Caregivers' Perception of Emotion-Focused Family Therapy for Adolescent and Young Adult Females with Anorexia Nervosa or Bulimia Nervosa

by

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Abstract

Emotion-Focused Family Therapy (EFFT) is an emerging therapeutic intervention in treating female adolescent and young adults with eating disorders. EFFT integrates the principles of family-based therapy and emotion-focused therapy. The main goal of the intervention is to empower parents to become their child's recovery and emotion coach. This study gathered parent's perceived obstacles and benefits of EFFT. The findings were that all eight parents had a positive experience of the workshop and cited multiple benefits to the workshop. The most notable identified benefit by parents was that they had noticed an improvement in the parent-child relationship. Further, parents stated that they felt empowered and hopeful after attending the workshop. The findings are relevant to eating disorder clinicians for two reasons. Firstly, the findings suggest that the EFFT model has the potential to improve the relationship between the parent and child. Secondly, parents perceived this intervention as beneficial.

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Introduction

An eating disorder is a persistent illness that can consume all areas of an individual's life. Consequently, this illness requires strategic long-term treatment. *The Diagnostic and Statistical Manual of Mental Disorders 5th edition* (*DSM-5*) outlines three categories of eating disorders: anorexia nervosa, bulimia nervosa, and binge eating (American Psychiatric Association [APA], 2013). However, the information in this literature review is in regards to anorexia nervosa and bulimia nervosa, thus the term eating disorder in this paper refers to these two categories in the *DSM-5*. Eating disorders are the third most chronic disease in adolescent females in Canada (Robinson, Strahan, Girz, Wilson, & Boachie, 2013). Approximately 50% of individuals struggling with an eating disorder will recover. An estimated 20-30% will have lasting symptoms, and approximately 10% will die within ten years (Fursland et al., 2012; Hurst, Read, & Wallis, 2012; Tasca, Ritchie, & Balfour, 2011). Suicide in this population is also common (APA, 2013; Hurst et al., 2012). In fact, anorexia nervosa has the highest mortality rate of any psychiatric illness (National Eating Disorder Information Centre, 2014). With these statistics the type of treatment delivery for an individual with an eating disorder is extremely important. As a result, the efficacy of treatment models for eating disorders is consistently researched.

In the past, eating disorders have typically been treated with Cognitive Behavioral Therapy or family-based therapy, however different models specific to treating eating disorders have recently been developed. This literature review focuses on four treatment models for adolescent and young adult females with eating disorders: cognitive behavioral therapy, Maudsley family-based therapy, emotion-focused therapy, and

emotion-focused family therapy. Family-based therapy has proven to be the most effective in treating adolescent females with eating disorders (Bean, Louks, Kay, Cornella-Carlson, & Weltzin, 2010; Downs & Blow, 2013; Glasofer & Devlin, 201; Grave, Calugi, Doll, & Fairburn, 2013; Robinson, Dolhanty, & Greenberg, 2013). The last two models of treatment have recently been applied to this population. Emotion-focused therapy and emotion-focused family therapy are significant as the models illustrate a shift in the treatment of eating disorders in adolescent females. Typically treatment models for eating disorders have focused on treating the behavioral symptoms of the disorders. However, emotion-focused therapy and emotion-focused family therapy emphasize the need to treat emotion regulation in the adolescent or young adult female. Due to emotion-focused family therapy being relatively new there is limited information in regards to the efficacy of this treatment model. This study focuses on the caregivers' perspective of this treatment model, including what they observed to be obstacles and benefits to emotion-focused family therapy. This research study asks the question "What do parents of female adolescents and young adults with anorexia nervosa or bulimia nervosa view as the obstacles and benefits of Emotion-Focused Family Therapy"?

Literature Review

Overview of Eating Disorders: Bulimia Nervosa and Anorexia Nervosa

Bulimia Nervosa (BN) is diagnosed based on the following diagnostic criteria in the *DSM-5*. The individual binge eats, which is defined as eating an excessive amount of food in a short period of time and the individual lacks control while they are eating. The individual uses purge behaviors, such as self-induced vomiting, diuretics, or excessive exercise, to maintain their weight. The binge/purge symptoms occur at least once a week

for three months. Lastly, the individual's self-esteem is based on their body weight (APA, 2013, p. 345). Alternatively, there are three diagnostic criteria in the *DSM-5* that must be met in order for an individual to be diagnosed with anorexia nervosa (AN) (APA, 2013). First, the individual must be restricting their intake of necessary nutrients, which leads to a "significantly low body weight". Second, the individual has "intense fear of gaining weight". Third, the individual has a distorted perception of their low body weight (APA, 2013, p. 338).

Additionally, a number of individuals with AN also use the binge-eating and purge symptoms described above for weight management, though it is more common for these individuals to use purge symptoms rather than binge symptoms (APA, 2013; Fursland et al., 2012; Guarda, 2008; Ivanova & Watson, 2014). Approximately 50% of individuals who have recovered from the restrictive symptomatology of AN move into strictly binge/purge symptoms (Fursland et al., 2012; Guarda, 2008; Ivanova & Watson, 2014). The *DSM-5* accounts for individuals crossing between the two eating disorders and states that a diagnosis needs to be based on symptoms that have occurred within the last three months (APA, 2013).

Although there are similarities between BN and AN there are also significant differences. Individuals tend to develop AN in earlier adolescence, whereas BN predominantly develops in later adolescence and young adulthood (Fursland et al., 2012). Moreover, individuals with BN typically maintain an average body weight, while individuals with AN have a lower than average body weight (APA, 2013). The most noticeable difference between the two eating disorders is the efficacy of treatment and the recovery rate. BN has been documented in the literature to have a much higher recovery

rate and lower relapse rate than AN. A possible explanation for this may be that BN has demonstrated to be more responsive to treatment intervention than AN (Schnicker, Hiller, & Legenbauer, 2013).

Etiology of Eating Disorders

When reviewing the literature there is a vast number of factors to take into consideration when speaking about the etiology of an eating disorder. The literature cites poor self-esteem, body dissatisfaction, and a high level of importance placed on thinness in society (APA, 2013; Fursland et al., 2012; Tasca et al., 2011). There is also information in the literature that indicates eating disorders are linked to genetics and body type (APA, 2013; Guarda, 2008; Hurst et al., 2012). Individuals diagnosed with AN have a predisposition for low body weight, whereas individuals diagnosed with BN are predisposed to having a higher body weight (APA, 2013; Tasca et al., 2011). Furthermore, early dieting practices have proven to contribute to the development of eating disorders later in life (Hurst et al., 2012; Tasca et al., 2011). The National Eating Disorder Information Centre (2014) reports

> ... girls who engaged in strict dieting practices: were 18 times more likely to develop an [eating disorder] within six months than non-dieters [and] had almost a 20% chance of developing an [eating disorder] within one year. Girls who dieted moderately were five times more likely to develop an [eating disorder] within 6 months than non-dieters. (Children and Adolescents section, para. 7)

There are a number of physiological reasons outlined in the literature that attempt to explain the etiology of eating disorders. However, there is more recent information to

suggest that there are greater issues than the above listed factors when examining the development of an eating disorder.

Recent literature has documented that adolescent females struggling with an eating disorder tend to have difficulties in regulating their emotions, experience interpersonal problems, and have an intolerance to distressing emotions (Fursland et al., 2012; Glasofer & Devlin, 2013; Guarda, 2008; Tasca et al., 2011). Svaldi, Griepenstroh, Tuschen-Caffier, and Ehring (2012) conducted research on emotion regulation in females with eating disorders compared to individuals without an eating disorder. The results of the research indicated that the group with eating disorders had a higher level of intense emotions, less awareness of their emotions, less emotion regulation skills, and less acceptance of emotions. Consequently, new research suggests there is efficacy for interventions that address emotion regulation in the treatment of eating disorders.

Interventions

Cognitive behavioral therapy

Cognitive Behavioral Therapy (CBT) has long been the most common therapy model in treating eating disorders, particularly with individuals with BN (Glasofer & Devlin, 2013; Tasca et al., 2011; Waller, Evans, & Stringer, 2012; Waller, Stringer, & Meyer, 2012). The CBT model focuses on treating both behavioral and cognitive symptoms of eating disorders. The focus in therapy is on weight gain, working on cognitive distortions related to self-image, and behavior distortions such as dieting, restricting, bingeing, purging, and excessive exercise (Glasofer & Devlin, 2013). The CBT clinician does not evaluate the client's history or address affect regulation in the individual. Rather the clinician focuses on changing the client's presenting

symptomatology by discussing how the client's distorted thoughts are related to their distorted behavior, with the ultimate goal of weight gain (Glasofer & Devlin, 2013). Furthermore, the role of the clinician is to provide psychoeducation on the ineffectiveness of the eating disorder in maintaining weight and the physical problems that are caused from eating disorder behaviors (Glasofer & Devlin, 2013). The purpose of psychoeducation is to provide information to a client on their mental illness to empower them to address the symptoms of their mental illness. Recent research by Glasofer and Devlin (2013) questions the use of psychoeducation in treating eating disorders, as they state that there is a lack of research into the effectiveness of psychoeducation with this population.

Research indicates the CBT model of intervention to be more effective in treating clients with BN than AN. The approximate recovery rate for clients with BN is 30-50% (Glasofer & Devlin, 2013; Waller, Stringer, & Meyer, 2012). Turner, Tatham, Lant, Mountford, and Waller (2014) conducted research into the efficacy of CBT and the techniques used by clinicians treating clients with eating disorders. The study findings demonstrated that CBT is most effective if the clinician uses the core techniques of CBT. These techniques include "cognitive restructuring, goal setting, problem solving techniques, relapse prevention, self-monitoring, nutritional counselling, stress management, and homework assignments" (Turner, Tatham, Lant, Mountford, Waller, 2014, p. 38). Regrettably, research indicates that many clinicians are not using CBT core techniques. Rather, they use an eclectic mix of techniques drawing from other models of therapy (Turner et al., 2014; Waller, Stringer, & Meyer, 2012). Based on the above

research it is clear that interventions rooted in the CBT model have the best recovery outcome when clinicians are confident and skilled in the core CBT techniques.

The CBT model focuses strictly on cognition and behavior, however given the affect intolerance in individuals with eating disorders intervention may need to include emotional regulation (Glasofer & Devlin, 2013; Guarda, 2008). Glasofer and Devlin (2013) argue that CBT is not a comprehensive approach to treating eating disorders, which is evident in the low recovery rate. The CBT model has recently been under scrutiny for not addressing clients' emotion dysregulation and interpersonal relationships. Consequently, professionals are developing a variation of the CBT model, titled Enhanced Cognitive Behavioral Therapy (CBT-E) (Grave, Calugi, Doll, & Fairburn, 2013; Fursland et al., 2012). The enhanced model of CBT dedicates part of the intervention to increasing mood regulation in clients. CBT-E still primarily focuses on behavior change and cognitive change through a psychoeducation approach, particularly in the initial stages of treatment. The final stage of treatment focuses on the client's maintaining mechanisms related to self-worth and emotions. This is done through psychoeducation and cognitive restructuring on how the client copes with emotions through symptoms, identifying triggers, and problem solving (Fursland et al., 2012). The intention is that through cognitive restructuring the client will stop using the symptoms to manage emotional distress. Grave, Calugi, Doll, and Fairburn (2013) researched the efficacy of CBT-E with AN clients and found that CBT-E had favorable results. Two thirds of the clients completed the intervention, all participants who completed the intervention had improved weight gain and cognitive functioning, and these improvements had been maintained sixty weeks after the intervention had been

completed. These results are significant as traditional CBT has been found to not be effective with AN clients. CBT-E is a recent, and possibly promising, therapeutic intervention in regards to treating BN and AN.

Maudsley family-based therapy

Maudsley family-based therapy, or the Maudsley approach, was developed by a group of psychiatrists at the Maudsley Hospital in London, England. It is a family-based approach specific to treating eating disorders (Maudsley Parents, n.d.). It is currently the most common treatment model when treating clients with AN, and is also used to treat clients with BN (Grave et al., 2013). The Maudsley approach is an integration of the following established family therapy models: Strategic, Structural, Milan Systemic, and Narrative (Hurst, Read, & Wallis, 2012). Treatment focuses on the dynamics within the family home, paying close attention to family dynamics and the parent-child relationship (Downs & Blow, 2013). Using narrative therapy, the eating disorder is externalized in treatment to avoid the parents from self-blame and from blaming their child (Hurst et al., 2012; Kaslow, Broth, Smith, Collins, 2012). Similar to CBT, the Maudsley approach also focuses on behavioral improvement and does not address affect regulation in the individual who has the eating disorder (Hurst et al., 2012; Robinson, Dolhanty, & Greenberg, 2013).

The Maudsley approach has a defined structure of intervention for treating eating disorders. The intervention consists of fifteen to twenty treatment sessions over a twelve-month period (Maudsley Parents, n.d.). There are three main areas that the therapist focuses on when utilizing this model. Firstly, the therapist works with the family to unite them against the eating disorder. This also includes shared information on the dangers of

the disorder. Secondly, the therapist assesses the family dynamics and relationships. Lastly, the therapist gives the parents the skills to instill change in the child (Downs & Blow, 2013; Maudsley Parents, n.d.). The last task is considered the most important aspect of the Maudsley approach. Parents spend the most time with their child, especially during distressing moments, such as meal times, thus they need to be equipped with the necessary skills in treating their child (Downs & Blow, 2013; Kaslow et al., 2012; Sepulveda, Lopez, Todd, Whitaker, & Treasure, 2008).

This model concentrates on stabilizing the diagnosed individual first and then working on larger issues. The first phase of treatment focuses on weight restoration. The basis of this phase is to take the individual's control over food away from them and give the control to the parents (Downs & Blow, 2013; Maudsley Parents, n.d.). The parent is taught specific skills during meal times to support their child in eating. The parents are taught to be simultaneously empathetic and directive; for example, the parent must be empathetic towards their child's struggle and at the same time they reiterate to their child that starvation is not an option (Downs & Blow, 2013; Maudsley Parents, n.d.). Thus, the parents regain control over food by monitoring their child's feeding, subsequently assisting in weight restoration in their child. The second phase of the Maudsley approach is to give responsibility of feeding back to the child once the child has regained and maintained a healthy weight level (Downs & Blow, 2013; Maudsley Parents, n.d.). The child is taught how to control food, instead of the eating disorder or their parents controlling food for them. The last phase is to assist the individual in establishing a positive identity (Downs & Blow, 2013; Maudsley Parents, n.d.). At this stage of treatment weight gain has been maintained for a period of time, the individual is not

engaging in eating disorder symptoms, and the individual has gained full independence of feeding. Therapy now shifts to focusing on the impact of the eating disorder on the family, family dynamics and relationships, and other adolescent or young adult issues (Downs & Blow, 2013; Maudsley Parents, n.d.).

There is a wealth of information on the efficacy of the Maudsley family-based therapy model due to the model being one of the leading treatment models for eating disorders. Results of recent outcome research support this model, particularly with clients with AN (Bean et al., 2010; Downs & Blow, 2013; Hurst et al., 2012; Kaslow et al., 2012; Robinson, Dolhanty, & Greenberg, 2013). The Maudsley approach has shown to have higher recovery rates and less hospital readmissions in AN clients when compared to CBT (Bean et al., 2010; Downs & Blow, 2013; Kaslow et al., 2012). Statistically, 50-75% of clients receiving the Maudsley approach are weight restored and 60-90% of clients are fully recovered within five years (Robinson, Dolhanty, & Greenberg, 2013). In regards to BN clients, the model has demonstrated to be as effective as CBT with recovery rates (Bean et al., 2010; Downs & Blow, 2013; Kaslow et al., 2012; Robinson, Dolhanty, & Greenberg, 2013). Moreover, one study compared a group of adolescents with AN who received the Maudsley approach in treatment to a group of adolescents with AN who received CBT, group therapy, interpersonal therapy, and experiential therapy (Bean et al., 2010). The results of the study indicated that the group that received the Maudsley approach had reduced eating disordered symptoms post treatment when compared to the non-Maudsley treatment group. Interestingly, the Maudsley treatment group were assessed to have higher levels of eating disorder symptoms than the non-Maudsley group prior to treatment (Bean et al., 2010). Further, this study concluded that

the Maudsley approach had a positive impact on client depression levels. Clients were assessed to have had their depression level decreased from moderate to no depression symptoms (Bean et al., 2010). The Maudsley approach has been praised for its ability to address the symptomatology of eating disorders as well as improve family functioning.

Continuing with the belief that parents are part of the solution and not the problem, a parent workshop has been integrated into the Maudsley approach. The main goals of the workshop are,

> to provide information regarding the illness, an understanding of treatment goals, space for self-reflection and [help] carers to gain confidence in their abilities to challenge the illness and therefore diminish their sense of burden, which [are] all related to general and specific dimensions of the care giving role. (Sepulveda et al., 2008, p. 590)

Research conducted on the efficacy of workshops for parents of children with eating disorders has been positive. Studies have demonstrated that the workshops have increased parents' self-efficacy in regards to caring for their child and decreased parents' distress (Sepulveda et al., 2008; Robinson, Strahan, et al., 2013). Research has shown that caregivers with strong skills has been linked to improving symptomatology in adolescents and young adults; it has proven to reduce eating disorder symptoms, depression, and anxiety in the individual (Robinson, Strahan, et al., 2013). Therefore, the focus on including families in treating eating disorders in adolescents and young adults has shown in multiple studies to have a beneficial impact on treatment outcomes.

Emotion-focused therapy

Emotion-focused therapy (EFT) is not a new treatment model, however it has recently become popular in treating eating disorders. This model gained popularity after research indicated that individuals with eating disorders have difficulties with emotion regulation and the current models were not addressing this issue (Fursland et al., 2012; Glasofer & Devlin, 2013; Guarda, 2008; Svaldi, Griepenstroh, Tuschen-Caffier, & Ehring, 2012; Tasca et al., 2011). EFT focuses on processing emotional experiences to improve affect regulation. The premise is that people have maladaptive emotion schemes that need to be restructured (Dolhanty & Greenberg, 2009). Thus, the goal of EFT is to create healthy emotional schemes so that the individual can appropriately manage emotions in their lives. A healthy emotional scheme is defined as having a "greater acceptance of the self and of internal experience," as well as adaptive emotional responses (Dolhanty & Greenberg, 2009, p. 367). Processing emotions occurs in therapy by

> attending to and increasing awareness, and expression of internal emotional states; learning to tolerate and regulate that experience; reflect and make meaning of it by symbolizing that experience in words, and transforming maladaptive emotions by activating healthy, adaptive ones, and their associated needs and action tendencies. (Ivanova & Watson, 2014, p. 283)

Furthermore, EFT also focuses on creating a positive identity within the individual by improving the individual's self-acceptance and internal emotional experience (Dolhanty & Greenberg, 2009). The desired outcome of EFT is for the individual to manage

distressing emotions by being capable of identifying the emotion, understanding the meaning of the emotion, and how to respond to the emotion.

This therapy model has been proposed to be suitable for treating eating disorders as it treats the concern of affect regulation in the individual (Dolhanty & Greenberg, 2009; Ivanova & Watson, 2014). As stated previously, research suggests that adolescent and young adult females struggle with emotion regulation. Therefore the emotion-processing component of therapy is appropriate with this population. The belief is that individuals with an eating disorder use restriction behaviors or binge/purge behaviors to manage their emotions, thus maladaptive behaviors are created to ease their emotional distress (Dolhanty & Greenberg, 2009; Ivanova & Watson, 2014; Robinson, Dolhanty, & Greenberg, 2013). This is called "alexithymia, or the inability to identify and label accurately affective experiences and emotion-processing deficits" (Robinson, Dolhanty, & Greenberg, 2013, p. 2). The individual becomes distressed and overwhelmed, as they are unable to attribute meaning to the emotion, consequently rendering them unable to solve the problem related to the emotion; hence, they disassociate from the emotion with eating disorder symptoms (Ivanova & Watson, 2014). The argument is that if the individual never learns to appropriately manage their emotions in treatment then there is a likelihood of relapse as affect regulation is a contributing factor in the maintenance of eating disorder symptoms (Robinson, Dolhanty, & Greenberg, 2013). The EFT model addresses this concern as it helps give the client techniques in expressing emotions and managing the individual's internal critical voice (Dolhanty & Greenberg, 2009).

An important role of the therapist is to observe the client to identify cues that the client is experiencing emotional distress. When emotional distress is assessed to be

present, the therapist then voices these observations to the client. This includes identifying physiological signs, such as tears in the client's eyes, that the client may be experiencing distress. The purpose of this is to help the client become attuned to when they are experiencing an emotional response so that they develop skills in identifying future emotions (Dolhanty & Greenberg, 2009). The therapist uses exploratory questions and reflecting comments to 'guess' what the client is feeling (Dolhanty & Greenberg, 2009; Ivanova & Watson, 2014). Additionally, the therapist may comment on the physiological signs a client is showing, then suggests what emotion the client is experiencing and connects the situation to the emotion. For example, the therapist may say "you look so distressed... if we imagine the eating disorder would be a relief, can you get at what it would be a relief from? What's pressing these tears...?" (Dolhanty & Greenberg, 2009, p. 375." This technique aides the client in identifying, labeling, and responding to their emotion appropriately. This aspect of therapy is important in restructuring the client's emotional schema. The literature notes that this affective restructuring intervention may be challenging with eating disorder affected clients as they have a tendency to show slight physiological signs and to ignore physiological signs (Dolhanty & Greenberg, 2009; Ivanova & Watson, 2014).

As stated earlier EFT has only recently been applied to treating individuals with eating disorders, thus the efficacy of the model is still in the research phase (Ivanova & Watson, 2014). The efficacy of the EFT model has shown promise as "preliminary results suggest that EFT is effective in alleviating the frequency of binge-eating and purging, improves emotion regulation, self-efficacy, psychiatric symptoms, and motivation to

change" (Ivanova & Watson, 2014, p. 283). As research is gathered, the EFT model may become more prevalent in treating eating disorders.

Emotion-focused family therapy

Emotion-Focused Family Therapy (EFFT) is an emerging model in treating eating disorders. The model is currently in the development and research phase. As the name suggests, EFFT blends the Maudsley family-based therapy model with the emotion-focused therapy model. EFFT uses aspects from the following therapy models: emotion-focused therapy, behavioral family therapy, motivational enhancement therapy, and the Maudsley approach (Emotion-Focused Family Therapy, 2014). While the Maudsley approach has one of the highest recovery rates for adolescents with eating disorders, especially in AN cases, there are still clients that do not benefit from this model. Robinson, Dolhanty, and Greenberg (2013) argue that the emotional processing component is necessary for clients not benefitting from family-based therapy, thus a conjunction of family-based therapy and emotion-focused therapy is needed.

The EFFT model outlines three phases in delivering treatment to the family who has a child with an eating disorder. The first phase is called Going Back in which the focus is on weight gain (Robinson & Dolhanty, 2013; Robinson, Dolhanty, & Greenberg, 2013). In this phase the therapist provides psychoeducation on eating disorders and symptom interruption strategies to the parents (Robinson & Dolhanty, 2013; Robinson, Dolhanty, & Greenberg, 2013). Like the Maudsley approach, EFFT regards parents as integral to the treatment plan when helping the child change their eating disorder behavior (Bloch & Guillory, 2011). The term 'parents' is used to define any person that is considered the child's primary caregiver, which can include grandparents, stepparents,

etc. The model can be used with single parents or couples. In EFFT the parents are referred to as their child's recovery and emotion coaches (Robinson & Dolhanty, 2013; Robinson, Dolhanty, & Greenberg, 2013).

The first phase includes training parents to become their child's emotion coach. Parents are taught how to assist their child in processing their emotions when their child becomes distressed and uses eating disorder symptoms as a maladaptive coping mechanism (Robinson & Dolhanty, 2013; Robinson, Dolhanty, & Greenberg, 2013). The therapist teaches parents skills on how to identify their child's emotions, including physiological signs of emotions, and how to empathetically respond to these emotions. Parents are instructed to identify the emotion, acknowledge and name the emotion to their child, validate the emotion, and then meet the emotional need of their child. The last step helps their child move forward from the emotion (Robinson & Dolhanty, 2013). The role of the therapist is to model emotion coaching in family sessions by attending to emotional responses in the way described above (Robinson & Dolhanty, 2013). The goal is for the child to learn how to positively cope with distressing emotions instead of using the eating disorder as a coping mechanism.

The initial phase also focuses on helping parents identify their own emotional blocks in helping their child through emotion processing. The purpose of this is for the parent to be completely emotionally available to aide in their child's emotional processing (Robinson & Dolhanty, 2013). Stillar et al., (2016) explains "when carers experience intense emotion (e.g. fear), they lose access to their caregiving instincts, acquired knowledge, and learned skills" (p. 3). Parents may not comply with treatment interventions for fear that it may not go well and fear that they may not be able to cope

with the outcome. The results of one study indicates that the more fear and self-blame that a carer experienced the more the carer was likely to utilize "recovery-interfering behaviors (Stillar et al., 2016, p. 8). Therefore, it is extremely important that parents process their own distressing emotions in order to be more effective when assisting their child.

The second phase of EFFT is called Getting Back on Track (Robinson & Dolhanty, 2013; Robinson, Dolhanty, & Greenberg, 2013). This phase occurs after the individual has made significant weight gains. During this phase there is an increased focus on the parents learning emotional attendance skills. Parents are asked to demonstrate to their child that they are able to carry their child's emotional burden until the child is strong enough to do so on their own (Robinson & Dolhanty, 2013; Robinson, Dolhanty, & Greenberg, 2013). The desire is that the parent-child relationship will be strengthened as the child begins to trust their parents' ability to attend to their emotions. Once the child begins turning to their parents to help them through emotionally distressing experiences the eating disorder symptoms become increasingly unnecessary (Robinson & Dolhanty, 2013; Robinson, Dolhanty, & Greenberg, 2013). This phase also focuses on relationship repair between the parent and child. The therapist in individual sessions works with the parents to identify past traumas, misunderstandings, and misattunements that may have contributed to the child's lack of emotional processing (Robinson & Dolhanty, 2013; Robinson, Dolhanty, & Greenberg, 2013). The parents then work with the therapist on conducting an apology to the child, regardless of whether the parents were responsible for the circumstance. The verbal apology includes an acknowledgement of the child's experience, imagining how it must have felt for the

child, and stating what the parents will do differently next time (Robinson & Dolhanty, 2013; Robinson, Dolhanty, & Greenberg, 2013). The apology allows the child to move forward from past hurts and further strengthens the parent-child relationship.

The final phase of EFFT is referred to as Moving Forward and focuses on terminating therapy (Robinson & Dolhanty, 2013; Robinson, Dolhanty, & Greenberg, 2013). This phase occurs once the child has maintained their weight, the eating disorder symptoms have been eliminated, and the eating disorder no longer controls family dynamics. By this time the parents have mastered the skills of emotion coaching and the therapist is no longer needed in this role. Further, the child is able to express their emotions to their parents and has begun to process their emotions independently (Bloch & Guillory, 2011; Robinson & Dolhanty, 2013; Robinson, Dolhanty, & Greenberg, 2013).

The EFFT model also offers a two-day, intensive, skill development workshop for caregivers of a child with an eating disorder. The intention of this workshop is to provide psychoeducation on eating disorders, recovery coaching skills, information on emotions, emotion coaching skills, and processing parental emotional blocks. The workshop is comprised of three modules: Becoming a Recovery Coach, Becoming an Emotion Coach, and Working Through Emotional Blocks (Robinson, Dolhanty, Stillar, Henderson, & Mayman, 2014). Robinson, Dolhanty, Stillar, Henderson, and Mayman (2014) conducted a mixed method study on the two-day EFFT workshop. Parents' self-reported increased self-efficacy, increased awareness of their role to assist children in managing emotions, and reduced self-blame. Further, parents self-reported that there was a decrease in parental fears of

> 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. (Robinson, Dolhanty, Stillar, et al., 2014, p. 6)

This is notable as parental fears can often be a barrier for a parent in following through with assisting their child in recovery. Additionally, the study indicated that 63% of parents immediately attempted recovery and emotion coaching skills within the first day of the workshop (Robinson, Dolhanty, Stillar, et al., 2014). Moreover, the qualitative analysis of the study demonstrated

> 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 care giving styles impact their supportive efforts were also very helpful. (Robinson, Dolhanty, Stillar, et al., 2014, p. 7)

Overall, parents gave very positive feedback about the workshop. An important aspect of the workshop is that it is offered to any caregiver of a child with an eating disorder, no matter the age of the child, the diagnosis of the child, or the involvement of the parent in the child’s life (Robinson, Dolhanty, Stillar, et al., 2014). Thus, the workshop is accessible to a variety of caregivers. The EFFT workshop has the potential to be a beneficial method of providing treatment information to caregivers, with one study indicating positive results of the efficacy of the workshop.

As stated above, the EFFT model is in the beginning phase of development and research. Therefore, there is limited research on the EFFT model and it's efficacy (Bloch & Guillory, 2011; Stavrianopoulos & Furrow, 2014). As the model is still being researched it must be used in conjunction with another therapy that has empirical support (Emotion-Focused Family Therapy, 2014.). However, the literature states that there is hope that this therapy will be an ideal blend between treating the eating disorder symptoms through behavior management, while simultaneously treating the affect regulation of the client through emotion processing.

Gaps in the Literature

After reviewing the literature, it is evident that there are various models being used to treat adolescent and young adult females with eating disorders. CBT and the Maudsley family-based approach have been the most common models in treating this population. There is a wealth of knowledge in the literature in regards to the efficacy of these models. Recently, EFT has been utilized as a treatment model for eating disorders. Due to the recent application of this model, there is some information on the efficacy of EFT in the literature.

The newest treatment model in treating adolescents and young adults with eating disorders is EFFT. The EFFT model is unique as it simultaneously treats symptomatology and affect regulation. The literature suggests that this model may be the most appropriate in treating adolescent and young adult females due to the model treating both behaviors and emotion processing. As the EFFT model is still in the development and research phase there is little information in regards to the application and efficacy of the model. With current literature strongly supporting the framework of the EFFT model

and the lack of current research into the efficacy of the model it is imperative that research be conducted in this area. There is a need for quantitative and qualitative studies on the application of EFFT when working with adolescents and young adults with eating disorders.

Theoretical Framework

This research study is guided by an attachment theoretical framework. Attachment theory postulates that children look to their primary caregivers for security and safety when they feel distressed. The caregiver provides protection and reassurance to the child, hence the child considers their caregiver a secure base (Bowlby, 2012). Attachment theory hypothesizes that a child creates an internal working model of the self, others, and the relationship between the two based on the attachment bond between the child and their primary caregiver, or attachment figure (Bowlby, 2012). There are four proposed attachment styles that children develop to their attachment figure, one secure attachment style and three insecure attachment styles. Blalock, Franzese, Machell, and Strauman (2015) summarize the different attachment styles as:

> the secure style is characterized by feeling worthy of love and trusting of others, the preoccupied (or anxious-ambivalent) style is characterized by feeling unworthy of love and trusting of others, the dismissive (or avoidant) style is characterized by feeling worthy of love and untrusting of others, and the fearful style is represents feeling unworthy of love and untrusting of others. (p. 90)

The child develops an attachment style based on the parenting style of the attachment figure and the attachment style is thought to persist with the child into adulthood

(Bowlby, 2012). The implication is that the type of attachment style a child develops will influence other relationships in adulthood, such as a relationship with a significant other.

Bowlby (2012) states that if the caregiver attachment bond is threatened or broken the child may experience a range of emotions, including jealousy, anxiety, anger, grief, and depression (p. 4). Subsequently, the child's behavior can be impacted when there is an insecure attachment. Without a secure base to turn to in distressing moments the child acts out to have their needs met. Regrettably, "the child's behavior is likely to elicit an unfortunate response from the parent so that vicious circles develop" (Bowlby, 2012, p. 143). The child's behavior that is developed due to the broken, or insecure, attachment is likely to continue into adulthood (Bowlby, 2012; Johnson & Makinen, 2001).

The attachment styles are developed over time, however sometimes there is a specific event that threatens the attachment bond. Johnson and Makinen (2001) state "negative attachment-related events, particularly abandonments and betrayals, often cause seemingly irreparable damage to close relationships" (p. 145). They refer to these events as 'attachment injuries.' An attachment injury occurs when an individual's attachment figure does not respond appropriately when the individual is in critical need of support (Johnson & Makinen, 2001). The individual views the action, or non-action, as a violation of trust or abandonment by the attachment figure. If reparation efforts are not made by the attachment figure then the relationship is unable to move forward (Johnson & Makinen, 2001). Johnson and Makinen (2001) have proposed that the attachment injury can be resolved if the attachment figure "acknowledges his/her part in the attachment injury and expresses empathy, regret, and/or remorse" (p. 153).

Thus, the goal of therapy, when practicing from an attachment theory perspective, is for the parent-child attachment to be positively reconstructed. This occurs by the parent and child examining past experiences that caused the fractured attachment (Bowlby, 2012). The therapist's role is to identify the attachment injury and work with the parent to resolve the injury. The intention is to repair the damaged attachment so that the parent-child relationship can move forward and develop future positive interactions.

Attachment theory is the foundation of the EFFT model. The belief is that adolescents and young adults that lack secure attachment with their caregiver have either heightened emotional distress or avoid emotional expression. The adolescent then develops maladaptive behaviors to cope with the emotion. The eating disorders literature notes that adolescent and young adult females with eating disorders have experienced attachment failures (Bloch & Guillory, 2011; Stavrianopoulos, et al. 2014). The parent has not appropriately responded to the child's emotional need in the past; this occurs in environments where emotions are dismissed, avoided, or there is a negative response to the emotion by the parent, consequently creating an insecure attachment in the child. With no secure base to turn to in distressing moments the child with an eating disorder uses eating disorder symptoms to manage their emotions as the child feels they can not rely on their parent due to an insecure attachment (Bloch & Guillory, 2011; Robinson, et al., 2013; Stavrianopoulos et al., 2014). This parent-child dynamic can create negative cycles of interaction in the future, which further impacts the parent-child attachment. Therefore, in the context of attachment theory, EFFT "strives to identify and restructure distressing cycles of interaction that create and sustain attachment insecurity," with the

intention of strengthening the child's secure base to their parent (Bloch & Guillory, 2011, p. 230).

Understanding that EFFT is rooted in attachment theory is key when conducting research into the efficacy of the model. Based on attachment theory, the primary concept of the EFFT model is that an adolescent or young adult female's affect regulation will improve if the parent-child relationship is strengthened. With improved parent-child affective expression, the child is less likely to use eating disorder symptoms to self-regulate their emotions. This key theoretical proposition suggests research should be conducted into how parent-child attachment injury develops and how these relational injuries can be repaired. The EFFT model places the parents at the forefront of therapy to incite change in their adolescent or young adult female. The model teaches parents how to support their child with eating disorder symptoms and emotional processing in the hopes that the parent-child attachment will be repaired over time. What will be significant is parents' experience of the EFFT process. If parents do not feel comfortable in their role in therapy then it can be assumed that EFFT would not be successful since the parents' involvement is a key component to EFFT. Therefore, exploring parents' thoughts on EFFT is essential to understanding the efficacy of the EFFT model.

The most significant limitation in the application of attachment theory when researching the treatment of eating disorders in adolescent and young adult females is the concern that other possible etiologies of eating disorders are not considered. However, recent literature has documented that adolescent females with eating disorders struggle with affect regulation and that there is a need to treat this in order to receive optimal recovery results (Fursland et al., 2012; Glasofer & Devlin, 2013; Guarda, 2008; Robinson

et al., 2013; Tasca et al., 2011). Thus, in keeping with recent research results, a focus on attachment is the most appropriate theoretical framework to apply when researching treatment models for adolescent and young adult females with eating disorders.

Study Design and Methodology

The research question for this study was, "What do parents of female adolescents and young adults with anorexia nervosa or bulimia nervosa view as the obstacles and benefits of Emotion-focused family therapy?". The purpose of the study was to gain insight into parents' experience of EFFT, not to determine a casual relationship. This research study was an exploratory, cross-sectional design study, as data was collected at one point in the therapy process.

Operational Definitions

The Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5) outlines three categories of eating disorders: Anorexia Nervosa, Bulimia Nervosa, and Binge Eating (American Psychiatric Association [APA], 2013). For the purpose of this study eating disorders refers to anorexia nervosa and bulimia nervosa. In this study, adolescent or young adult refers to age thirteen to twenty-four. Parent is defined as the adolescent's primary caregiver. This can include biological parents, stepparents, and extended family. Further, the study focuses on parents who attended the EFFT workshop. Thus, EFFT is defined as the EFFT workshop not individual EFFT therapy. This decision was made because the EFFT workshop is standardized compared to individual EFFT therapy. Lastly, obstacle is defined as any aspect of therapy that hinders the parent from following-through with the therapy model. While benefit is defined as any marked improvement in the parent's ability to respond to their daughter's needs.

Participant Recruitment

The unit of analysis for sampling was parents of adolescent or young adult females with eating disorders. This study used non-probability sampling, specifically a mix between convenience sampling and snowball sampling. Five of the participants were drawn from one practitioner's private practice; these participants were readily accessible and voluntarily signed up for the study. The practitioner forwarded an email, composed by the researcher, to previous attendees of the EFFT workshop. The email outlined the purpose of the study, criteria for eligibility to participate, and the process of the study (Appendix B). Potential participants were asked to contact the researcher directly. Furthermore, snowball sampling was used to identify private practitioner's to draw participants from. Three more practitioners were identified and were asked to send the same email to their clients who had participated in the EFFT workshop. It should be noted that there was a low response rate from the advertising emails. Due to the low response rate, the researcher attended two separate EFFT workshops to advertise the study to workshop participants. The facilitators of the workshop were not present while the researcher discussed the study with potential participants.

Eight parents agreed to participate in this study. The criterion for participants was that they had attended the EFFT workshop, were English speaking, and were able to give informed consent. All eight parents met the criteria for eligibility. Four of the participants were recruited through the email process, while the other four were recruited through the in-person recruitment process. Each parent was required to sign a Letter of Informed Consent (Appendix C) prior to the interview.

Data Collection and Analysis

Data was collected through semi-structured interviews. Six of the interviews were conducted over the phone, while the other two interviews were conducted over Skype or FaceTime. The interviews ranged in length from thirty minutes to sixty minutes, with the average interview length being forty-five minutes. The interview started by asking the parent demographic questions, specifically: the age of their daughter, their daughter's diagnosis, their age, their level of education, and when they had attended the workshop. Eleven open-ended questions related to the parents' experience of the EFFT workshop were prepared ahead of time, however the interview was flexible and clarifying questions were asked as the interview progressed (Appendix D). All of the interviews were audio recorded on a recording device. After the interview was completed the recording was transcribed. Each interview was reviewed separately for major concepts.

Ethical Considerations

Approval was obtained from the Research Ethics Board of the University of the Fraser Valley on March 11, 2015 (Appendix A). A number of steps were taken to protect the confidentiality of participants. Interviews were recorded on a password protected phone, then transcribed and saved on a password protected computer. The researcher was the only one who transcribed the interviews. Each participant was given a pseudonym at the time of transcription; the pseudonym will be used when a participant is referred to in the findings.

As stated previously, all of the participants were sent an email from their private practitioner with information about the study. This may have affected participants' willingness to participate. On the one hand, participants may have felt obligated to

participate; on the other hand, participants may have been unwilling to participate in fear that their confidentiality may be broken. As stated above, the researcher used a number of steps to protect the participants' confidentiality. Further, the email and consent form explicitly stated that each participant's participation in the study would be kept strictly confidential, including from their own therapist, however there was still the chance that this may have impacted their decision to participate in the study.

Another ethical consideration was the emotional response that could have been elicited in participants due to the questions they were asked regarding their daughter's eating disorder. Participants were asked to divulge private information on a sensitive matter. Prior to the interview participants were informed that they did not need to answer questions that made them feel uncomfortable. They were also told that they could end the interview and withdraw from the study at any point. All of this information was also included in the Informed Consent Letter (Appendix C), which each participant signed a copy of. The Informed Consent Letter also included contact information of a private practitioner that they could contact after the interview if they felt they needed to debrief the interview process. No participants demonstrated extremely distressing emotions during the course of the interview. Further, all participants participated for the duration of the interview and answered all questions.

Study Limitations

This study is exploratory in design with a limited sample size. The results cannot be generalized to the larger population. As this is a recently developed therapy model there are very few EFFT practitioners, therefore there is a small population of EFFT clients to draw a sample from. There was a low response rate from possible eligible

participants that were contacted. It is possible that the participants who did volunteer may be biased about the EFFT workshop, which may have motivated their choice to participate in the study.

Moreover, the participants were interviewed at varying times after they had attended the workshop. Three participants were interviewed within one month after attending the workshop, three participants were interviewed two to six months after the workshop, one participant was interviewed six months to one year after the workshop, and one was interviewed over a year from the date of attending the workshop. This may alter the data in two significant ways. Firstly, the parents who were interviewed shortly after the workshop may not have had a chance to practice the skills they learned or may not have experienced any noticeable long-term change. Secondly, the parents who had a longer time frame between the interview and the workshop may not remember their experience of the workshop as accurately or may have forgotten some of the information they learned.

Findings

Demographic Summary

Of the eight participants six were female and two were male. The age range for the participants was forty-six to sixty-three with an average age of fifty-three. Three of the participants' highest level of education was a graduate degree, one participant had obtained an undergraduate degree, three had a college diploma or trade, and one participant had a high school diploma. The age of the participants' daughter ranged from seventeen to twenty-four with an average age of nineteen. The daughters of five participants were diagnosed with anorexia nervosa, two of the daughters were diagnosed with bulimia nervosa, while one daughter was diagnosed with anorexia nervosa, bulimia

nervosa, and binge-eating disorder. Further, six of the participants reside in Canada, one participant resides in the USA, and one participant resides in the UK. Finally, as stated above, the length of time between the workshop and the research interview varied between participants. The range in time lapse between the research interview and attending the workshop was three weeks to one and half years. It is important to note as well that one participant had taken the workshop twice.

After all of the interviews had been completed the interviews were compared for the purpose of identifying common themes. The major themes in the research include an improved parent-child relationship, the parent feeling empowered, and awareness of parent blocks and utilizing emotion coaching skills. Parents also identified benefits and obstacles of the EFFT workshop. Lastly, parents were asked to compare the workshop to other services that they or their daughter and previously received.

Parent-child Relationship

A major theme in the data was that every participant interviewed stated that they noticed a positive change in their relationship with their child since attending the EFFT workshop. When analyzing the data, the parents cited three aspects of their parent-child relationship that had improved. Firstly, four parents described the parent-child relationship as being more tranquil. The words used in the interviews to illustrate how the relationship had changed were: “freer,” “easier,” “calm,” “peaceful.” and “relaxed.” Cheryl stated that her anxiety has decreased, consequently decreasing the anxiety her daughter was experiencing. Anne has also noticed that her daughter has presented less worried. Abigail describes it as “us becoming more comfortable with each other again… less fear around it. I’m not as afraid of her emotion so she’s not afraid to be herself

around me. It's kind of coming together in a calm and peaceful relationship." It appears that parents were able to work through their fear and anxiety, or parent blocks, during the EFFT workshop. With the dynamic of fear being removed from the relationship, the parent appeared to be able to concentrate on their relationship with their daughter instead of focusing on the overwhelming fear associated with the eating disorder.

Secondly, there was an increase in the effectiveness of the communication between the parent and child. Frank, described the impact as simply increasing the frequency that they communicated. Prior to the workshop "there was not a lot of communication other than what was necessary to live and function in the same house," however now he is trying harder to find ways to communicate with her. Frank said "rather than just closing myself down and our relationship down I am actually trying to just engage with her." For other parents, the parent-child communication was described as being deeper than before the workshop. The overall level of effectiveness of communication has increased because both the parent and the daughter is more comfortable engaging in difficult conversations. Cheryl has noticed, "when I try things she will say 'mom that's not helping.' She gives feedback, so now I know that didn't work and I will try something different." For Cheryl, it is exceptional that her daughter is asking for what she needs. Cheryl said, "she obviously feels more comfortable expressing herself." Further, Anne stated that her daughter is initiating discussions about emotions. Additionally, Nick describes his situation as "it's almost like she wants to talk to us but we were a little too nervous to bring things up. So when we do bring things up now she tends to be a little more open about it." As a parent becomes more comfortable with emotion coaching, their daughter is becoming more comfortable engaging in challenging

discussions. This is because parents are encouraging their child to talk about their emotions, while simultaneously creating an environment that demonstrates to their child it is safe to talk about emotions. Therefore, a noticeable benefit of emotion coaching is an increase in the quality of communication in the parent-child relationship.

Lastly, four of the eight parents stated that the relationship has improved because their daughter's trust in them had increased. These parents described their daughter acting more genuine in the relationship. Additionally, the honesty and openness has increased in the relationship. Lucy summarizes

> Yes, there is a change in the sense that the relationship is so much more deep and open and loving. She knows she can count on us 110% no matter what she is going through. And that was also part of her twisted thinking, thinking that "I don't want to expose this ugly side of me," because of all the guilt and the shame. She realized that by exposing this we still love her regardless. There is nothing she can do or not do that will make us love her any less. So I think in that sense, yes, there has been a really positive change in our relationship.

While many of the parents voiced that they already had a close relationship with their daughter, they feel that their relationship has become even stronger since attending the EFFT workshop. The majority of the parents credited the improved relationship to the new way that they were interacting with their daughter. They were using the skills of emotion coaching to deepen the level of communication between them and their daughter. This increased the trust in the parent-child relationship because the child knows that the parent can be relied on, no matter the situation. Overall, the parent using effective communication and the daughter's

increase in trust in her parent appears to have improved the parent-child relationship.

Parent Empowerment

Seven of the eight parents reported feeling more empowered after the workshop. Although, parents were not specifically asked about empowerment, seven parents expressed feelings of empowerment throughout the interview. Four of these seven parents explicitly used the word "empower." For the purpose of this paper, the feeling of empowerment meant the parent felt they possessed the skills and ability to help their daughter. Further, it gave parents hope that their situation could change and that they could be a part of that change. A number of parents described feeling powerless prior to the workshop because they did not know how or, in some cases, were told that they could not help their daughter. Many parents described the workshop as giving them hope because they were finally being told that they are a part of the solution. As Cheryl says

> we were a part of this eating disorder when it came about and so we are a part of the solution as well. Can't just say it's her eating disorder so she needs to do all the work and she needs to get better because it's a family disease so we all need to do the work. We are a part of this so we need to get down on our hands and knees. We were a part of this from the beginning.

Further, six of the parents reported that they felt more empowered because they were given skills (the steps to emotion coaching) on how to assist their daughter. One parent was appreciative that the skills were a "step-by-step structured approach that we can rely on." Additionally, parents acknowledged that these skills could be used to address their daughter's emotional state, as well as to interrupt the eating disorder

symptom in the moment. Moreover, two parents expressed that their anxiety had decreased as a result of knowing that they had skills that they could rely on. Teaching parents the skills to assist their daughter improved their capability, thus giving them a feeling of empowerment. As discussed in the literature review, parental empowerment has a positive impact on the child's treatment outcomes. Furthermore, it is a key component of the EFFT model. In this study participants have clearly articulated that the workshop was effective in making them feel empowered.

Parent Blocks and Emotion Coaching

When reviewing the interviews it was apparent that the impact of learning about parent blocks and the technique of emotion coaching was varied between participants. As stated in the literature review, parent blocks are strong emotions that a parent experiences that impedes their ability to assist their child in recovery. Emotion coaching is a set of skills that parents can utilize to help their child process distressing emotions.

Five of the eight parents stated that there was a positive impact in learning about their personal parent block. These parents spoke at length in the interview about their emotions, particularly fear, and how this impacted how they responded to their daughter. Prior to the workshop, they stated that they had an immense amount of fear in speaking with their daughter about how she was feeling. The root of their fear in addressing their daughter's emotional distress was that their daughter would become too heightened, subsequently making the situation worse. Maria said that she was afraid she would "push her [daughter] too far." She states that

> it's one thing to say "I see your sad" and "I think you're sad because of this or that," but to think she might actually not want to stay and talk about it and then go off by herself and do something to herself was really scary.

Abigail made a similar statement to Maria's, stating "in my mind things would escalate and get worse. I didn't think we had the stability to engage and bring the emotion down." Additionally, Cheryl cited that her difficulty in helping her daughter when her daughter was emotional was that she was "still dealing with so much of my stuff." Cheryl stated that she struggled in supporting her daughter when her daughter was expressing anger due to discomfort with anger that stems from what she learned about expressed emotion in her family of origin. Cheryl states that the workshop helped her recognize this block in herself and to not be afraid of anger. Lastly, Anne said that the parent blocks "gave me a view of the obstacles that were in my way to be able to be in support of her." Working through her parent block gave her a different perspective on how she had been responding to her daughter's emotions and that her previous response had not been helpful. These five parents acknowledged in the interview the significance of processing their parent blocks in order to be present for their daughter's emotional needs. Samantha describes it as

> taking the element of fear out of it all… at any given moment things can go sideways. I'm not as concerned about that happening. I'm not anticipating it so I'm not as on edge… I sort of know that if it happens we will be there for it whatever it is.

She states that this has allowed her to be more present in the moment with her daughter, rather than being pre-occupied with her own feelings. Summarily, she

states "I'm not finding it as scary. And therefore we are facing it differently." When listening to these five parents stories it appears that processing their parent block assisted them to be present for their daughter's emotional needs instead of focusing on their own emotional needs.

It was noticed when reviewing the interviews that the same above five parents stated that they found learning about emotion coaching beneficial. All five of the parents stated that they utilize this skill on a regular basis to assist their daughter when she is distressed or engaging in eating disorder symptoms. In fact, four of these five parents demonstrated the skills of emotion coaching throughout the interview. These five parents described attending to their daughter's emotions, labeling the emotions, and validating the emotion. Maria describes the changes she made after learning how to use emotion coaching with her daughter. She used to say "it's going to be okay, don't be sad" when her daughter was upset, now she says "you look sad and I get why you're sad, and it does suck, and it is sad, and it is hard." Cheryl explained a similar experience, stating "instead of acknowledging her feelings I would want to take them away…that denied her [of] her feelings... now I sit down and drop everything and sit and talk about it." Moreover, it is important to note that two of the four parents found the steps of emotion coaching natural. However, one parent acknowledged the difficulty in learning how to emotion coach her daughter, stating "for me it was gaining the confidence. It takes practice."

Conversely, there were two parents, Frank and Nick, who both stated that there was no impact in learning about parent blocks during the workshop. Further, both Frank and Nick expressed that they struggle with emotion coaching and self-report not using the skills of emotion coaching. Frank expressed his hesitancy in attending to his daughter's

emotions as not wanting to upset her. Frank explains further, stating, “it’s always been my instinct to give her a cuddle and tell her ‘everything’s going to be alright’ and ‘we’ll sort it out' and I don’t think that will ever change.” Nick states that the steps of emotion coaching are “difficult to remember” and “awkward.” He acknowledges that with practice it may become easier, however he remembers this information from the workshop the least. It is noteworthy that the parents who stated they benefited from learning about parent blocks also regularly utilize the emotion coaching skills, while the parents who stated there was no impact from learning about parent blocks appear to have more challenges with the emotion coaching skills.

Parents’ Perceived Benefits of the EFFT Workshop

When asked to describe their overall experience with the EFFT workshop, all eight parents stated that it was a very positive experience. They listed other benefits from taking the workshop that have not yet been discussed. Four of the parents noticed a positive impact from doing the apology exercise with their daughter. As stated in the literature review, a verbal apology by the parents to the child helps repair the relationship and allows the child to move on from past hurts. The noticed benefit was that it opened up conversation between the parent and child, giving more opportunities to discuss emotional topics with their daughter. Moreover, four of the participants cited the role-playing exercises in the workshop as extremely valuable. Furthermore, two of the participants noticed that the workshop helped them develop individually as a person. One parent said “call it a personality workshop for me.” Additionally, four of the parents identified that the workshop had improved their relationships with other individuals. Two of these four parents said that they are more aware of others’ emotions and empathetic to

others' situations, resulting in overall improved interactions with others. As well, three of these four parents said that they are using emotion coaching with individuals other than their daughter (ex. other children in the home, husband, co-workers, neighbors, etc.).

Parents' Perceived Obstacles of the EFFT Workshop

Two obstacles were identified by the participants. The main obstacle was the amount of information presented in a short time frame. All eight participants stated that it was an immense amount of information presented in two days. None of the participants suggested deleting any of the material from the workshop because they found all of the information valuable. However, it was hard for them to remember the information afterward. Three parents suggested a follow-up session at a later date where they could re-group with the facilitator. It was suggested that during this follow-up session some of the material could be reviewed. As well, during this session parents could ask for assistance if they were having challenges with particular skills.

Another identified obstacle was the size of the group in the workshop. Three of the eight parents stated that the size of the group was a challenge. Two of these parents estimated that between twenty to thirty people attended their workshop. The main challenge in regards to group size was getting "off-track" from the material. This was largely attributed to the number of people asking questions specific to their personal situation. While it was recognized by these parents that this could be helpful it also meant that the conversation was off-topic at times. This raises the concern that the first identified barrier would likely be exacerbated in a situation where the workshop group size was too large.

Comparison to Other Services

Seven of the eight participants attended services other than the EFFT workshop for their daughter's eating disorder. Six of these seven parents identified that there was a major difference between the EFFT model and the other services. These six parents stated that the workshop was immensely more helpful for them than the other services. Four of these six parents stated that this was the first time that they were given skills in how to interact with their child. The previous services they had attended focused on education of eating disorders or were parent support groups. Anne commented that after the other services she "didn't change anything [she] was already doing" because these services did not offer her an alternative way of approaching the eating disorder. Again, the feelings of empowerment and hope came up for parents when they talked about having the skills to help their child.

Moreover, three of the parents explicitly stated that they were not a part of the service or treatment plan offered to their daughter. Abigail summarized her experience as

> I'm giving my daughter to them and they are going to help her and I'm going to go to these parent groups so I can get help coping with this and I didn't have anything to do with her getting better

Another parent, Maria, states that she had been asked to leave the room during a meeting with a professional. This response by the professional made her feel like she was to blame for the eating disorder. On the other hand, with the EFFT approach, Maria describes it as "we're all in this together. We're all going to help her get well together."

Further, Abigail spoke about how the EFFT model focuses on the capability of the parent to help their daughter. The EFFT model concentrates on empowering parents by teaching them the skills to attend to their daughter's needs, which results in the parents being a key part of their daughter's treatment plan. This approach clearly resonates with parents.

Discussion and Implications for Policy, Practice and Research

From the findings of this study the EFFT model has the potential to be an effective treatment model. All eight participants had a positive experience of the EFFT model and appreciated the approach of the model. Participants voiced a number of positive outcomes from taking the EFFT workshop. Of most importance, participants noticed an improvement in the parent-child relationship. It appears that the improvement in the relationship could be attributed to the parent using emotion coaching with their daughter. When a parent used emotion coaching skills it encouraged the daughter to discuss her emotional experience. Based on the findings it appears that when a parent uses emotion coaching, the daughter begins to learn that she can trust that her parent is capable of coping with her distressing emotions. Emotion coaching can demonstrate to a child that it is okay to have upsetting emotions and that the parent can handle these emotions. Thus, the daughter's trust in her parents begins to increase, subsequently improving the parent-child relationship. The daughter becomes more willing to express her emotions with her parent, with the knowledge that her parent can manage these emotions.

This finding is congruent with recent literature on eating disorder interventions for adolescent and young adult females. The literature has identified the need to treat affect regulation in conjunction with treating the cognitive and behavioral

symptomatology of the eating disorder (Fursland et al., 2012; Glasofer & Devlin, 2013; Guarda, 2008; Tasca, Ritchie, & Balfour, 2011). EFFT was recently developed to address this gap in treatment models for adolescent and young adult females with eating disorders (Robinson, Dolhanty, & Greenberg, 2013). EFFT strives to stabilize the individual's behaviors while simultaneously treating affect regulation. Emotion coaching is designed to assist the child with the eating disorder to regulate their affect. This is an implication for practice as this finding suggests that emotion coaching has the potential to be helpful in assisting the child to regulate emotions. Based on this finding the therapist can teach emotion coaching skills to the parent with the knowledge that this skill may also treat the child's affect dysregulation.

Furthermore, this finding aligns with attachment theory, the theoretical underpinning of the EFFT model. In EFFT treatment, the premise is that the parent-child attachment is rebuilt over time through the actions of emotion coaching. Thus, improving the parent-child relationship and overall family functioning, with the outcome that the daughter no longer needs the eating disorder symptoms to cope. The daughter's trust in her parents has been renewed and she now has a secure base to turn to when she is experiencing distress.

Additionally, the findings indicate that there may be a connection between parent blocks and emotion coaching. The five parents who self-reported that they had gained insight into learning about their personal parent block also self-reported that they utilized emotion coaching, while two of the parents self-reported there was no impact of learning about their parent blocks also struggled with the steps of emotion coaching. This raises the question of whether the level of understanding a parent has of their parent block is

related to their ability to use the emotion coaching skills. This question is beyond the scope of this study and is an area to be explored in future research.

Furthermore, the two parents who self-reported that there was no impact in learning about parent blocks and had difficulties with emotion coaching were both fathers. The EFFT model could be strengthen by studying how fathers respond to being trained to utilize the component parts. On the other hand, the five parents who understood the parent blocks and emotion coaching components were all mothers. This has an implication for practice and research. This study is unable to draw any conclusions in this regard due to the small sample size. However, this is an indentified area for future research. As well, future research could be conducted into the utilization of the EFFT model with co-parenting couples where both parents learn and practice the component elements of the model.

Conclusion

This research explored the question, "What do parents of female adolescents and young adults with anorexia nervosa and bulimia nervosa view as the obstacles and benefits of Emotion-focused Family Therapy?" All eight participants had a positive experience with the workshop and voiced that they had noticed positive outcomes from taking the workshop, primarily in regards to the parent-child relationship. Further, parents stated that they felt empowered and hopeful after attending the workshop. The majority of parents also identified that there was a positive impact of learning about their personal parent block. This is a promising new therapy model that has major implications for positive treatment outcomes for female adolescents and young adults who are diagnosed with Anorexia Nervosa and Bulimia Nervosa.

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Appendix A

Certificate of Human Research Ethics Board Approval, University of the Fraser Valley

UNIVERSITY OF THE FRASER VALLEY

Certificate of Human Research Ethics Board Approval - Amendment

Contact Person	Department	Protocol
Kristi Breugem	Social Work	757S-15
Co-investigator(s)		
Leah Douglas; Glen Paddock		
Title of Project		
Parents' Perception of Emotion-Focused Family Therapy for Adolescent and Young Adult Females with Anorexia Nervosa or Bulimia Nervosa		
Sponsoring/Funding Agency		
N/A		
Institution(s) where research will be carried out		
University of the Fraser Valley; Three Story Clinic		

Review Date:	Amendment Date:	Original Approval Date:	Approval Term:
23-Mar-15	22-Mar-15	11-Mar-15	11-Mar-15 - 10-Mar-16

Certification:

The protocol describing the above-named project has been reviewed by the UFV Human Research Ethics Board, and the procedures were found to be in compliance with accepted guidelines for ethical research.

[redacted]

Andrea Hughes, Chair, Human Research Ethics Board

NOTE: This Certificate of Approval is valid for the above noted term provided there is no change in the procedures or criteria given.

If the project will go beyond the approval term noted above, an extension of approval must be requested.

Appendix B

Email Requesting Participation

Hello,

My name is Kristi Breugem and I am a social work student in the Master of Social Work program at the University of the Fraser Valley. Allow me to tell you a little more about myself. I received my Bachelor of Social Work at the University of British Columbia Okanagan in Kelowna, BC. Also, I am a new mom to a 9 month old boy who is keeping me VERY busy.

I am currently conducting research on parents (or primary caregivers, including grandparents) who have attended the Emotion-Focused Family Therapy workshop. The title of the research is: **Caregivers' Perception of Emotion-Focused Family Therapy for Adolescent and Young Adult Females with Anorexia Nervosa or Bulimia Nervosa.**

Purpose/Objectives of the Study
In this study I am hoping to learn about caregivers' experience with Emotion-Focused Family Therapy (EFFT). Please see the attachment for more information or contact me directly.

Procedures involved in the Research
Participation in this study will involve one interview approximately one hour in length where you will be asked approximately ten questions in regards to your experience with EFFT.

Interviews will be completed individually from other caregivers. Couples can choose to do the interview together. **I am very flexible on interview days and times and can conduct the interviews by phone, Skype, or Facetime.**

If you are interested in participating in this study please contact me by email:k[redacted] or by phone: [redacted]

--
Regards,

Kristi Breugem

Appendix C

Letter of Informed Consent

Kristi Breugem
School of Social Work and Human Services
University of the Fraser Valley
33844 King Road
Abbotsford, BC V2S 7M8
[redacted]

February 23, 2015

Caregivers' Perception of Emotion-Focused Family Therapy for Adolescent and Young Adult Females with Anorexia Nervosa or Bulimia Nervosa
Letter of Informed Consent

Purpose/Objectives of the Study

In this study I am hoping to learn about caregivers' experience with Emotion-Focused Family Therapy (EFFT). The overall question that this study aims to answer is "What do caregivers of female adolescents and young adults with anorexia nervosa or bulimia nervosa view as the obstacles and benefits of Emotion-focused family therapy?".
I will be interviewing caregivers individually to gain insight into the personal experiences caregivers have had with EFFT. After interviewing various caregivers I will be reviewing the information for commonalities among participants.

Procedures involved in the Research

Participation in this study will involve one interview approximately one to two hours in length where you will be asked a series of questions in regards to your experience with EFFT. For example, you may be asked the following questions: "Overall how would you describe your experience with EFFT?", "Are you responding differently to your daughter's eating disorders symptoms since attending EFFT?", and "Has there been a change in your relationship with your daughter since attending EFFT?".
Interviews will be completed individually from other caregivers. Couples can choose to do the interview together. Your therapist will not be present for the interview or aware of your participation. The interview will be recorded with an

audio tape recorder to ensure that the information is accurately summarized. The interviews will be transcribed by myself.

Potential Harms, Risks or Discomforts to Participants

As the questions that you will be asked are of a sensitive nature you may feel uncomfortable at times with the conversation. You do not need to answer questions that make you feel uncomfortable. You can stop the interview at any point if you do not wish to continue. If you feel distressed after the interview please contact your therapist, Natasha Files, at 604-563-3093 for assistance.

Potential Benefits

This is an opportunity for caregivers to describe their experience with EFFT. This knowledge will gain insight into the therapy model.

Confidentiality

The audio recording will be transcribed by myself after the interview and will be stored on a secure computer to ensure that it remains confidential. Once the recording has been transcribed it will be deleted. The transcriptions stored on the computer will be saved for five years, after five years this data will be deleted (May 2021).
Any identifying information that you provide during the interview will not be included in the study so that your privacy is respected. Pseudonyms will be used in the transcription and the results of the study to protect your identity. Anything you say in the interview will not be shared with anyone else without your permission.
If at any point you disclose that you are considering harming yourself or others, or that you have abused or neglected a child, I will be required to report this information for the safety of yourself and others.

Participation

Participation in this study is voluntary and you may withdraw your consent to the study at any time without consequences. In cases of withdrawal any information that you have provided will be destroyed unless you indicate that you would still like your information to be included in the study.
Please note that you can refuse to answer some questions in the interview and still remain a part of the study.

Study Results

The results of this study will be published in the University of the Fraser Valley's library. Study results may also be presented at the University of the Fraser Valley, in the community, and at professional conferences. This study may also be published and submitted for publication in academic journals. Your anonymity will be guaranteed under any of the above circumstances.

If you wish to see the results of the study please contact Kristi Breugem at [redacted]

Questions

If you have any questions about the study please contact Kristi Breugem at [redacted]

If you have any ethical concerns about this research study, please contact Adrienne Chan, UFV Associate Vice President of Research, Engagement, and Graduate Studies, at 604-557-4074 or Adrienne.chan@ufv.ca.

The ethics of this research project have been reviewed and approved by the UFV Human Research Ethics Board.

Consent Form

By signing below I agree to participate in this study, titled **Caregivers' Perception of Emotion-Focused Family Therapy for Adolescent and Young Adult Females with Anorexia Nervosa or Bulimia Nervosa**

I have read the information presented in the letter of informed consent being conducted by Kristi Breugem and faculty at the University of the Fraser Valley. I have had the opportunity to ask questions about my involvement in this study and to receive any additional details.

I understand that if at any point I disclose that I am considering harming myself or others, or that I have abused or neglected a child, the researcher will be required to report this information for the safety of myself and others.

I understand that I have the right to withdraw from the study at any time and that confidentiality and/or anonymity of all results will be preserved. If I have any questions about the study, I should contact Kristi Breugem at 604-854-0802. If I have any ethical concerns about this research study, I should contact Adrienne Chan, UFV Associate Vice President of Research, Engagement, and Graduate Studies, at 604-557-4074 or Adrienne.chan@ufv.ca.

▫ I give consent to be audio recorded for the duration of the interview.

Name (please print) _____

Signature _____

Date _____

Principal Investigator Name (please print) _____

Signature _____

Date _____

Once signed, you will receive a copy of this consent form.

Appendix D

Interview Guide

Introduction Questions:
1. How old is your daughter?
2. How old are you?
3. What is your highest level of education?
4. How long ago did you attend the Emotion-Focused Family Therapy (EFFT) workshop?
5. What is your daughter's diagnosis?

EFFT specific questions:
1. Overall how would you describe your experience with EFFT?
2. What was the impact of the EFFT workshop, if any?
3. What did you learn that was the most valuable, if anything?
4. What did you learn that was the least valuable, if anything?
5. Are you responding differently to your daughter's eating disorders symptoms since attending EFFT?
6. Are you responding differently to your daughter's emotions since attending EFFT?
7. Did you try the relationship repair skill (the apology) with your daughter? If yes, what was the impact? How soon after the workshop did you try it?
8. Has there been a change in your relationship with your daughter since attending EFFT?
9. What was the impact of learning about parent blocks?
10. Have you made any changes as a parent?
11. Have you attended previous services for your adolescent daughter's eating disorder? How did EFFT compare to these other services?
12. Do you have any additional thoughts that you would like to add to the interview?

13. Would you like the results of this study? How can I send you them?