Emotion-focused Therapy: Creative Applications in the Treatment of Eating Disorders and the Supervision of Clinicians

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Disclosure Statement

- No involvement with industry to declare
- We cannot identify any potential conflict of interest

Special thanks to…

- Credit Valley Hospital
- Southlake Regional Health Centre
- The Hospital for Sick Children
- Sudbury and Region EDP
- Alberta and Region EDP
- Juno House
- Thunder Bay and Region EDP
- The Province of Newfoundland
- Halifax and Region EDP

Learning Objectives

- Understand the general principles of the EFFT model
- Identify the 'emotional blocks' common to parents and clinicians
- Gain exposure to EFT techniques used in processing these "blocks"

Here is where our story begins…

One day, a young therapist embarked on a journey to find the "something more" she believed existed for the treatment of eating disorders.

She met a wise man with a white fluffy beard who taught her everything she needed to know about emotion and mental health and illness.

After countless hours in the wise man's cavern observing case after case, EFT for individual adults with AN was born.

At about the same time, in a far away land across a large pond, FBT for families of children and adolescents with AN was being used with much success

Both approaches had their strengths and weaknesses...

FBT's story was largely focused on a behavioral recovery and EFT didn't involve the family quite enough... And on that basis, emotion-focused family therapy was eventually developed...

What a ride that was... Let us briefly walk you through the integration...

Brief introduction/review of:

- Individual EFT for ED (Dolhanty & Greenberg)
- FBT (Lock et. al)
- Integration of EFFT (Lafrance Robinson & Dolhanty)
- New Applications with parents and clinicians

Overview of Individual EFT for ED

Mini Review: Emotions and Eating Disorders

- Aversive
- Difficulty identifying
- Difficulty regulating
- Avoidance
- "Out of touch"

Eating Disorder as Regulation

- Low self-efficacy in managing painful affective experience
- Pain avoidance
- Under-regulation
- Over-regulation
  - Fear losing control
  - Rigid response patterns

"I'd rather die than feel."

Emotion-Focused Therapy

Works with experienced emotion in the session to process and overcome avoidance as a means of coping with overwhelming affect

Emotion-Focused Processing

Involves:

A) Accessing Emotion

B) Modulating and Understanding Emotion

C) Transforming Emotion

Three Main "Chair" Tasks

- Self-critical dialogue
  - Self and self: Internal "critic" and "experiencing" self
- Unfinished business
  - Self and other: Address significant other in the empty chair
- Self-interruption (blocking emotion)
  - Self and self: Two chairs to see how she blocks or interrupt her feelings

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Case Example

- 24 years old
- Previous 9 years BMI 11
- Full relapse after prior hospitalizations
- Recent discharge AMA from in-patient unit
- BMI 16 (30 lb weight gain in hospital)

Treatment

- Weekly outpatient individual sessions of Emotion-Focused Therapy
- Sessions as needed with dietitian
- Followed medically by physician specializing in eating disorders

At 18 Months....

- Eating and weight maintained; medically stable
- Improvements in mood as well as alexithymia and IA
- Appropriate recreation/socializing/leisure ; career/interest devt
- Healthy relationship
- Moved out of parents' home
- TODAY: Years later, she is married and parenting a step-child – no relapse!

Video Demonstration

Settings

- Individual therapy
- Group therapy for adults/teens (outpatient, day treatment or inpatient)
- Adjunct to family or dyadic therapy if applicable

Overview of Traditional FBT

Rationale (Lock et al.):

- The family is seen as the most important resource for recovery
- A non-blaming approach is taken as to the cause of the eating disorder
- Target of the intervention is 'the ED'
- Structural changes needed within the family system to defeat the ED
- Therapist resists the 'expert' stance
- Medical safety precedes adolescent issues e.g. focus is solely on restoring the young person's health. Treatment consists of 3 phases for approximately 12 months.

Three phases of treatment

- ***Phase I***: Establish healthy eating and curtail purge behavior (1-10 sessions or as needed)
- ***Phase II***: Return control of eating and weight management to the adolescent (Sessions 11-16 or as needed)
- ***Phase III***: Address family and normal adolescent developmental issues (Sessions 17-20 or as needed)

Overview of the Integration – EFFT

- Overall FBT is very effective but many clients and parents do not respond to FBT and/or struggle to cope with the feelings and struggle that emerge throughout the symptom interruption process.
- To address this, we integrated emotion-focused concepts and techniques (including parent/child dyad work) to the model
- Model covers the lifespan but for time purposes we will present child/adolescent version only

Phase 1 – EFFT: "Going Back"

FBT

- Parent is expert on child and therapist is expert on eating disorders.
- Parent's re-feed and interrupt symptoms as if tending to a younger child.

"Feed the baby"

EFT

- Parent is expert on child and therapist is expert on emotion
- Parent is supported throughout the re-feeding process
- Parent is supported to become child's emotion coach and identify miscues
- Tasks include:
  - helping child to attend to, label, express, organize and understand her feelings, validating and soothing.

"Rock the baby"

Phase 2 – EFFT: "Getting Back on Track"

FBT

- Parent's gradually return control of eating over to teen.
- Therapist explores teen issues and development of ED.

EFT

- Parent's develop an increased ability to be their child's emotion coach.
- Parent anticipate and meet child's emotional needs, including those which were previously unknown or concealed ("speak the unspoken").
- Parent may "apologize" for past injuries/losses and shoulders part of the responsibility for the development of the ED.

Phase 3 – EFFT: "Moving Forward"

FBT

- Assist the family to return to normal life cycle.
- Assist the family in supporting child's journey towards development of healthy identity.

EFT

- Parent continues to respond to child's emotions / soothe.
- Child's capacities for self-soothing continue to emerge.
- Direct support to parents re: navigating the separation–individuation process.

Contrasting FBT and EFFT

	FBT	+ EFT
Therapist stance	Expert/consultant on eating disorders	Expert/consultant on emotion
Parental role	Take charge of child's feeding / interruption of sxs to then return control	Take charge of making sense of, and regulating child's emotions until child can self-soothe
Developmental view	As if tending to a young child	As if tending to a young child
Exposures	Present feared foods/challenges	Speak the unspoken/support the processing of painful emotion/memories
Intervening with shame/blame	No-blame model	No-blame blame model (lift blame so they can take it)
Intervening when stuck	When stuck, reiterate severity of the problem	When stuck, process p/t emotional blocks

But then! There was more!

For some reason though there were still some parents who really struggled with refeeding and/or emotion coaching…

Underneath their denial, resistance, defensiveness, anxiety, anger, (etc!), we discovered deep dark wounds that were incredibly humbling…sometimes even downright scary…

So did that mean wounded parents couldn't save their wounded child?

No way! How unfair! Then and there, EFT with parents was born!

Common Blocks – I'd rather have a sick kid than a dead one…

- Fear that if I push too hard, the distress could lead her to commit suicide, or she could shut me out completely…
- Fear of "babying" my daughter and preventing her from becoming independent (or encouraging her eternal dependence on me)
- Fear of going into an emotion and making it worse/not knowing what to do/not being able to do anything

And all of this was consistent with another model being shared!

- The cognitive interpersonal maintenance model of eating disorders for carers

"Carers' expressed emotion (e.g. emotional overinvolvement, criticism and hostility) and enabling and accommodating Behaviours are proposed to maintain the illness. The model, which can be applied trans-diagnostically, describes a causal chain whereby high levels of carer unmet needs and a reduced ability to cope contribute to carers' high expressed emotion and ineffective strategies in managing symptoms. These responses cause distress in carers and allow eating disorder symptoms to flourish."

Goddard, Macdonald, Sepulveda, Naumann, Landau, Schmidt and Janet Treasure (2011)

Video

Summary

- EFT helps to process potential blocks (that may be outside of the parent's awareness), and
- Allows parents to reflect on these blocks in order to inform more effective parenting strategies consistent with recovery

Settings

- EFT parent group (hopefully you will hear more about this next EDAC – super fascinating ☺)
- Adjunct to family-based therapy
- Adjunct to client's individual therapy (if adult client does not agree to family involvement)

The next chapter…

Our story became more popular than we could have ever imagined and we were invited to train programs far and wide… From Coast to Coast and even across the seas…

There we noticed that different clinicians struggled with different issues about the treatment approaches… But they weren't always consistent.

Some worried about confidentiality, while others did not… Some worried about burdening the parents, while others did not… Some worried that if pushed too far, clients could commit suicide but others did not???

And all of this was consistent with other models that were being shared!

- Therapist-drift Model (Waller, 2009)
- Clinician-factors that may interfere with clinical decisions/ practices:
  1. Clinician cognition
  2. Clinician behaviour
  3. Clinician emotion

- The Iatrogenic Maintenance Model of Eating Disorders (Treasure, Crane, McKnight, Buchanan, Wolfe, 2011)
- Clinician-factors that negatively influence treatment of Eds
  1. Interpersonal factors
  2. Pro-eating disorder beliefs
  3. Thinking style
  4. Emotional style

Common Blocks – If I push too hard, I may kill them

- Reliving past traumas with clients/families
- Seeing the client as fragile or unmotivated
- Believing the ED is an illness to do with food / BI
- Forgetting that child really wants her parents involved no matter her age
- Not believing in, or feeling empathy for the parents
- List of others…

Videos (of our very own colleagues)

- EFT helps us to identify potential blocks that may be outside of our awareness, and allow us to reflect on them in order to inform more objective treatment decision-making

Settings

- Trainings
- Supervision (individual or group)

Summary – Creative Applications of Emotion-focused Therapy

- Theory and technique to either process blocks and/or heal vulnerabilities that will increase self-efficacy with emotion and promote recovery of the affected individual
- Agents of change not only include the client, but also the parent and the clinician
- 3x the opportunities for solutions = increased chance of recovery

Happily ever after?

Although research is in its preliminary phases, as a programwe have seen:

- recovery rates increase (and more quickly)
- dropout rates decrease (hardly any!)
- increase in family involvement across the lifespan (70-90 year old moms involved in their child's care!)
- Clinicians more supportive of one another and more objective in decision-making

Happily ever after?

- Not quite…still a ways to go…There are still some families we haven't quite reached… But we're a lot closer than we've ever been!
- Our next step is to integrate EFFT with the New Maudsley (Treasure and colleagues) to continue the evolution…