Emotion-Focused Family Therapy for Eating Disorders

A New Approach to Working With Families

Renfrew Conference Presentation
Philadelphia, PA
November 2013

Gwenn Kudler Gelfand LCSW

Special Thanks to

Dr. Adele Lafrance Robinson

and

Dr. Joanne Dolhanty

www.emotionfocusedfamilytherapy.org

It is my goal to…

- Present new ideas, information, metaphors and theoretical lenses through which to examine ED cases
- Present some emotion-focused principles and techniques to integrate in your theory and practice
- Present some family-friendly principles and techniques to integrate in your theory and practice
- Present a new treatment model for you to consider when the standards aren't facilitating recovery

Core Beliefs of EFFT

1. We believe that all children – **regardless of their age** – want their parents/caregivers to help them heal – even when they try to convince us otherwise

2. We believe in the extraordinary healing power of parents and caregivers

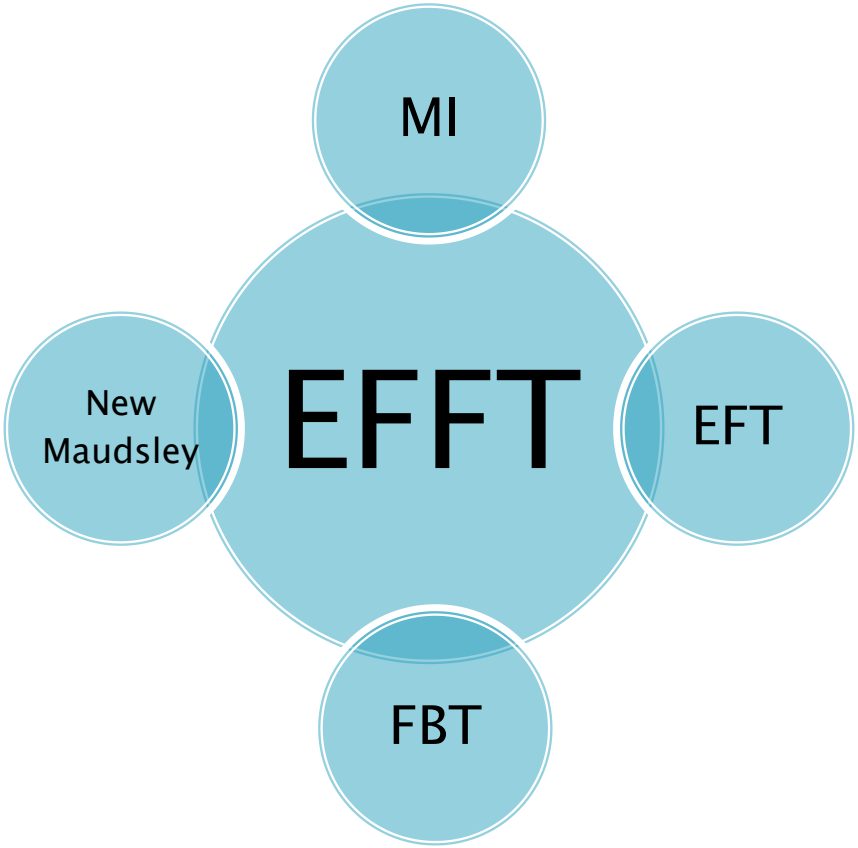
3. We believe that parents and caregivers can learn ALL of the skills they need to become their child's mental health coach

4. We believe that parents and caregivers can overcome their fears that may keep them paralyzed, or stuck in unhelpful patterns of relating to their child

5. We believe that parents and caregivers just need to be coached. They also need for us to believe in them until they do.

6. Therapists are not immune to the influence of emotion in their practice. They can also process these emotions in order to help the family get on track with recovery, even in the most dire of circumstances.

How we got here...



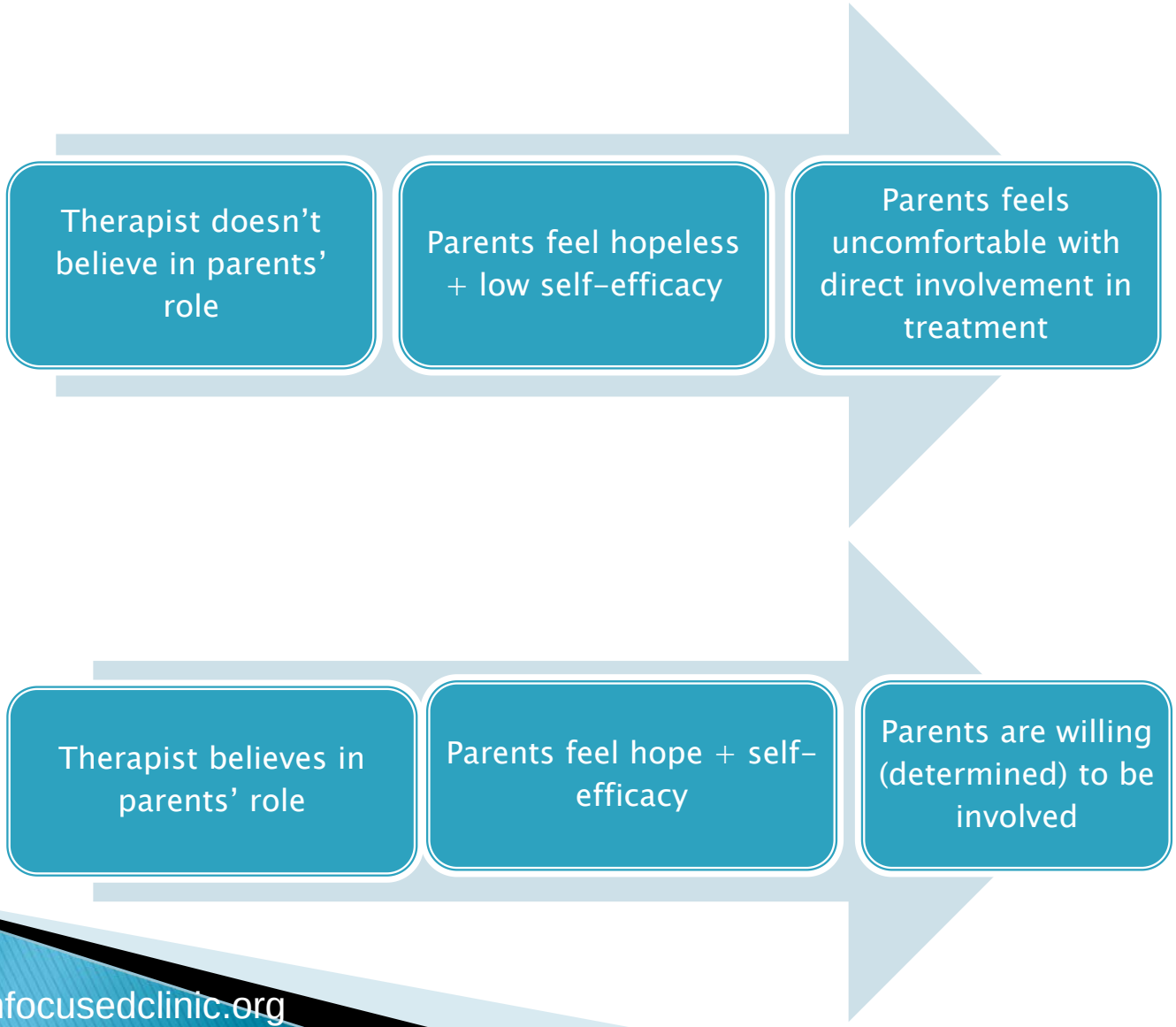
Fundamentals of EFFT

- Family-Focused
- Parent Empowerment
- Skills Training
- Emotion-Focused

Family-Focused

- Regardless of their age, all children want to be supported by their parents, and all parents want to support their child in their recovery.
- “I don’t want my parents involved” = “I desperately want my parents involved but I’m scared it won’t go well,”
- “I don’t want to be involved in my child’s treatment” actually means: “I desperately want to support my child but I’m scared it won’t go well.”
- This new “lens” through which to filter “resistance” allows the therapist to harness the intrinsic motivation of the individual and the family to collaborate in the recovery process.

Parent Empowerment



Skills Training

- Finding their "zone of proximal development"
  - find the balance between respecting family's capacity to activate resources and recognizing that some families need more skill development than others

- Providing skills training as if the parents were **new nurses** being trained on the inpatient ward (with teaching, videos, role plays)

- Providing skills training as if the parents were **new therapists** being trained on the inpatient ward (with teaching, role plays)

Emotion-Focused

- Low self-efficacy with emotion is believed to feed the ED AND emotional style in the family can maintain the illness – this conceptualization informs all interventions

- Therapist seeks to understand individual and family dynamics in terms of "emotion-processing" style AND interrupts family's cycle of emotion avoidance

Emotion-Focused

- Therapist trains parents to be the emotion coach and to engage in relationship repair – if necessary.
- This new emotional style of supporting their child will also increase parents' efforts with refeeding/symptom interruption
- Therapist attends to and helps to process the parents' fears/wounds to unleash their strength : "Until the parent's cries are heard s/he cannot hear the cries of the child"

The Nuts and Bolts of EFFT

We support **parents and caregivers** to:

1. Become their loved ones' **recovery coach** (via the support of refeeding / interruption of symptoms)
2. Become their loved ones' **emotion coach** (via the support of processing of emotion)
3. Support their loved one to **heal old wounds** (via relationship repair)
4. **Work through fears** or emotional "blocks" (that may interfere with 1,2 and 3)

We support **clinicians** to:

1. **Process emotional "blocks"** that may interfere with the delivery of the model

Becoming a Recovery Coach

- We coach parents and caregivers to take on the role of recovery coach much like the **nurses** do on an inpatient ward in order to support refeeding and interrupt symptoms

We Teach Strategies to Support Refeeding and Symptom Interruption

- Meal support strategies (sitting with loved one, chair placement, coaching phrases, text messages)

- Strategies to support the interruption of symptoms (supervision and distraction post-meals, asking direct questions about symptoms, text messages, support re: exercise)

The Nuts and Bolts of EFFT

We support **parents and caregivers** to:

1. Become their loved ones' **recovery coach** (via the support of refeeding / interruption of symptoms)
2. Become their loved ones' **emotion coach** (via the support of processing of emotion)
3. Support their loved one to **heal old wounds** (via relationship repair)
4. **Work through fears** or emotional "blocks" (that may interfere with 1,2 and 3)

We support **clinicians** to:

1. **Process emotional "blocks"** that may interfere with the delivery of the model

Brief Review about Emotion

- Emotions are fundamentally adaptive and aid in survival
- Help us to survive by providing an efficient, automatic way of responding rapidly to important situations (prepare us for action)
- How? They are an alarm system providing information about the self and the world

Brief Review about Emotion

Every emotion:

- Has a bodily felt sense
- Has a label that can be communicated in words
- Has a need
- Has an action tendency

Listening to the emotion prepares us for action – it also reduces the stress on the body by bringing the systems back to baseline (see the work of Gabor Mate for more on that)

Emotion Basics

LABEL	FEAR
Bodily Felt Sense	
Need	
Action Tendency	

LABEL	FEAR	SADNESS	ANGER
Bodily Felt Sense	Heart racing Sweaty palms Slowed digestion Etc....		
Need	Safety		
Action Tendency	Run, hide, etc.		

SADNESS

LABEL	FEAR	SADNESS	ANGER
Bodily Felt Sense	Heart racing Sweaty palms Slowed digestion Etc....		
Need	Safety		
Action Tendency	Run, hide, etc.		

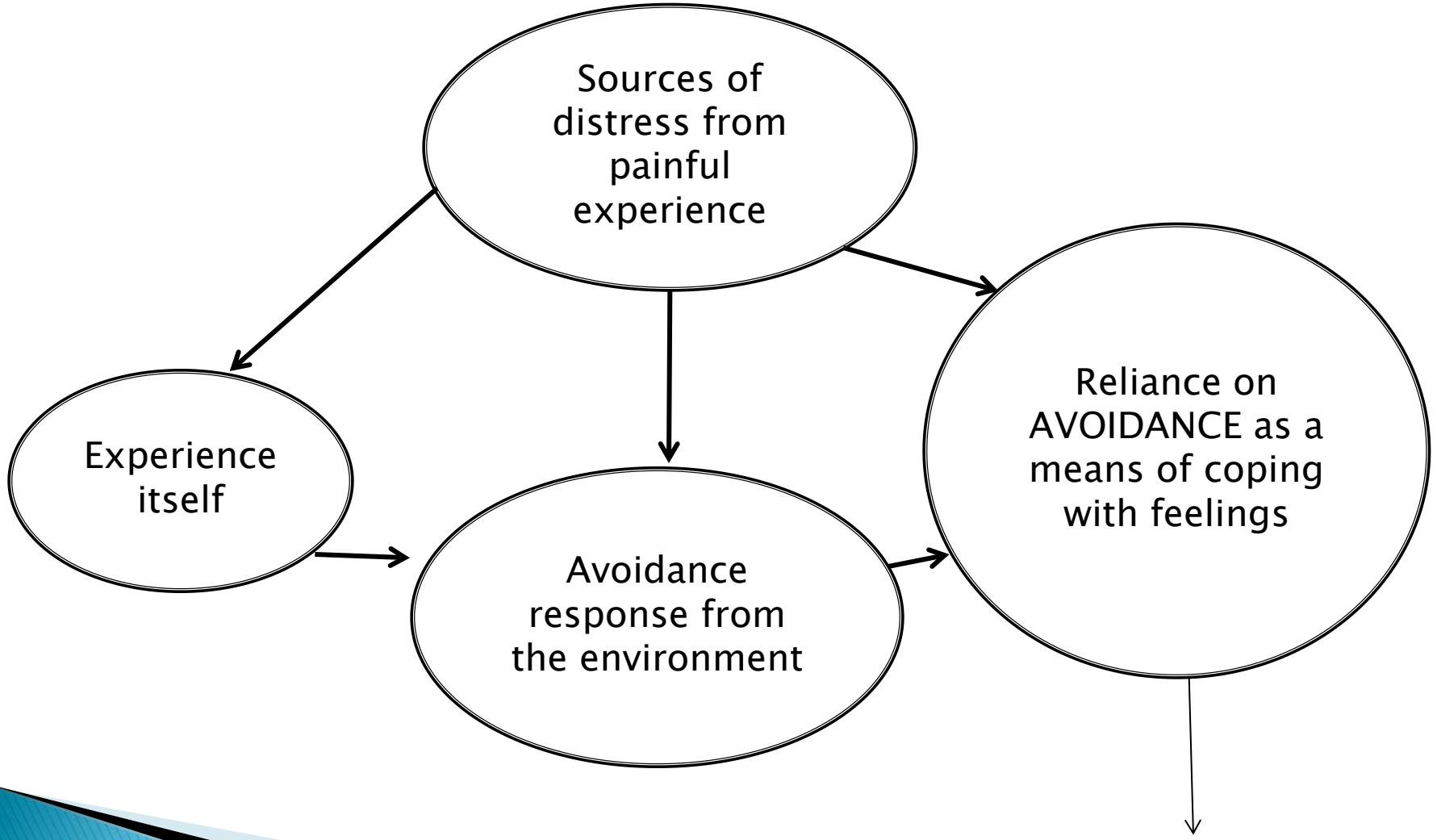
LABEL	FEAR	SADNESS	ANGER
Bodily Felt Sense	Heart racing Sweaty palms Slowed digestion Etc....	Heaviness slowness	
Need	Safety	Comfort	
Action Tendency	Run, hide, etc.	Reach out for a hug	

ANGER

LABEL	FEAR	SADNESS	ANGER
Bodily Felt Sense	Heart racing Sweaty palms Slowed digestion Etc....	Heaviness slowness	
Need	Safety	Comfort	
Action Tendency	Run, hide, etc.	Reach out for a hug	

LABEL	FEAR	SADNESS	ANGER
Bodily Felt Sense	Heart racing Sweaty palms Slowed digestion Etc....	Heaviness slowness	Heart racing Feeling hot / flushed Tension in the body
Need	Safety	Comfort	Setting a boundary
Action Tendency	Run, hide, etc.	Reach out for a hug	Defending the boundary

It's Not What Happens – It's What Happens Next



Function of the Eating Disorder

In terms of emotions…

- The eating disorder is a way of protecting the self and avoiding painful feelings.

Emotions and Eating Disorders

Clients use eating disorder symptoms to avoid or
cope with emotions and/or painful memories

- **AN**: Restricting numbs feelings
- **BN**: Binge eating pushes down feelings; vomiting/laxatives/exercise purge emotions
- **BED**: Binge eating comforts, soothes

"The only thing worse than feeling a painful feeling is *not* feeling it."

Rationale for Emotion Coaching

- Teach parents to become their child's emotion coach so that...
- Their child feels like their parents "get it" – they are not alone to face life's challenges. They will feel safe going back to them for support next time.
- Their child learns that emotional challenges are part of life and that they can be dealt with (much like dealing with thirst, hunger or fatigue)
- Their child feels like their parents can tolerate/handle that they have problems and they will learn through them how to handle them (internalize the ability to regulate and problem-solve) instead of using symptoms to cope

Steps of Emotion Coaching

1. Attend to emotion
2. Label and express the emotion
3. Validate the emotion
4. Meet the associated need (soothe, protect, reassure, assert, set-limits)
5. (Fix it [Redirect / Problem-solve])

From BUT to BECAUSE...

- I get how you would have felt that way but...

is transformed into:

- I get how you would have felt that way because...

AND REMEMBER:

Genetics / Super-feeler status is at the foundation of it all and so it won't always "make sense" to parents or reflect the "reality" of what happened!

Emotion Coaching

The most versatile tool in EFFT!

- Clinician to Child
- Clinician to Parent
- Parent to Child (most important!)

Attend, Name, Validate

Clinician to Client:

A patient tells you she doesn't want her parents involved in treatment.

- Name the different emotions she may be feeling
- Validate the experience

Attend, Name, Validate

Parent to Child:

Your child is furious that you are involved in her treatment. She threatens to cut you out of her life if you continue to attend appointments with or without her.

- Name the different emotions she may be feeling
- Validate the experience

Attend, Name, Validate

Clinician to Parent:

A mom tells you that she doesn't think you're helping enough. She questions your credentials and criticizes your work.

- Name the different emotions she may be feeling
- Validate the experience

Practice & Demo

- Client:
  - Picture your mom in the chair
  - Tell her about something difficult

- Therapist
  - Attend to the emotion (bodily felt sense)
  - Help to label the emotion
  - Validate the emotion / experience
  - Help the client to express the healthy need

The Nuts and Bolts of EFFT

We support **parents and caregivers** to:

1. Become their loved ones' **recovery coach** (via the support of refeeding / interruption of symptoms)
2. Become their loved ones' **emotion coach** (via the support of processing of emotion)
3. Support their loved one to **heal old wounds** (via relationship repair)
4. **Work through fears** or emotional "blocks" (that may interfere with 1,2 and 3)

We support **clinicians** to:

1. **Process emotional "blocks"** that may interfere with the delivery of the model

Relationship Repair: When is it appropriate?

- 1. If the family recognizes a familial pattern of emotion avoidance they would like to resolve
- 2. If the child blames herself for the ED and this self-blame is crushing her – stopping her from being able to receive help / move forward in her recovery
- 3. If the child feels broken or crazy due to having an ED / mental health issues
- 4. If the child holds resentment from the past or the parent/child relationship is strained

Relationship Repair: Why is it appropriate?

- 1. These patterns / injuries may have contributed to her tendency to avoid emotion (and turning this around can free her from needing ED symptoms to cope)

- Sharing the burden for the ED can help her feel less self-blame AND feel less broken/crazy which will lead to her ability to accept help more readily and have more hope for the future

- Healing the relationship will allow her to be more willing to accept parents' support (without it her chances of recovery significantly decrease)

AND REMEMBER:

Super-feeler status is at the foundation of it all and so it won't always "make sense" or reflect the "reality" of what happened!

Relationship Repair

- How we do it? One of the ways we can deeply validate another is through the words: “I am sorry”

- The is a communication of deep empathy and togetherness (versus self-blame) and it is very effective.

!

How the Apology Works…

- Opens the vault to discuss old hurt, anger, feelings in general – increases competence with emotion **(increasing confidence with emotions; making symptoms less necessary)**

  - Shows loved one that you can "handle it"; makes them more likely to talk about other sources of pain, fear anger… **(especially if they think you can't handle it) (increasing confidence with emotions; making symptoms less necessary)**

  - Helps loved one "unload" hurt, pain anger, shame; Validates and soothes the emotion **(increasing confidence with emotions; making symptoms less necessary)**

How the Apology Works…

- Helps loved one to let go of old injuries, especially if they do blame events from the past ; feel “not broken” **(increasing confidence with emotions; making symptoms less necessary)**

- Helps families to heal old wounds, improve relationships **(increasing confidence with emotions; making symptoms less necessary)**

Apology: 4(+1) Magic Ingredients

1. Acknowledge the unique impact of the injury and how it may have contributed to a style of emotion avoidance (divorce, moving, getting cancer! + suppression of emotion)

2. Express appreciation for "what it must have been like" (label and validate)

3. Apologize and communicate authentic remorse

4. State what could have been done instead (even if it's: I should have found a way)

5. (Wait for the blast/denial and repeat steps 1-4)

"That must have been so hard. I am so sorry. Knowing what I know now, I would have done things differently. I would have done X, Y, Z."

Applications

- Parents do it on their own

Or

- Dyad sessions

Let's practice...

1. Acknowledge the injury/ relationship style
2. Express appreciation for "what it must have been like" (label and validate)
3. Apologize and communicate authentic remorse
4. State what could have been done instead (even if it's: I should have found a way)

Summary – Relationship Repair

- Relationship repair allows the child – supported by her parents – to work through previously unmanageable emotional experiences and memories.
- This support will lead to an increase in the child's feelings of confidence in managing painful emotions as well as strengthening the parent-child bond.
- It also creates a safe space for the child to free herself from blame for the development of the illness and self-reproach for what she feels she is "putting her family through."

The Nuts and Bolts of EFFT

We support **parents and caregivers** to:

1. Become their loved ones' **recovery coach** (via the support of refeeding / interruption of symptoms)
2. Become their loved ones' **emotion coach** (via the support of processing of emotion)
3. Support their loved one to **heal old wounds** (via relationship repair)
4. **Work through fears** or emotional "blocks" (that may interfere with 1,2 and 3)

We support **clinicians** to:

1. **Process emotional "blocks"** that may interfere with the delivery of the model

3. Working through “Blocks”

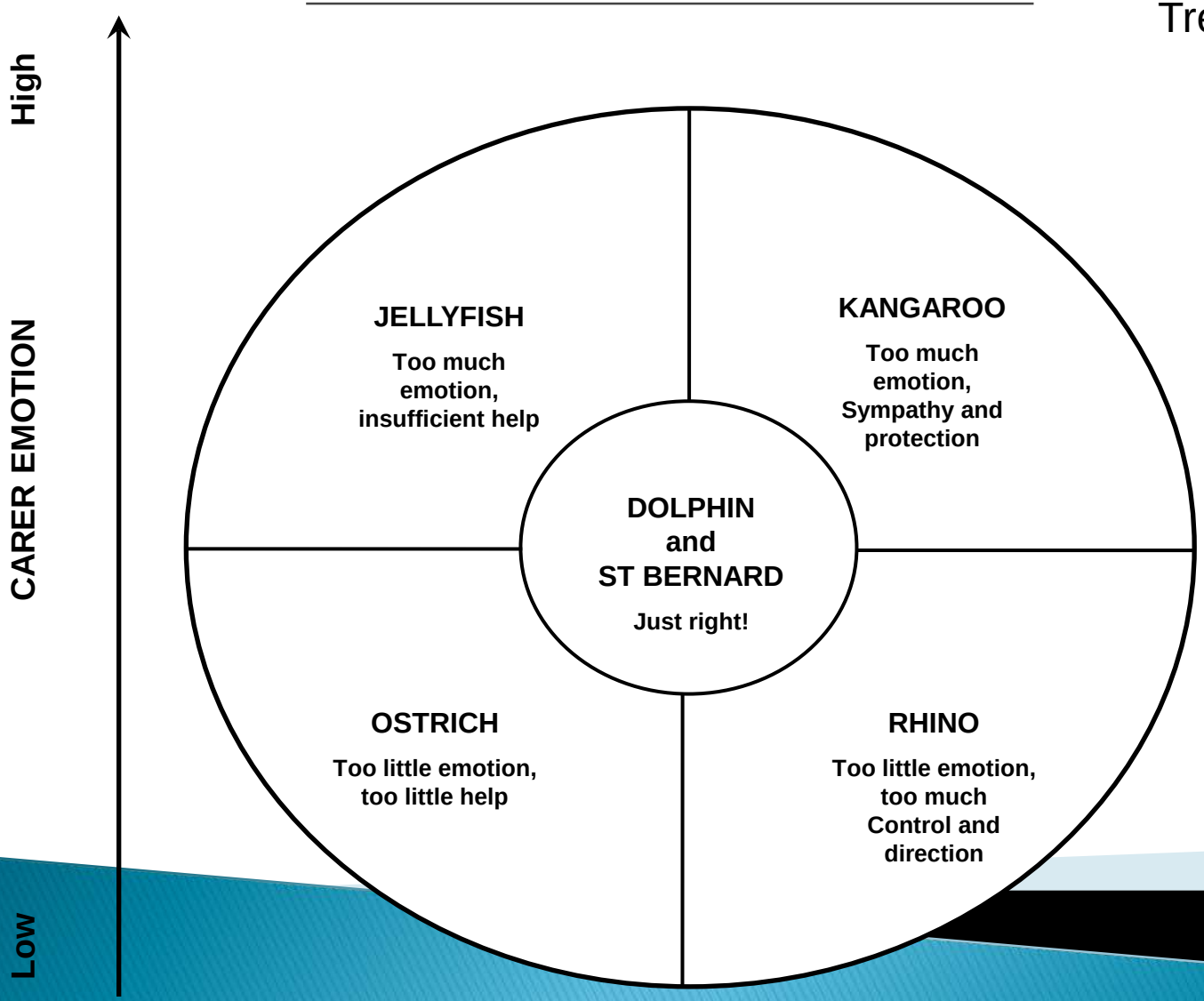
- **One of the most critical components of the work**
- Fears and emotional obstacles will undoubtedly surface for parents in this challenging and novel journey.
- Left unprocessed, these fears and obstacles will interfere with parents’ ability to be effective in these new roles.
- These “emotional blocks” are NORMAL and to be expected – but they need to be worked through

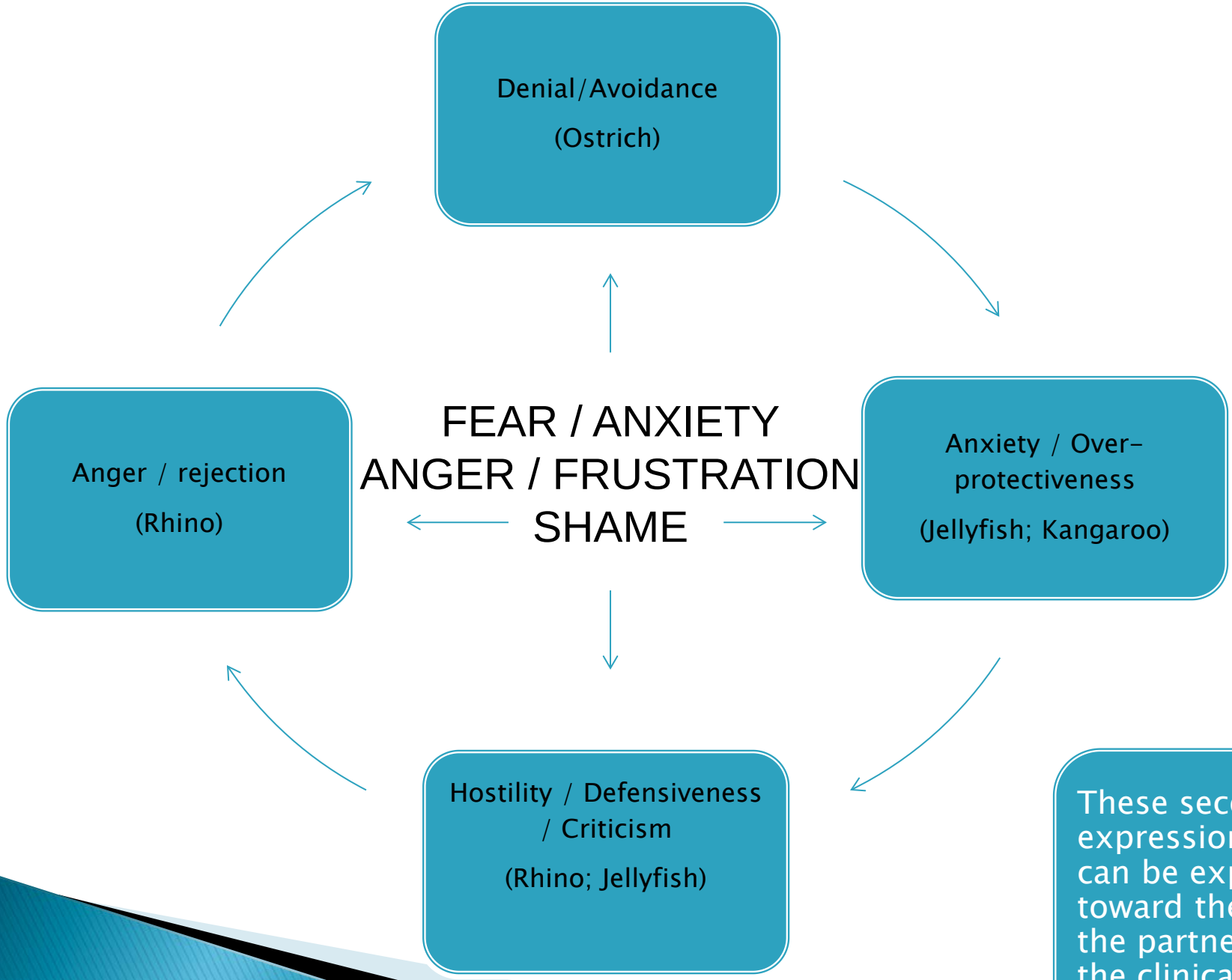
How Parental Blocks are Addressed

1. Animal Models and Education about the Process

ANIMAL METAPHORS FOR CARING

Treasure et al.





These secondary expressions of fear can be expressed toward the child, the partner or even the clinical team

How Parental Blocks are Addressed

1. Animal Models and Education about the Process

2. Parent Traps Measure

Measure to Assess Parent Traps

- Fear of being rejected
- Fear that I will break down, explode in anger or do/say something I will regret.
- Shame! If I face her pain, it will be proof that my worst fear will have come true – I broke her. I will be to blame. Others will blame me.
- Fear of putting strain on my couple relationship or alienating other children/family members
- Fear of causing her too much suffering
- Fear of babying her and preventing her from becoming independent (or encouraging her eternal dependence on me)
- Fear of pushing her "too far" – to emotional or physical disconnection, symptom-shifting, cutting, depression or worse – suicide.

How Parental Blocks are Addressed

1. Animal Models and Education about the Process
2. Parent Traps Measure
3. Skills Training (how to deal with suicidality, running away)
4. Emotion Coaching

Emotion Coaching with Parents

- Can be used with parents who are stuck in their own grief, fear, anger or shame
- By feeling heard and understood, the parent becomes more capable of becoming attuned and responsive to the emotional needs of their child
- We are also healing intergenerational cycles of emotion avoidance and pain. Your emotion coaching is soothing to the parents too. They will be more likely to soothe their child.

No such thing as a parent who "doesn't get it"

- These parents are simply "more" motivated to avoid something "worse" from happening!
- They need support and skills training (in suicide assessment and prevention for example) to release themselves from the shackles of their fear (p.s. "I don't want to be involved in my child's treatment" actually means "I desperately want to save my child but I'm scared I will screw it up and make things worse")
- The New Maudsley adds to this intervention with the use of Animal Models

Summary – Parent Blocks

- Using a variety of techniques, and a new "lens" through which to see parental "blocks", EFFT allows the clinician to find new paths to recovery in the face of impasses that may have otherwise interfered with recovery.

Order of Interventions

- Recovery coaching is most important – however, interventions are concurrent.
- Emotion coaching and relationship repair can increase the effectiveness of parents' efforts with refeeding / symptom interruption
- Parental blocks are addressed as they surface to stay on track with recovery

A Mother's Story...

- The family engaged in standard ED therapies, + other therapies, for over three years
- At the height of her illness, the child's BMI was 12. She was diagnosed with primary amenorrhea and extreme bone loss. The eating disorder was complicated by GI issues.
- The child was hospitalized in her home town and out of town (4 times for a total of 9 months in hospital). She did not attend school on a regular basis.
- For the last two of the three years, the child spoke very few words, and these in whispers.

The Nuts and Bolts of EFFT

We support **parents and caregivers** to:

- [x] 1. Become their loved ones' **recovery coach** (via the support of refeeding / interruption of symptoms)
- [x] 2. Become their loved ones' **emotion coach** (via the support of processing of emotion)
- [x] 3. Support their loved one to **heal old wounds** (via relationship repair)
- [x] 4. **Work through fears** or emotional "blocks" (that may interfere with 1,2 and 3)

We support **clinicians** to:

1. **Process emotional "blocks"** that may interfere with the delivery of the model

Canadian Study re: ED Tx

- Given the potential for grave consequences related to ED, different factors that may hinder treatment outcome need to be explored

- Objective: To explore the perception of the influence of emotions in clinical decision-making in child and adolescent eating disorders

Inspired by…

- Waller (2009) and Treasure & colleagues (2011) developed different theoretical models that consider the role of clinicians' own emotions in the delivery of treatment
  - Avoiding, accommodating, and enabling

Participants

- 119 ED clinicians from across Canada who currently work with children/adolescents
- Average of 9 yrs experience working with ED
- 72% currently worked within an ED program that serviced children/adolescents
- 95% received informal and/or formal supervision

Participants Cont'd

Discipline	% of sample
social work	28%
psychology	18.6%
nursing	16.9%
dieticians	11.9%
physicians	7.6%
psychiatrists	3.4%

Measure

- Online survey
- 13 questions relating to the influence of emotions in clinical decision-making when working with child and adolescent ED

To what extent do you feel your emotions negatively influence your clinical decision-making in each of the following specific situations?

- Determining the degree of involvement of critical/ dismissive parents in tx - 58.3%
- Supporting the child/teen's travel plans (e.g. overseas) - 45.8%
- Determining the degree of involvement of non-custodial/ alienated parents in tx - 37.5%

- Deciding to make individual tx with the child/teen the primary mode of tx 37.5%
- Allowing for passes – 36.4%
- Determining the intensity of tx required – 31.8%
- Discharging the child/teen from tertiary care – 31.3%
- There are more but these are the items endorsed by at least 30% of the sample

Which of the following concerns do you believe have a negative influence on your clinical decision-making?

- Arousing a hostile/negative reaction from the child/adolescent/parent/family - 47.1%
- Not having the right skills to help the child/parent/family - 40.3%
- Being blamed/being to blame for lack of tx progress - 37%
- Being disliked by parents/family/child/adolescent - 35.3%
- Causing the child/family to disengage from tx - 35.3%
- Making decisions/recommendations that may be unpopular with, or contrary to other team members - 31.9%

In response to your own emotions or to those of others, do you engage in any of the following behaviours?

- Focusing on another, less emotionally arousing topic with the child/parents – 35.3%
- Overemphasizing minor improvements in the child/parents – 32.8%
- Rationalizing with the child/parents – 31.1%
- Bartering/negotiating with the child/parents – 26.1%

Conclusions

- Given the high stakes & intense nature of the work, it is not surprising that many ED clinicians reported that their emotions may have a negative influence on their clinical practice

- A relatively large % of clinicians identified some of their own fears that may negatively influence their clinical decision-making

- When emotions are high (their own or those of others) clinicians report engaging in some avoidance and rationalizing behaviours that may affect tx outcomes

Conclusions Cont'd

- Need for increased awareness about emotions in clinical decision-making, greater access to supervision, & time for self-reflective practices
- Focus should also be on normalizing these processes in general – to address them and to reduce the likelihood of their interference with tx delivery (and ultimately client outcomes)
- Results of the current study are likely an underestimate of the frequency of this phenomenon

EFFT Supervision Model

1. Clarify the specific emotional stuck point

2. Attend to and assist in the processing of the clinician experience via emotion coaching

3. Engage in experiential supervision in order to resolve potential "emotional blocks" (that may be outside of awareness) in order to allow for more objective treatment decision-making

The Nuts and Bolts of EFFT

We support **parents and caregivers** to:

- ☑ 1. Become their loved ones' **recovery coach** (via the support of refeeding / interruption of symptoms)
- ☑ 2. Become their loved ones' **emotion coach** (via the support of processing of emotion)
- ☑ 3. Support their loved one to **heal old wounds** (via relationship repair)
- ☑ 4. **Work through fears** or emotional "blocks" (that may interfere with 1,2 and 3)

We support **clinicians** to:

- ☑ 1. **Process emotional "blocks"** that may interfere with the delivery of the model

Emotion-Focused Family Therapy

1. We believe that all children – **regardless of age** – want their parents/caregivers to help them heal – even when they try to convince us otherwise

2. We believe in the extraordinary healing power of parents and caregivers

3. We believe that parents and caregivers can learn ALL of the skills they need to become their child's mental health coach

4. We believe that parents and caregivers can overcome their fears that may keep them paralyzed, or stuck in unhelpful patterns of relating to their child

5. We believe that parents and caregivers just need to be coached. They also need for us to believe in them until they do.

6. Therapists are not immune to the influence of emotion in their practice. They can also process these emotions in order to help the family get on track with recovery, even in the most dire of circumstances.

Future Directions – Carer Workshop

- On the basis of this model, a 2-day carer workshop was developed that covers each of the 4 domains of treatment

- Pilot workshops were delivered at HSN in Sudbury, at CHEO in Ottawa and at the Maudsley Hospital in the UK

- Workshops were offered to carers of children, adolescents and adults – whether they were on the wait-list or in treatment

Future Directions – Preliminary Results

- After 2 days, carers experienced:
  - significant increase in self-reported self-efficacy with their role in their child's treatment
  - significant and positive change in the way they regarded their role in supporting their child with their emotions

Carers also reported behavioral changes after each day of the workshop.

Follow-up studies are in progress with 7 different sites across Canada

Questions and Discussion