile or involvement in treatment.
- Working with parents' emotions and emotional reactions to their child's struggles has the potential to improve supportive efforts.
- An emotion-focused family therapy intervention for parents yields high satisfaction rates, improves parental self-efficacy and reduces fears regarding their involvement, including self-blame.

Keywords: Emotion-focused Family Therapy, Eating Disorders, Treatment

Eating disorders are serious health conditions that affect individuals across the lifespan (Fairburn, Cooper, Doll, Norman, & O'Conner, 2000; Lewinsohn, Striegel-Moore, & Seeley, 2000; Wilfley, Kass, Kolko, & Stein, 2011). They are associated with impaired quality of life (Jenkins, Rienecke Hoste, Meyer, & Blissett, 2011) as well as with high morbidity and premature mortality (Gowers & Bryant-Waugh, 2004; Smink, van Hoeken, & Hoek, 2012). Although there continue to be advances in treatment for eating disorders, there remains a need for more effective treatment, as most long-term outcome studies demonstrate adult relapse rates up to 67% (Field et al., 1997) and adolescent recovery rates up to 57% (Steinhausen, 2002).

Emotion and Eating Disorders

Although the conceptualization of eating disorders into broad categories (anorexia nervosa, bulimia nervosa, binge-eating disorder and unspecified eating disorder) is used in both the Diagnostic Statistical Manual for Mental Disorders (American Psychiatric Association, 2013) and the International Classification of Diseases (World Health Organization, 1992), scientists have begun to question the appropriateness of this model in favour of the transdiagnostic model of eating disorders (Fairburn, Cooper, & Shafran, 2003; Wade, Bergin, Martin, Gillespie, & Fairburn, 2006). The transdiagnostic model of eating disorders moves beyond illness and diagnostic symptoms, favouring the underlying factors that maintain an eating disorder, regardless of subtype. Although there are a multitude of factors identified in the literature, it is widely accepted that the role of emotion and its avoidance are

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central in eating disorders (Dolhanty & Greenberg, 2007; Harrison, Sullivan, Tchanturia, & Treasure, 2009). For example, individuals with eating disorders present with significant impairment in emotion regulation across subtypes (Brockmeyer et al., 2013), and a central function of the eating disorder can be understood as an attempt to manage difficult emotions (Cockell, Geller, & Linden, 2002; Treasure, Schmidt, & Troop, 2000).

Involvement of Parents

Parents of children with eating disorders should be considered a valuable resource by treating professionals and supported to take an active role in their child's recovery (Le Grange, Lock, Loeb, & Nicholls, 2010). Although parents are regarded as critical partners in care in the context of family-based therapy for eating disorders in adolescents (Le Grange, Lock, & Dymek, 2003; Lock & Le Grange, 2012), parents of adult children with an eating disorder continue to be vastly underutilized. To our knowledge, the New Maudsley Model is the exception in that parents of adult children are an integral part of the treatment and their active involvement is regarded as critical to the recovery process (Treasure, Schmidt, & Macdonald, 2009). Moreover, there is a growing body of literature suggesting that the emotions of parents of individuals with an eating disorder impact their caregiving efforts (Goddard et al., 2011; Kyriacou, Treasure, & Schmidt, 2008; Lafrance Robinson, Dolhanty, & Greenberg, 2013; Schmidt & Treasure, 2006; Sepulveda, Lopez, Todd, Whitaker, & Treasure, 2008). For example, the cognitive-interpersonal maintenance model of eating disorders suggests that caregivers can experience emotional arousal as a result of their loved one's illness, which then can lead them to engage in behaviours that can inadvertently contribute to its maintenance (Goddard et al., 2011; Kyriacou et al., 2008). Studies have shown that an intervention targeting this negative cycle and providing skills to enhance self-efficacy in the caregiver has resulted in improvements for both the caregiver and the individual with an eating disorder (Sepulveda et al., 2008; Treasure, Sepulveda, et al., 2007; Treasure, Smith, & Crane, 2007; Whitney et al., 2012).

Emotion-Focused Family Therapy for Eating Disorders

Emotion-focused family therapy (EFFT) is a treatment approach for eating disorders, the foundation of which is rooted in a deep belief in the healing power of families (Lafrance Robinson et al., 2013). As a transdiagnostic and lifespan model, the aim of EFFT is to enhance the role of caregivers (parents, relatives, spouses, etc.¹) in treatment

delivery using a skill-based approach. There are three main domains of intervention, which include support and education for parents in (1) mastering the skills, tasks and the feelings involved in recovery coaching; (2) mastering emotion coaching; and (3) managing emotional blocks that may surface along the way (see Lafrance Robinson et al., 2013, for a review). Four core principles inform the EFFT approach.

A Focus on Family

Regardless of their age, individuals want to be supported by their parents, and parents want to support their loved one in recovery. Filtered through the EFFT lens, resistance to parental involvement (on the part of the parent or loved one) is rooted in fears about the outcome and feelings of low self-efficacy rather than in reluctance to offer or receive support.

The Centrality of Emotion

A central function of the eating disorder can be understood as an attempt to manage and avoid stress and emotion. As a result, a full recovery from an eating disorder necessitates mastery over intense emotional experience. As such, an EFFT therapist seeks to work with the family to interrupt any patterns of emotion avoidance and provides parents with emotion-processing skills such that their loved one gains a new confidence in being able to turn to them instead of to symptomatic behaviours in times of emotional need.

The Importance of Parent Empowerment

The uncovering of parental self-confidence and strength is a central task within EFFT. This can only be achieved when the therapist holds a deep belief in parents' ability to take on a significant role in their loved one's recovery—even when parents present themselves initially as critical, dismissive, hopeless or suffering from physical or mental illness.

The Need for Skill Development and Training

While respect for the capacity of families to activate their own internal resources to support the recovery of their loved one is inherent in the EFFT approach, so too is the provision of skill training. These skills are referred to as 'advanced caregiving skills' as they are not required under 'normal' circumstances and their absence is not perceived as having led to psychopathology.

Study Objectives

On the basis of the EFFT model, a 2-day intervention was developed for parents of children with eating disorders, regardless of the age of the child and regardless of treatment status. This intensive intervention was developed

¹The term 'parents' will be used given the study's focus on this population.

to be time and cost efficient while providing parents with concrete skills in each of the domains of recovery. This paper aims to examine the feasibility and preliminary outcomes of this intervention. It is predicted that parents who complete the intervention will report (1) improvements in self-efficacy with respect to supporting the recovery of their child's eating disorder, (2) a positive shift in their attitudes regarding their role as their child's emotion coach, and (3) a decrease in the fears related to their engagement in their child's recovery. Satisfaction and intentions regarding skill implementation will also be explored.

METHOD

Description of Intervention

A structured, manualized intervention, based on the principles of EFFT, was developed for parents of individuals with eating disorders. The first author who is a psychologist and co-developer of EFFT delivered the intervention. The main goals of the intervention were to educate and support parents in mastering the skills involved in recovery coaching, emotion coaching and processing emotional blocks to effective caregiving. The intervention included three modules. The modules covered the following topics: (1) eating disorders basics and recovery coaching, (2) emotion basics and emotion coaching and (3) emotional blocks. The intervention was designed to be interactive and skills-based and included experiential activities. The intervention was developed initially as a 1-day intervention and piloted with three groups of 15–20 parents who felt that more time was required in order to adequately cover the material. As a result of the feedback from the pilot, the intervention was delivered over 2 days, and more time was allotted to the section on emotional blocks since these processes were most often at the root of parents' difficulties with supportive efforts.

Becoming a Recovery Coach (Approximately 3 h)

The first module of the intervention focused on providing basic psycho-education about eating disorders and their impact, and empowering parents to take on the task of recovery coaching. Although the nature and intensity of involvement could vary according to their child's developmental age, motivation and symptom pattern, all parents were provided with skills to increase their involvement in the behavioural recovery from the eating disorder. For example, parents were taught skills for meal support and symptom interruption via a meal-support video as well as a role-play.

Becoming an Emotion Coach (Approximately 6 h)

In order to lay the groundwork for emotion coaching, the second module included information about emotion

basics (e.g., every emotion has a bodily felt sense, name, need and action tendency) as well as the role of emotion and its avoidance as an underlying factor related to the onset and maintenance of eating disorder symptoms. Emphasis was placed on the fact that emotion avoidance within the child and the family can be targeted and transformed, whereas so many of the other risk factors related to eating disorders are unchangeable (e.g., genetics, socio-cultural factors and age of onset of menarche). Parents were then taught the five steps of emotion coaching, as if they were psychotherapy students learning active techniques for the first time. Derived from the work of Greenberg (2002, 2004) and influenced by Gottman (1997), the steps include (1) attending to the child's emotional experience by acknowledging its presence, (2) naming the emotion, (3) validating the emotional experience and (4) meeting the emotional need. For example, parents were coached to respond to sadness with soothing and to anger with helping their child to set appropriate boundaries. As a fifth and final step, parents were equipped with skills to (5) help their child to move through the emotional experience, including problem solving if necessary. Parents were provided with opportunities to practice the skills of emotion coaching with the support and guidance from the facilitator as well the group of parents in attendance.

In the context of emotion coaching, parents were also provided with education and skills to help facilitate relationship repair if necessary. Relationship repair was deemed an appropriate intervention for parents if (1) they identified a pattern of emotion avoidance in the family that they wanted to interrupt in order to support recovery; (2) their child blamed himself or herself for his or her mental health struggles and this self-blame was leaving him or her feeling undeserving of his or her family's support; (3) the relationship with their child was distant or hostile, making it difficult for parents to take on an active role in treatment; or (4) the family reported having experienced traumas or serious conflicts that they believed might have influenced the child's difficulties with emotions.

Working Through Emotional Blocks (Approximately 3 h)

The third and final module of the parent intervention included helping parents to identify their own 'emotional blocks' that would likely surface while supporting their child. Examples of such blocks included fears that the stress associated with the tasks of recovery may lead their loved one to depression, running away, self-harm or even suicide. Parents were reassured that the occurrence of such blocks is very normal, that they occur regularly in clinicians, and that the process of working through them is essential to a family-based recovery. In fact, as the parents grappled with this module, it became clear to them that processing these blocks actually allowed them to regain access to their healthy parenting instincts. Paradoxically, as

this work deepened, the parents' need for specific skills felt less pressing. To aid in the process of identifying, understanding and depathologizing emotional blocks, parents were also presented with the New Maudsley's animal models (Treasure, Smith, & Crane, 2007). The animal models illustrate common behaviours and emotional response patterns that parents tend to engage in when caring for someone with an eating disorder. Over the course of the two days, parents had the opportunity to share with other group members their own 'emotional blocks' both in theory and as they emerged throughout the intervention. They were also invited to discuss strategies to reduce the influence of these strong emotional responses on caregiving efforts.

In terms of setting, the intervention took place in a large room with conference-style tables and chairs in an outpatient hospital-based clinic in Ontario, Canada. Participants viewed slides projected on a large screen and had handouts containing all content with them at their tables. Participants completed pre-test measures upon arrival and post-test measures at the end of the second day of the intervention.

Participants

Participants included 24 mothers and nine fathers who attended to support their adolescent or adult child in their recovery from an eating disorder (mean age of the child was 18 years and ranged from 13 to 31 years). The sample included eight sets of parents as well as 17 parents who attended without their co-parent (16 mothers and one father). Families were recruited from a specialized eating disorder treatment programme. Fifty-two percent of families had a child on the wait list for treatment, while 32% of families had a child involved in active treatment within the programme (mean duration of service was approximately 1 year and ranged from 2 weeks to 6 years).² In terms of symptom onset, according to a parent report, 41.7% of children first displayed eating disorder symptoms less than 1 year ago, 37.5% between 1 and 2 years ago and 20.8% more than 2 years ago. Primary symptoms of concern were reported to include restricting in 80% of cases, bingeing in 64% of cases, over-exercising in 52% of cases, purging in 28% of cases and use of laxatives in 12% of cases.

Measures

Parental Self-Efficacy

Parental self-efficacy was assessed using a revised version of the Parents versus Anorexia Scale (PvA; Rhodes,

Baillie, Brown, & Madden, 2005).³ The PvA was designed to study parental self-efficacy, i.e., the 'ability of a parent to adopt a primary role in taking charge of the [eating disorder] in the home setting for the purpose of bringing about the recovery of their child' (Rhodes et al., 2005). Seven items make up the scale, and these are rated on a five-point Likert scale (Strongly disagree, Disagree, Neutral, Agree, Strongly agree). Total scale scores can range from 7 to 35. A lower scale score indicates a lower level of self-efficacy, whereas a higher scale score indicates a higher level of self-efficacy. Sample items include 'I feel equipped with specific strategies for the task of bringing about the complete recovery of my child in the home setting' and 'It is more my responsibility than my child's to bring him/her to a healthy weight'. The reliability coefficient for this measure was strong ($\alpha = 0.91$).

Parents' Beliefs About Children's Emotions—Guidance Scale

The Parents' Beliefs About Children's Emotions Questionnaire (PBCE; Dunsmore, Her, Halberstadt, & Perez-Rivera, 2009) is a measure consisting of statements that relate to beliefs, attitudes and feelings about emotion. Parents are asked to describe the extent to which they agree with the items on a six-point Likert scale (1 = *strongly disagree*, 6 = *strongly agree*). The subscales of focus in this study were (1) parents' beliefs about guiding their children's emotions (PBCE-Parent; 10 items, sample item: 'It's a parent's job to teach children how to handle negative feelings') and (2) parents' beliefs that children can guide their own emotions (PBCE-Child; nine items, sample item: 'Children can learn how to handle their emotions'). The parental subscale scores can range from 10 to 60 ($\alpha = 0.81$). The higher the parental subscale score, the stronger the parents' belief in their role of helping their child to learn to manage their emotions. The child subscale scores can range from 9 to 56 ($\alpha = 0.80$). The higher the child subscale score, the stronger the parents' belief that children can manage their emotions on their own.

Parent Traps Scale

The Parent Traps Scale (PTS; Lafrance Robinson, 2014) is a newly developed measure designed to assess the degree to which parents feel vulnerable to fears that can interfere with their ability to refeed their child and interrupt eating disorder symptoms. Items were developed on the basis of clinical experience and parent feedback. Parents are asked to rate on a seven-point Likert scale (ranging from *not at all likely* to *extremely likely*) the extent to which they feel vulnerable to 15 different fears when supporting their child's behavioural recovery (e.g., 'fear of being rejected by my

²The remaining 16% of families were engaged in services not specific to an eating disorder, including independent counselling, unspecified outpatient services and psychological treatment for another mental illness.

³The revision of the scale was minor. Statements referring to 'anorexia' were revised to reflect the different eating disorder symptoms.

child'; 'fear of breaking down or burning out throughout the process'; and 'fear of pushing my child too far with treatment and leading her to depression, running away or suicide'). Total scale scores can range from 7 to 105 ($\alpha=0.90$). A higher total scale score on this measure indicates a higher level of parental fears related to their engagement in recovery tasks.

End-of-Group Questionnaire

The End-of-Group Questionnaire was designed to measure three factors: parents' actual change; their intention to change, i.e., their intention to engage differently in their child's recovery after the intervention; and satisfaction with the intervention. In terms of actual change, parents responded to the following: 'After the first day of the workshop, did you do anything differently to support your loved one with meal support (refeeding/interruption of symptoms), emotion coaching or relationship repair?' To assess intention to change, parents were asked to comment on the following open-ended question:

After this second day of the workshop, do you intend to do anything differently in the next day or two to support your loved one with meal support (refeeding/interruption of symptoms), emotion coaching or relationship repair?

In addition, satisfaction was measured using 5 seven-point Likert scale questions ranging from *strongly disagree* to *strongly agree* (sample items: this intervention presented new information and concepts; and this intervention addressed my family's needs; $\alpha=0.92$). Participants were then invited to complete an open-ended question asking them to identify the most valuable component(s) of the intervention.

DATA ANALYSIS

Some participants chose not to complete all items; therefore, the number of participants varies between tests. Repeated measures *t*-tests were used to compare pre- and post-intervention total scores for the PvA, the PTS and the subscales of the Parents' Beliefs About Children's Emotions Scale. Since the PTS was a newly developed measure, repeated measures *t*-tests were also run for each individual item. Parents' actual change and intentions to change were analysed using consensual qualitative research analysis of the responses to each of these open-ended questions. Parental satisfaction with the intervention was analysed using frequency distributions from a seven-point Likert scale, which ranged from *strongly disagree* to *strongly agree*. Thematic analysis of open-ended questions regarding the most helpful components of the intervention was carried out following the intervention. Answers to the open-ended

questions were coded in three steps: (1) major themes related to the most helpful components of the intervention were identified, and initial coding categories were determined; (2) two separate coders independently categorized each participant's answers using the coding scheme; and (3) the two coders then reviewed all ratings together to arrive at a consensus.

RESULTS

Parental Self-Efficacy

The pre-intervention total mean on the PvA was 18.56 (standard deviation [SD] = 3.39). It was predicted that parental self-efficacy would improve following the intervention. The total score on the measure improved significantly following the intervention ($M=26.06$, $SD=4.10$, $t(31)=-9.44$, $p<0.001$; Table 1). For example, participants felt more confident in their parental instincts and felt better equipped with practical strategies to help bring about recovery in their child. The effect size was large ($d=3.39$).

Parental Beliefs About Children's Emotions

Parents' Needs to Guide

The pre-intervention mean for the Parent Subscale (PBCE-Parent) was 46.15 ($SD=4.97$). It was predicted that following the intervention, parents would experience positive attitudinal changes regarding parent's role as emotion coach. The results indicated that the Parent Subscale total score increased significantly following the intervention ($M=51.27$, $SD=3.47$, $t(25)=-4.97$, $p<0.001$; Table 1). Therefore, following the intervention, participants felt that it was more appropriate for parents to support their child to manage and express their emotions. The effect size was large ($d=1.99$).

Children Are Capable on Their Own

The pre-intervention mean for the Child Subscale (PBCE-Child) was 20.57 ($SD=7.42$). It was predicted that following the intervention, parents would be less likely to agree that children should learn how to manage and express their emotions on their own. The results revealed that the Child Subscale total score decreased significantly following the intervention ($M=13.93$, $SD=6.41$, $t(29)=6.04$, $p<0.001$; Table 1), and the effect size was large ($d=2.24$). Therefore, following the intervention, parents felt that it was less appropriate for children to learn how to manage and express their emotions on their own.

Emotional Blocks

The pre-intervention total mean on the PTS was 57.43 ($SD=18.86$). It was predicted that following the intervention,

Table 1. Means, standard deviations, *p*-values and effect sizes for parent measures

| | Pre | | Post | | <i>n</i> | <i>p</i> | Effect size (<i>d</i>) |
|-------------------------------|-------|-------|-------|-------|----------|----------|--------------------------|
| | M | SD | M | SD | | | |
| PvA total | 18.56 | 3.39 | 26.06 | 4.10 | 32 | <0.001 | 3.39 |
| PBCE-Parent | 46.15 | 4.97 | 51.27 | 3.47 | 26 | <0.001 | 1.99 |
| PBCE-Child | 20.57 | 7.42 | 13.93 | 6.41 | 30 | <0.001 | 2.24 |
| PTS total | 57.43 | 18.86 | 42.68 | 19.16 | 28 | <0.001 | 1.72 |
| Rejection [†] | 3.97 | 1.91 | 3.00 | 1.59 | 31 | 0.01 | 0.97 |
| Strain [‡] | 3.61 | 1.95 | 2.75 | 1.86 | 28 | 0.05 | 0.79 |
| Other children [§] | 3.39 | 1.96 | 2.74 | 1.79 | 31 | 0.05 | 0.74 |
| Abnormal [¶] | 3.23 | 2.09 | 2.39 | 1.75 | 31 | 0.01 | 0.95 |
| Anger ^{††} | 4.65 | 1.68 | 3.68 | 1.70 | 31 | 0.01 | 0.98 |
| Miss out ^{‡‡} | 4.19 | 1.78 | 3.16 | 1.83 | 31 | <0.001 | 1.47 |
| Set limits ^{§§} | 3.97 | 1.78 | 3.23 | 1.63 | 31 | 0.04 | 0.78 |
| Chubbiness ^{¶¶} | 2.19 | 1.66 | 1.90 | 1.30 | 31 | 0.22 | 0.46 |
| Suffering ^{†††} | 3.77 | 2.00 | 2.87 | 1.73 | 31 | 0.02 | 0.93 |
| Breakdown ^{‡‡‡} | 4.77 | 1.78 | 3.90 | 1.85 | 31 | 0.02 | 0.89 |
| Pushed too far ^{§§§} | 4.55 | 2.03 | 2.87 | 1.80 | 31 | <0.001 | 1.57 |
| Dependence ^{¶¶¶} | 3.90 | 1.97 | 2.58 | 1.71 | 31 | 0.001 | 1.34 |
| Own past ^{††††} | 2.48 | 1.98 | 3.06 | 2.11 | 31 | 0.07 | 0.70 |
| Symptom shift ^{‡‡‡‡} | 3.84 | 1.79 | 3.03 | 1.91 | 31 | 0.02 | 0.89 |
| Self-blame ^{§§§§} | 3.65 | 1.99 | 2.39 | 1.61 | 31 | 0.001 | 1.31 |

PTS items are as follows:

[†]Fear of being rejected by my child/loved one.

[‡]Fear of putting strain on my couple relationship.

[§]Fear of alienating other children/family members.

[¶]Fear that my child/loved one will be seen as abnormal or mentally ill.

^{††}Fear that I will do/say something I will regret out of frustration or anger.

^{‡‡}Fear that my child/loved one will miss out on normal activities or special occasions.

^{§§}Fear of being unable to follow through on set limits for health (activity/eating).

^{¶¶}Fear of making my child/loved one 'chubby'/encouraging 'unhealthy' foods.

^{†††}Fear of causing suffering to my loved one/child/family.

^{‡‡‡}Fear of breaking down or burning out throughout the process.

^{§§§}Fear of pushing my child/loved one 'too far' with treatment (leading to depression/running away/suicide).

^{¶¶¶}Fear of babying my child/loved one and preventing her or him from becoming independent.

^{††††}Fear of having to face my own past along the way.

^{‡‡‡‡}Fear that my child/loved one's symptoms will shift (e.g., go from restricting to purging).

^{§§§§}Fear of being blamed or being to blame.

SD = standard deviation. M = mean. PvA = Parents Versus Anorexia Scale. PTS = Parent Traps Scale.

parents would experience a decrease in the intensity of their fears that could interfere with their engagement with the tasks of recovery. The results showed that the total score on the measure decreased significantly following the intervention ($M = 42.68$, $SD = 19.16$, $t(27) = 4.47$, $p < 0.001$; Table 1). The effect size was large ($d = 1.72$). The items most sensitive to change included parental fears related to pushing their child 'too far' with treatment (causing them to become depressed, run away or commit suicide), causing their child to miss out on normal life experiences, preventing their child from achieving independence and being blamed or being to blame (Table 1).

Parents' Actual Change and Intentions to Change

Actual Change

On the second day of the intervention, parents were asked if they had attempted meal support or emotion coaching to

support their child's recovery the night before. Sixty-three percent of the sample reported having implemented at least one new strategy to support their child in the domains of recovery or emotion coaching. Of those, 57% reported engaging in recovery coaching using strategies taught during the first day of the intervention, and 81% of the sample reported that they attempted emotion coaching with their child. With respect to recovery coaching, one parent reported that they were able to provide 'consistent praise, support and encouragement so she could get through the meal. I was able to provide distraction—these strategies were valuable for her to manage her meal' (parent of a 15-year-old child). Another reported, 'I told my daughter that I was going to cook supper and she must eat with me' (parent of a 16-year-old child), while another reported 'I told [my spouse] that my daughter had to have the ham for supper tonight' (parent of a 21-year-old child). In terms of emotion coaching, one parent reported

I was able to be empathic with my daughter who expressed her fear before dinner. I attended, labelled and validated her emotions, and in turn, she was able to hug me and I could see she knew I was there for her. (Parent of a 15-year-old child)

Another parent reported, 'I told my daughter that I understand how hard it is to eat her meal when she gets so much pain after eating—who wouldn't find that hard?' (parent of a 21-year-old child).

Intentions to Change

Following the second day of the intervention, parents reported on their intentions to try new strategies to support their child in the domains of recovery or emotion coaching. Eighty-five percent of the sample reported intentions to implement at least one new strategy to support their child. In the domain of recovery coaching, 67.9% of parents reported intentions to engage in meal support by incorporating refeeding and symptom interruption strategies that had been targeted throughout the intervention. For instance, one parent stated that they would 'set up a structured meal system to eliminate the bingeing' (parent of a 17-year-old child), while another reported that they would 'take over the preparation of her lunch and supper and we will discuss the foods she feels are taboo' (parent of a 27-year-old child). Yet another 'will be diligent in providing meal support and supervision' (parent of a 16-year-old child).

In terms of emotion coaching, 92.9% of parents reported intentions to use strategies in this domain to support their child's recovery, including relationship repair. For example, one parent described an intention to 'apply the steps: attend, label, validate and meet the need—to better equip [my] daughter with the necessary skills to reach autonomy' (parent of a 20-year-old child). Another shared that when they notice that their daughter is upset, they will 'not leave her alone but use the steps' (parent of a 13-year-old child), while another parent reported that they will 'step outside my comfort zone and change how I would normally react' to her emotions (parent of a 15-year-old child). Yet another parent reported that they would 'listen better [...] to my [spouse] and daughter's emotions. I'm going to stop trying to fix everything from the start' (parent of a 20-year-old child). With respect to relationship repair specifically, one parent indicated an intention to 'take away the burden and guilt she carries' (parent of a 15-year-old child), while another intended to 'apologize for not recognizing that she needed me' (parent of a 25-year-old child).

Intervention Satisfaction

A subset of participants ($n = 25$) completed a questionnaire regarding their satisfaction with the intervention. One-hundred percent of the sample either 'strongly agreed'

or 'agreed' that new information and concepts were presented throughout the intervention and that the ideas presented would be useful in their parenting. Ninety-six percent of the sample 'strongly agreed' or 'agreed' that the role-plays, examples and handouts used throughout the intervention were helpful, and 88% percent of the sample 'strongly agreed' or 'agreed' that this intervention met their expectations. Finally, 80% of the sample 'strongly agreed' or 'agreed' that this intervention addressed their family's unique needs.

A qualitative analysis of open-ended questions regarding the most helpful components of the intervention was conducted. The researcher organized responses according to emerging themes. A second researcher reviewed the initial clustering of themes and six themes were identified (Table 2). The analysis indicated that participants most benefited from (1) engaging in experiential exercises, (2) having a group leader who actively attended to participants' emotions, (3) learning the steps of emotion coaching and (4) experiencing the group processes. Additionally, parents reported that learning about (5) the importance of active involvement and (6) the ways in which their own emotional and caregiving styles impact their supportive efforts were also very helpful (refer to Table 2 for themes and examples).

DISCUSSION

The current pilot study examined the outcomes of an EFFT group-based intervention for parents of children

Table 2. Themes for most helpful components of the intervention

| Theme | Example items |
|----------------------------------|---|
| Experiential activities | 'Role-plays—attend, label, validate' 'The opportunity to practice' |
| Emotion-focused presenter | 'Role-playing—demo how hard it is' 'Really attending to people's struggles' 'Stopped to address the emotions' 'Presenter was honest and didn't sugar-coat' |
| Emotion coaching | 'There is a process and it works' 'Learned how to understand my daughter's emotions' 'Steps and process of being an emotion coach' |
| Group processes | 'Trusting environment—participants/clinician' 'Meeting other parents, feeling "not alone"' |
| Importance of active involvement | 'Open dialogue' 'Strategies to help with the behavioural symptoms of eating disorder' |
| Parental blocks | 'Useful techniques' 'Getting to the root of my emotions' 'By not doing anything—who I am protecting' |

struggling with an eating disorder. To our knowledge, this is the first behavioural and emotion-focused intervention to include parents of children of all ages and with various eating disorder symptom presentations. Overall, this intervention seems a worthwhile object of future study in that significant differences were noted across a number of domains and effect sizes were notable.

In terms of recovery coaching, results of this study suggest that involvement in this intervention may have led to improvements in parental self-efficacy with respect to their role in their child's recovery from the eating disorder. This result is promising, given that parental self-efficacy is regarded as a possible mechanism of change in recovery from an eating disorder (Lafrance Robinson et al., 2013). In fact, it is interesting to note that the PvA pre-intervention means in this study (18.67) were equivalent to those reported pre-intervention in Lafrance Robinson and colleagues (2013) and Girz, Lafrance Robinson, Foroughe, Jasper, and Boachie (2013) (16.65 for mothers and 18.05 for fathers and 17.58 for mothers and 17.00 for fathers, respectively), suggesting similar levels of low self-efficacy across these diverse parent populations. Even more noteworthy was the finding that post-intervention PvA means (26.06) were equivalent to means recorded in each of these studies following 3 months of active family-based treatment (23.42 for mothers and 21.33 for fathers in the day treatment sample and 21.15 for mothers and 22.15 for fathers in the combined outpatient and day treatment sample). Although a number of interpretations are possible, this finding provides some optimism regarding the possible benefits of this broad-based, low-cost intervention. For example, the resources required include a salary for one clinician trained in EFFT, handouts for parents, a snack for the meal support role-play and room rental for 2 days.

Participants also seemed to shift in their views regarding children's capacity to manage distress and work through emotions on their own, and the importance of parental support in doing so. These findings are directly related to the purpose of emotion coaching in that individuals with eating disorders, regardless of their age, can greatly benefit from parental support with emotion processing. This support is critical in managing the flood of emotions that often emerges as the behavioural recovery from an eating disorder commences, as well as in the internalization of these skills, rendering symptoms unnecessary to cope with stress or pain.

With the exception of Treasure, Sepulveda, et al. (2007), to our knowledge, no other treatment models in the field specifically target the impact of parents' emotions on their ability to support their child's recovery. This is despite the fact that it is widely accepted that strong emotions in carers can have negative consequences on their loved one's recovery. As such, we are most excited about the findings related to emotional blocks. Participation in this

intervention seems to have resulted in a reduction of a number of fears that can interfere with parents' efforts to refeed their child and interrupt symptoms. This intervention also seemed to have reduced parents' feelings of self-blame—a finding that is significant, given that many parents naturally (and yet erroneously) feel to blame for their child's illness and that the field of eating disorders is emerging from a long history of parent blame. In fact, at first glance, the focus on both family patterns of emotion avoidance and relationship repair may feel reminiscent of the parent-blaming past; however, the data reflect our experience of these interventions as hopeful, healing and most importantly, non-blaming.

Also noteworthy was the fact that after only 1 day of receiving this brief intervention delivered in a group format, parents reported engaging in numerous new behaviours in relating to their loved one around the eating disorder, and expressed clear and specific intentions of doing even more to engage in the tasks of recovery after the second day. In addition to the shifts noted above, the intervention also yielded high rates of satisfaction.

LIMITATIONS AND FUTURE RESEARCH

Despite its important contributions to the field, this exploratory pilot study is not without limitations. Although this EFFT intervention appears to have benefitted the parents who participated, firm conclusions about its effectiveness cannot be drawn due to the study design, including the short time between measurement intervals. The generalizability of our results is also limited by the fact that follow-up data was not available. In addition, the demographic data obtained from parents were self-report in nature and in some cases were impossible to verify with clinical records. Outcome data were also self-report or attitudinal in nature, thus leading to the possibility of response bias. Finally, some of the measures used were experimental in nature, and thus, published validation studies were not available.

In terms of future research, on the basis of the preliminary findings of this pilot study, it is recommended that additional group-based EFFT interventions should continue to be explored with the addition of long-term follow-up in order to evaluate whether changes are maintained over time. In addition to a randomized control design, future studies should explore the differential impact of the various treatment modules as well as the relationships among different variables (such as treatment status, diagnosis and age) and parent and child outcomes verifiable by objective indicators. Finally, mixed-method follow-up studies will be essential in order to better understand the long-term outcomes related to this intervention.

Overall, based on this study's findings, EFFT appears to be a promising practice that could allow for greater access

to resources for parents on wait lists, as an adjunct to treatment or on their own if their child refuses treatment or does not consent to their parent's formal involvement in the treatment. The fact that this intervention was short-term, required few resources and was delivered to parents of children of all ages with varied symptom profiles is also reason for optimism.

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