Clinical Psychology and Psychotherapy
Clin. Psychol. Psychother. (2013)
Published online in Wiley Online Library (wileyonlinelibrary.com). **DOI:** 10.1002/cpp.1861

Practitioner Report

Emotion-Focused Family Therapy for Eating Disorders in Children and Adolescents

Adèle Lafrance Robinson,[1]* Joanne Dolhanty[2] and Leslie Greenberg[3]
[1] *Department of Psychology, Laurentian University, Health Sciences North, Sudbury, Ontario, Canada*
[2] *Mount Pleasant Therapy Centre, Toronto, Ontario, Canada*
[3] *Department of Psychology, York University, Toronto, Ontario, Canada*

Family-based therapy (FBT) is regarded as best practice for the treatment of eating disorders in children and adolescents. In FBT, parents play a vital role in bringing their child or adolescent to health; however, a significant minority of families do not respond to this treatment. This paper introduces a new model whereby FBT is enhanced by integrating emotion-focused therapy (EFT) principles and techniques with the aims of helping parents to support their child's refeeding and interruption of symptoms. Parents are also supported to become their child's 'emotion coach'; and to process any emotional 'blocks' that may interfere with their ability to take charge of recovery. A parent testimonial is presented to illustrate the integration of the theory and techniques of EFT in the FBT model. EFFT (Emotion-Focused Family Therapy) is a promising model of therapy for those families who require a more intense treatment to bring about recovery of an eating disorder.

Key Practitioner Message:
- More intense therapeutic models exist for treatment-resistant eating disorders in children and adolescents
- Emotion is a powerful healing tool in families struggling with an eating disorder
- Working with parent's emotions and emotional reactions to their child's struggles has the potential to improve child outcomes

Keywords: family-based therapy, emotion-focused therapy, eating disorders, emotion

FAMILY-BASED THERAPY

Family-based therapy (FBT) is currently regarded as best practice for the treatment of child and adolescent eating disorders (EDs). Influenced by strategic and structural family therapy principles and techniques, traditional FBT (also referred to as the 'Maudsley' method) is a highly regarded outpatient treatment model. It is agnostic in its approach, in that there is no 'anorexigenic' family, and parents are empowered to play a pivotal role in their child's recovery (Lock & le Grange, 2005). Therapists act as consultants to help the family uncover their strengths in order to fight the ED.

The therapy model consists of three phases that span over a period of six to twelve months. The first phase of the treatment model is focused on supporting the parents to promote weight gain in their child, in addition to interrupting symptoms and normalizing eating patterns and food choices. Once the child's weight nears full restoration, the second phase of treatment is initiated, and the therapist supports the family to return control over eating to the adolescent. For example, the adolescent may be encouraged to make appropriate food choices more independently, and parents may begin to reduce supervision one meal or snack at a time. This process continues until the adolescent reaches an age-appropriate level of autonomy around food choices and feeding. It is also in this phase that the therapist and family begin to explore previously set-aside adolescent and family issues outside of the illness. In the third and final phase of treatment, the treatment focus shifts toward the development of adolescent identity, including the need for the family to adjust to the emerging independence of the adolescent (Lock, le Grange, Agras, & Dare, 2002).

This model of treatment, with its strong emphasis on behavioral change, can be very effective in the treatment of children and adolescents with EDs (see Loeb & le Grange, 2009 for a review). For example, studies examining the outcomes of FBT have shown that between 50 and 75% of adolescents with anorexia are weight restored at the end of treatment. Long-term follow-up studies have also shown 60–90% of adolescents have fully recovered four to five years later (le Grange & Eisler, 2009). In terms of bulimic presentations, adolescents treated with FBT

*Correspondence to: Adèle Lafrance Robinson, Department of Psychology, Laurentian University, Sudbury, Ontario, Canada.
E-mail: acrobinson@laurentian.ca

Clinical Psychology & Psychotherapy

have been found to have higher rates of abstinence from binge eating and purging at the end of treatment and at 6-month's follow up when compared with adolescents treated with supportive psychotherapy (Le Grange, Crosby, Rathouz, & Leventhal, 2007). Recently, this approach has also been adapted to day hospital program and has yielded favorable outcomes (Girz, Lafrance Robinson, Foroughe, Jasper, & Boachie, 2012). Although many adolescents and their families recover with FBT, a significant minority do not respond adequately to this treatment modality (Eisler et al., 1997; Lock et al., 2010; Treasure & Russell, 2011). In such cases, we have found that what is needed is a family-based treatment model that targets emotion processing and emotion regulation skills as much as it does refeeding and symptom interruption, especially in the early phases of treatment.

EMOTION PROCESSING AND EATING DISORDERS

Alexithymia, or the inability to identify and label accurately affective experience, and emotion-processing deficits, characterize the ED population (Becker-Stoll & Gerlinghoff, 2004; Bydlowski et al., 2005). A central function of the eating disorder can be understood as an attempt to control affect (Cockell, Geller, & Linden, 2002; Treasure, Schmidt, & Troop, 2000; Vitousek, Watson, & Wilson, 1998), and the role of emotion in the pathogenesis, maintenance and relapse of EDs is widely accepted (see Fox & Power, 2009; Treasure, 2012 for a review). A number of factors make an ED a compelling solution to the management of unwanted negative emotion. For example, symptoms may regulate or soothe an emotional sense of some combination of feeling insecure and unloved, or humiliated, trapped and powerless. Starving numbs, binging soothes and vomiting provides relief (Dolhanty & Greenberg, 2007). Attempts at recovery are met with a resurgence of previously avoided feelings that are experienced as being intolerable, the desire to escape them increasing the potential for relapse (Federici & Kaplan, 2008). As such, in addition to the focus on a behavioral recovery, there is an increasing focus on emotion processing skills as a target of various new therapies for eating disorders in adult populations (Corstorphine, 2006; Fairburn, 2008; Money, Davies, & Tchanturia, 2011; Safer, Telch, & Agras, 2001; Wildes & Marcus, 2011), including emotion-focused therapy (Greenberg, 2004).

EMOTION-FOCUSED THERAPY AND EATING DISORDERS

Individual emotion-focused therapy is recognized as an evidence-based treatment for depression and trauma (EFT; American Psychological Association [APA], Divisions 12 & 56). A key principle of EFT is that emotion is fundamental in the construction of the self and is a key determinant of self-organization (Greenberg, 2010). For example, in healthy development, caregivers' responses to emotional reactions in the developing child validate the emotion and provide coaching both in attending to and in handling the array of emotions the child will experience (Greenberg, 2002). Such accurate processing of emotions promotes efficacy and resiliency in dealing with future emotional challenges. If for some reason the early experience of emotion is met with problematic responses from the environment, the self will struggle to cope, both with the difficult emotion itself and with the inadequacy of the environment (Haslam, Arcelus, Farrow, & Meyer, 2012). For example, a family rule that one must not show anger may result in a maladaptive response by which healthy anger is suppressed. Dismissing tears or the reaching out for affection may result in maladaptive shame and in the suppression of the healthy expression of sadness or longing for a connection. Over time, this suppression of emotion, especially in the face of more emotionally evocative events including reaching adolescence, parental divorce, loss of a loved one or traumas, can contribute to the development of psychopathology. One of the goals of EFT is then to support the development of emotional intelligence to facilitate clients' ability to perceive and emotionally respond to environmental situations in both healthy and adaptive ways (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, 2008; Greenberg & Pascual-Leone, 2006).

More recently, EFT has shown promise for the treatment of EDs in adults (Dolhanty & Greenberg, 2007; Dolhanty & Greenberg, 2009). The primary goal of the therapy is to process the presenting maladaptive emotions that diminish the self, such as rage, shame, self-loathing and passive, hopeless despair. Specifically, EFT promotes in-session experiencing of emotion with the goal of fostering, with the supportive guidance of the therapist, an acceptance of experienced emotion, a capacity and proficiency in regulating emotion and in self-soothing, and a transformation of destructive or 'maladaptive' emotions to more healthy alternatives. Individuals experience renewed hope in the possibility that they may recover from their ED by means of working to identify, accept, allow and alter maladaptive emotional reactions, thereby altering dysfunctional behavior patterns and rendering the eating disorder unnecessary as a means of coping.

EMOTION-FOCUSED FAMILY THERAPY FOR EATING DISORDERS

Similar to the belief in FBT that parents can be empowered to guide their child's behavioral recovery, and in line with

the theory and techniques of EFT, we believe that parents —with supportive guidance from therapists—can also support their child in the processing of emotions, increasing their emotional self-efficacy, deepening the parent-child relationships and thereby making ED symptoms unnecessary to cope with painful emotional experiences. Similar to the New Maudsley method (Treasure, Schmidt, & Macdonald, 2010), this 'supportive guidance' from the therapist is essentially a teaching of specific skills to parents who, while wanting to help their child, may lack essential skills to aid in the recovery of this disorder. This lack of skill can frequently thwarts clinician 'experts' and can leave families feeling helpless to accomplish the tasks required.

As such, the primary aims of Emotion-Focused Family Therapy include (1) helping parents to support their child's refeeding and interruption of symptoms; and 2) supporting parents to become their child's 'emotion coach.' The broad ways in which EFT principles can be integrated into FBT are represented in Table 1.

Integration of Family-based Therapy and Emotion-focused Therapy

Phase I: 'Going Back'

In Phase I of the FBT model, the primary task is to coach parents to take on the role of refeeding their child and interrupting ED symptoms, as if tending to a younger child. The therapist helps the family to use their many skills and resources for these tasks and supports the parents in discovering previously untapped strengths. Throughout the process, parents are encouraged to use their intimate knowledge of their child to find new ways to support their child's restoration of health. The parent is regarded as the expert on their child, whereas the therapist acts as a consultant with ED-specific knowledge.

When emotion-focused therapy principles are included in the model, the therapist educates both the child and her parents about emotion, the function of the ED in terms of avoiding or managing emotions and the importance of processing emotion. In the context of individual and family sessions, parents receive specific education and training on becoming an emotion coach. For example, in individual sessions with the parent, the therapist teaches the parent a simple and specific set of skills on how to identify and respond to signs of emotion, thereby increasing feelings of self-efficacy for the tasks ahead. Parents learn to identify the physical signs of emotional expression such as slumping shoulders and welling tears for sadness and tension or averted eyes for anger. The parent is then taught to attend to the emotional experience by acknowledging the presence of the emotion, providing the label consistent with the bodily felt sense, validating the experience and meeting the emotional need. Specifically, parents are coached to respond to sadness with soothing, to fear with protection and to anger with setting of appropriate boundaries. They are also taught to identify and respond appropriately to their child's 'miscues,' that is, behaviors or statements that are inconsistent with felt emotions and associated needs. For example, a parent whose child's dominant presentation is hostile is taught to attend and respond to the inevitable vulnerable hurt that underlies the display of anger.

This process of emotion coaching is on the basis of the theoretical framework of emotion-focused therapy whereby every emotion has a bodily felt sense, can be named, must be validated and has an associated need that must be met for resolution of the emotional challenge. In the family sessions, the therapist models these skills by

Table 1. Emotion-Focused Family Therapy: the integration of emotion-focused therapy in family-based therapy

	FBT	+EFT
Phase 1	Parents are experts on child and therapist is expert on eating disorders. Parents are supported to refeed and interrupt symptoms as if tending to a younger child. 'Feed the baby'	Parents are experts on child and therapist is expert on emotion. Parents are supported to become child's emotion coach and identify miscues. 'Rock the baby'
Phase 2	Parents gradually return control of eating over to their child. Therapist explores child/adolescent issues and the development of ED.	Parents develop an increased ability to be their child's emotion coach, including 'speaking the unspoken.' Parents share the responsibility for past injuries/losses to free the child from her own crushing self-blame.
Phase 3	Therapist assists the family to return to normal life cycle. Therapist assists the family in supporting child's journey towards development of healthy identity.	Parents continue to respond to the child's emotions/soothe. The child's capacity for self-soothing continues to emerge. Therapist supports the parents in processing their own emotional reactions to the child's individuation and identity development.

FBT = family-based therapy. EFT = emotion-focused therapy. ED = eating disorder.

responding in this way to the child's emotion. The therapist is like a conduit between parent and child in that emotion coaching is mediated and supported by the therapist. In this phase, the therapist actively speaks for each to the other, to help interpret and untangle interactions as the family engages in a new and at first uncomfortable way of relating to one another.

As with refeeding and the interruption of symptoms, the therapist works to identify and strengthen the parents' innate ability to attend in this way to their child's feelings —an ability that may have been thwarted and dampened by circumstances, family dynamics or the presence of the ED itself. The emotion coaching in Phase I, like the process of refeeding and symptom interruption, involves attending as one would to a younger child while maintaining language and boundaries suitable to an adolescent. As one parent in treatment referred to it, the process reflects a developmentally appropriate version of 'rocking the baby.'

Phase II: 'Getting Back on Track.'

In Phase II of FBT, the focus is on returning control over food and feeding back to the child. For parents, this phase is marked by a struggle between nurturing their child's resuming control of food intake and continuing to work toward the full resolution of ED symptoms. Parents are also encouraged to support their child's re-engagement in previously set-aside social or other activities whereas the ED continues to be managed behaviorally.

The added EFT component in this phase is focused on supporting the parents to become increasingly competent and independent from the therapist in being their child's emotion coach. Parents' increased ability to respond to their child's emotions will allow them to attend to, name, validate and meet the needs of the child's emotions more spontaneously, both in the sessions and at home. Therapists also teach parents enhanced empathy skills, including the ability to imagine being in the child's experience, past and present. This level of empathy facilitates a deepening of the parent-child relationship, including an increase in trust, leading to the child sharing with the parents past emotional struggles that may have been previously unknown or concealed. For example, the child may not have communicated her own sadness for fear, this would hurt her depressed parent. Having been prepared for this in earlier sessions with the therapist, the parent can now provide reassurance that she is in fact capable of handling the child's emotion despite her own struggles. Over time, this process will contribute to the development of the child's own ability to regulate her emotions and to self-soothe, making ED symptoms feel less necessary in the face of her pain. Furthermore, effective emotional coping strategies can allow the child to communicate directly to her parents when all is not well, rather than communicating this through the ED, as this piece of work will have provided her with evidence that her parents can 'handle it.'

Therapists also support the parent to reflect on and identify any possible lived traumas, separations, conflicts, misunderstandings, or even misattunements that could have contributed to the child's struggles with emotion that may in turn have contributed to the development or maintenance of the illness. In the context of individual sessions, parents are prepared and coached to 'speak the unspoken,' that is, what they imagine the identified experiences and associated pain must have been like for their child to experience. They are taught to attend to and support the processing of the child's emotions once the old pain is evoked, and also to express healthy accountability in response to their child's pain, without 'taking it personally.' This can be done either in session with the support of and guidance from the therapist or at home. When parents can do this, it is very powerful: 'I'm so sorry you had to go through that. That must have been awful for you. I should have found another way.' When parents respond to their child by validating her pain, shouldering some of the burden and acknowledging 'injuries, losses, and failures,' the child can begin to work through previously unmanageable emotional experiences and memories with their parents' support.

These emotion-focused interventions serve two functions. The first is to increase the child's feelings of self-efficacy with respect to the experiencing and processing of painful emotions. The second function is to create a safe space for the child to free herself from blame for the onset and development of the illness and self-reproach for what she feels she is 'putting her family through.' In fact, a very moving aspect of the 'back on track quality' of this enhanced phase is the relief and appreciation with which the child responds to the parent who validates her painful experience and feelings, engendering a shift from placing 'blame' on themselves or others to a sense of shared responsibility and empowerment for how to face challenges and move forward with recovery. Thus, 'back on track' really signals letting go of old injuries and moving to the balancing act of the child being able to rely on the parents and feel comforted by them at one moment and feeling secure enough to push them away and test the limits the next.

Phase III: 'Moving Forward.'

Phase III of FBT starts when the family has successfully navigated the transition phase and the child continues to be symptom-free, in addition to maintaining the weight her body requires. In the family context, the ED is no longer defining family members' interactions with one another, and the family is adjusting to life without the ED. The therapist is also assisting the family in

supporting the child's journey towards healthy development of adolescent identity.

The EFT component during this phase has the child and parent working together with emotion in such a way that the therapist can fade increasingly into the background. The process of attending and responding to their child's emotions becomes more automatic for the parents, and the child is better able to express her needs. When past injuries and difficulties are processed and emotional needs are met by the parents, the child is then able to move to the more developmentally appropriate tasks of separation and identity formation. The child is encouraged to communicate to her parents the fears and feelings that may impede her ability to embrace her own identity. Education and support on the process of separation and individuation are emphasized. This is especially relevant because it is in contrast to normal development where the separation-individuation process is more gradual. With recovery from an ED, depending on the age of the child, the adolescent can move through the stages much more rapidly, making it difficult for the parents to adjust to her emerging independence. The parents are also supported in their ability to recognize the child's struggle to assert her uniqueness. This will include supporting the parents to support their child as she experiments with asserting her identity, develops and manages relationships with peers and looks toward the future. This process also allows the child to feel safe relinquishing the goal or wish of having all of the previously unmet needs met now by the parents and to begin to turn to appropriate peer sources of support as well.

PARENTAL BLOCKS

Starting in Phase I, the therapist begins to identify 'emotional blocks' that are interfering with the parent's ability to participate in refeeding/symptom interruption and/or become the child's emotion coach. Subtle or sometimes very evident emotional blocks can be at the root of enabling behaviors, disengagement, defensiveness or even criticisms of the child, the co-parent or the clinicians. The emotions underlying these 'blocks' may need to be attended to in order to lessen their interference with the interventions. For example, parental depression will have compromised the ability to perceive and respond to the child's emotional needs. In Phase I, the therapist will focus on raising awareness of this process and expressing empathy for the parent. What we have observed is that in some cases, simply bringing into awareness the impact that their own mood can have can help the parent attend to their child's emotional needs more effectively. The therapist also expresses deep and specific empathy for the parent's own emotional pain. The empathy from therapist to parent facilitates empathy from parent to child.

Should the parental blocks continue to emerge from Phase I to Phase II, more intensive intervention can follow. For example, if the therapist identifies markers of shame in the depressed parent, the therapist works with the parent individually using EFT 'chair-work' (Greenberg, 2010) to attend to the old wounds that are being activated by the process. In one case, the parent engaged in this treatment approach expressed ongoing difficulty tolerating 'failures' during the refeeding process as a result of deep fears that these 'failures' confirmed for her that she was a 'bad mom.' Another parent expressed difficulty tolerating her daughter's sadness and anger, having suffered quietly for many years and feeling shame at 'having caused her daughter to have suffered a similar fate.' Other parents have resisted introducing 'forbidden' foods due to the fear that the stress associated with this intervention may lead their child to shift from restricting to purging, or worse to depression, running away, self-harm or suicide. In these instances, the therapist helps to identify the emotional blocks within the parent(s) in order to work through them in the context of an individual session using emotion-focused therapy techniques.[1] 'Treat the parent, heal the child'.

FBT + EFT: PARALLELS AND ENHANCEMENTS

The added component of EFT to the FBT model in many ways parallels the spirit of FBT.

Parental role. In Phase I, parents are instructed to take charge of the refeeding and interruption of symptoms, as they are supported to take charge of attending to, making sense of and helping to regulate their child's emotions.

Belief in the parents. Parents are viewed as the most powerful agents of change both in refeeding and emotion coaching. There is also a deeply held conviction that parents' love for their child and wish for her recovery will enable them to take on these challenges with the support and guidance of the clinician or team.

Therapist Stance. Although parents are viewed as the experts on their child, therapists are regarded as

[1]Similarly, in the EFFT model, when treatment is stuck, therapists also complete a self-assessment in order to identify and work through potential emotional blocks in administering the therapy. For instance, despite holding the belief that parents are the best resource for recovery, some therapists trained in the model have reported difficulties when implementing the model with low-income families, or single-mothers, due to an underlying or unspoken fear of over-burdening the parent(s). By processing their own fears, therapists using this model have been able to overcome these blocks and better support parents struggling to take charge of their child's recovery.

consultants not only with respect to EDs, but also healthy emotional development.

Developmental approach. Similar to the parents taking over refeeding and the interruption of symptoms until the adolescent is capable of resuming this responsibility, there is a period of going into reverse developmentally, during which the parents attend to their child's emotional experiences as if she were younger. The goals are similar in that eventually, she will gain mastery over feeding, as well as mastery over the processing of emotion, including self-soothing.

Exposures. Parents are encouraged to present feared foods; in the same way, they are supported to coach their child to attend to, name, make sense of and process avoided emotions and memories.

Thus many of the enhancements of emotion-focused principles and techniques that are integrated into traditional FBT are highly consistent with the original model. However, other components of the FBT + EFT model expand, and, in our opinion, enrich the traditional approach, offering new pathways to recovery for those families for whom the original model was insufficient or ineffective.

Externalization of the illness. In traditional FBT, the ED is externalized in order to remove the blame from the child. Once again, this is a sound rationale and is used in the integrated approach, specifically when parents or siblings are blaming the child for the impact of the illness on the family. The difference is that in the integrated approach, the clinician helps the family to uncover the function of the ED as a means of avoiding or coping with painful emotion. The ED is therefore not perceived as external to the self similar to an enemy or intruder. Rather, it represents the self's desperate efforts to manage unwanted affect and cope with adversity that needs to be transformed with emotion coaching and healthy strategies for regulating affect.

Skill development. Perhaps one of the departures from the FBT model, and more in line with the New Maudsley model (Treasure et al., 2010), is the emphasis on providing specific skill development for parents for whom trust in their ability as parents is not sufficient for the task of effectively intervening in the child's eating disorder.

Intervening with parental self-blame, shame. One of the most significant departures from the traditional model, and one that will surely evoke trepidation in the clinician new to EFFT, is the approach toward parental self-blame. In traditional FBT, one of the early objectives is to work at absolving the parents of any blame and dispel any guilt parents may feel about their child's condition. The rationale for this is that if parents are overburdened with self-blame, this will decrease their effectiveness in taking charge of their child's recovery (Lock et al., 2002). We could not agree more with this rationale. The challenge as we see it is that ignoring parents' deep sense of guilt and debilitating self-blame for their child's condition does not effectively remove blame and guilt from the equation. In fact, consistent with EFT principles, the avoided feelings can lead to unspoken processes that interfere with parent's ability to engage the tasks of treatment. In these cases, an explicit part of the treatment is to attend to the parent's experience and work through their shame, guilt and fear. These maladaptive emotions can then be replaced by the parent's naturally wanting to shoulder part of the responsibility for the path their child has taken, with the goal of relieving the child of their own heavy burden of self-blame and shame. Reassurance that they are not to blame contradicts parents' own internal sense, whereas this approach explicitly processes the defensiveness and paralysis engendered by the maladaptive self-blame. This technique actually frees parents to embrace the tasks of refeeding, interruption of symptoms and emotion coaching while also validating their sense that 'EDs happen to families, not to individuals.'

Stuck points in the therapy In the original model, when the therapist becomes exhausted in the face of little to no progress with the child's symptoms, or the parents ability to take over, there is not much to be done except reiterate the severity of the problem and the need to take charge. This is where the integrated model provides a framework for diagnosing the process interfering with treatment and implementing appropriate interventions to resolve the impasse. For example, the therapist can meet individually with the parent to work through an underlying fear that the refeeding process will cause the child too much distress and perhaps ultimately lead to self-harm or suicidality.

ONE PARENT'S EXPERIENCE OF EMOTION-FOCUSED FAMILY THERAPY

The following testimonial illustrates the application of the EFFT model. It was written by a parent of a child (Amy, pseudonym) whose family engaged in traditional FBT, among other therapies, for over three years. At the height of her illness, Amy's BMI was 12. She was diagnosed with primary amenorrhea and extreme bone loss. In addition, due to her multiple hospitalizations and poor health, Amy was unable to attend school on a consistent basis and was completely isolated from her peers. For the last two of the three years, Amy spoke very few words, and these in whispers. After another terrifying relapse, during which Amy lost eleven pounds in three weeks (all while being supervised during every meal and snack), the family engaged in EFFT:

'If I could express, in one word, the feeling that best describes these last years, it would be terror. Bone chilling, deep in the soul terror that haunts you even when the sun is out and everyone is smiling, that wakes you up with nightmares, and that robs you of your own personal dignity.

In three years, we spent nearly nine months in hospital, with five admissions. We faced it all. We saw psychiatrists, psychologists, private therapists, gastroenterologists, interns, medical students, nurses, dietitians, pediatricians, school counselors, and teachers. There were MRIs and CAT scans, colonoscopies, feeding tubes and therapies. We had family-based therapy, CBT, pain management, until at one time, we actually attended 5 appointments per week. We fed and refed. We supervised. We coached, we modeled. Sometimes I just layed in bed at night and felt numb. Our life was so surreal. And through it all, I watched my daughter, I held her, I cried, I 'buckled down.'

Finally, after six months (two and a half of which were in hospital), our daughter had reached a satisfactory weight and was holding her own. But then a nose dive came again, and I was faced with my gut instincts. We were headed for another relapse and the possibility that a permanent feeding tube was the only alternative to maintaining our daughter's health. Her last admission had been very grave. At five feet, eight inches, she weighed 79 pounds, her resting pulse was 31, her blood pressure was bottoming out, and she had lost 25% of her bone mass. I could not go back down that road. My ability to have faith in any kind of treatment again was next to none, but my fear was bigger. And so with trepidation I took a risk, without first even letting my daughter or husband know, and stepped into a new world.

I was already a 'Maudsley' mom. I could have recited the rules to you. But 'Maudsley' only fed my daughter. And even with close to weight restoration, her fears were overwhelming, her food avoidance was set in stone, and her torment was so visible. She was like a walking robot. She went through all the motions, her body was bigger, but her fears were in complete control. There were rituals, and avoidances, and patterns that we couldn't touch. She was so afraid. I was so afraid to make her suffer more. I was so lost. So scared. So very very alone.

Emotion-Focused Family Therapy gave me back something. My motherhood. My nurturance. My confidence. Little by little we faced our fears. I learned how to carry so many of my child's burdens for her, by owning the struggle and freeing her from the need to shoulder all the guilt and fear and loneliness. I remember my profound relief when I could finally understand how terrified she must have been, lying in bed, alone, knowing that even I could not save her. I told her how sorry I was, for having let her down, having not watched more closely, and taken over for her, when she couldn't do it for herself. For the first time in three years, she wept uncontrollably. I made a promise—never again. Not on my watch. I will keep you well, when you are unable to do it for yourself, and eventually you will be able to do it on your own.

Every day, for the past six months, we continue to feed our daughter. And supervise. But now, food is not all we feed her. Through emotional coaching, we slowly learned how to provide for her all of the emotional support she needed until she could internalize it. It was like a miracle to watch. In the past six months, I've spent hundreds of hours holding her, smoothing back her hair, sitting by her bedside singing and telling stories, meditating, soothing, massaging, and 'holding hope' when it seemed hopeless for her. I'll never forget the moment the therapist told me: 'Forget what everyone else is telling you.' 'It's like the baby. You don't put the baby on the floor and leave it there. You pick her up - no matter how long she cries - you rock the baby.' I could do that! And I did. And gradually things began to change. There have been tears—lots of them. Anger. Yelling. Fears. Defiance. I've faced a thousand fears—we all have.

My daughter now weighs her actual weight—not just one to keep her from losing her menstrual cycle! She laughs, she cries, she is in the world as a true life force. And each day we are healing. The disorder takes up hardly any space in our lives anymore. And my daughter is 'launching' into the world with more than just her weight having been restored. Food alone, is not enough.'

It has been over three years since Amy's parents first engaged in EFFT, and more than two and a half years since her mother wrote this testimonial. Amy continues to be symptom-free and is completely on track developmentally. For example, all medical indicators are in the normal range (with the exception of bone density) and she weighs 100% of her ideal body weight according to her growth and weight history. Amy completed high school and went on to university on scholarship where she is in her second year. She lives on her own (and has done so since first year) and has an active social life, including a boyfriend. When she is faced with life's challenges, Amy turns to her parents and peers for support, or she manages the situations independently and, more importantly, she does so without the use of symptoms to cope.

SUMMARY

The integration of the theory, tasks and techniques of EFT significantly enhances traditional FBT and is a promising option for those families who require a more intense treatment model. The role of parents in the areas of refeeding and interruption of symptoms, and emotion coaching, facilitates the active and explicit treatment of

both the behavioral and emotional difficulties associated with the ED. Using this approach, not only is the child's health restored, but she will become equipped with the emotion regulation skills necessary to face the challenges ahead, including the tasks of separation and individuation. The child's newfound mastery over emotion may also lead to a decreased risk of relapse. Finally, EFFT allow the family to find new paths to recovery in the face of clinical impasses that interfere with treatment.

REFERENCES

Becker-Stoll, F., & Gerlinghoff, M. (2004). The impact of a four-month day treatment program on alexithymia in eating disorders. *European Eating Disorders Review, 12*(3), 159–163.

Bydlowski, S., Corcos, M., Jeammet, P., Paterniti, S., Berthoz, S., Laurier, C., Chambry, J., & Consoli, S.M. (2005). Emotion-processing deficits in eating disorders. *International Journal of Eating Disorders*, *37*(4), 321–329

Cockell, S.J., Geller, J., & Linden, W. (2002). The development of a decisional balance scale for anorexia nervosa. *European Eating Disorders Review, 10*(5), 359–375.

Corstorphine, E. (2006). Cognitive—emotional—behavioural therapy for the eating disorders: Working with beliefs about emotions. *European Eating Disorders Review, 14*(6), 448–461.

Dolhanty, J., & Greenberg, L. (2007). Emotion-focused therapy in the treatment of eating disorders. *European Psychotherapy, 7*(1), 97–116.

Dolhanty, J., & Greenberg, L.S. (2009). Emotion-focused therapy in a case of anorexia nervosa. *Clinical Psychology & Psychotherapy*, *16*(4), 366–382.

Eisler, I., Dare, C., Russell, G.F.M., Szmukler, G., le Grange, D., & Dodge, E. (1997). Family and individual therapy in anorexia nervosa: A 5-year follow-up. *Archives of General Psychiatry, 54*(11), 1025–1030.

Elliott, R., Watson, J., Goldman, R., & Greenberg, L. (2004). Learning emotion-focused therapy: The process-experiential approach to change. Washington, DC: American Psychological Association.

Fairburn, C. (2008). Cognitive behaviour therapy and eating disorders. New York, NY: Guilford Press.

Federici, A., & Kaplan, A. (2008). The patient's account of relapse and recovery in anorexia nervosa: A qualitative study. *European Eating Disorders Review, 16*(1), 1–10.

Fox, J.R., & Power, M.J. (2009). Eating disorders and multi-level models of emotion: An integrated model. *Clinical Psychology & Psychotherapy, 16*(4), 240–267.

Girz, L., Lafrance Robinson, A., Foroughe, M., Jasper, K., & Boachie, A. (2012). Adapting family-based therapy to a day hospital programme for adolescents with eating disorders: preliminary outcomes and trajectories of change. *Journal of Family Therapy.* DOI: 10.1111/j.1467-6427.2012.00618.x.

Greenberg, L. (2002). Emotions in parenting. In L. Greenberg (Ed.), Emotion-Focused Therapy: Coaching Clients to Work Through Their Feelings (pp. 279–299). Washington, DC: American Psychological Association.

Greenberg, L.S. (2004). Emotion—focused therapy. *Clinical Psychology & Psychotherapy, 11*(1), 3–16.

Greenberg, L. (2008). Emotion and cognition in psychotherapy: The transforming power of affect. *Canadian Psychology, 49*(1), 49–59.

Greenberg, L. (2010). Emotion-focused therapy: A clinical synthesis. *The Journal of Lifelong Learning in Psychiatry, 3*(1), 32–42.

Greenberg, L.S., & Pascual-Leone, A. (2006). Emotion in psychotherapy: A practice-friendly research review. *Journal of Clinical Psychology, 62*(5), 611–630.

Haslam, M., Arcelus, J., Farrow, C., & Meyer, C. (2012). Attitudes towards emotional expression mediate the relationship between childhood invalidation and adult eating concern. *European Eating Disorders Review, 20*(6), 510–514.

Le Grange, D., & Eisler, I. (2009). Family interventions in adolescent anorexia nervosa. *Child and Adolescent Psychiatric Clinics of North America*, *18*(1), 159–173.

Le Grange, D., Crosby, R.D., Rathouz, P.J., & Leventhal, B.L. (2007). A randomized controlled comparison of family-based treatment and supportive psychotherapy for adolescent bulimia nervosa. *Archives of General Psychiatry, 64*(9), 1049–1056.

Lock, J., & le Grange, D. (2005). Family-based treatment of eating disorders. *International Journal of Eating Disorders*, *37*(S1), S64–S67.

Lock, J., le Grange, D., Agras, W.S., & Dare, C. (2002). Treatment manual for anorexia nervosa: A family-based approach. *Family Therapy, 29*(3), 190–191.

Lock, J., le Grange, D., Agras, S., Moye, A., Bryson, S.W., & Jo, B. (2010). Randomized clinical trial comparing family-based treatment with adolescent-focused individual therapy for adolescents with anorexia nervosa. *Archives of General Psychiatry, 67*(10), 1025–1032.

Loeb, K.L., & le Grange, D. (2009). Family-based treatment for adolescent eating disorders: Current status, new applications and future directions. *International Journal of Child and Adolescent Health*, *2*(2), 243–253.

Money, C., Davies, H., & Tchanturia, K. (2011). A case study introducing cognitive remediation and emotion skills training for anorexia nervosa inpatient care. *Clinical Case Studies*, *10*(2), 110–121.

Safer, D.L., Telch, C.F., & Agras, W.S. (2001). Dialectical behavior therapy for bulimia nervosa. *The American Journal of Psychiatry, 158*(4), 632–634.

Treasure, J. (2012). Emotion in eating disorders. *European Eating Disorders Review*, *20*(6), 429–430.

Treasure, J., & Russell, G. (2011). The case for early intervention in anorexia nervosa: Theoretical exploration of maintaining factors. *The British Journal of Psychiatry, 199*(1), 5–7.

Treasure, J., Schmidt, U., & Macdonald, P. (2010). The Clinician's Guide to Collaborative Caring in Eating Disorders. London: Routledge.

Treasure, J.L., Schmidt, U.H., & Troop, N.A. (2000). Cognitive Analytic Therapy and the Transtheoretical Framework. In K.J. Miller, & J.S. Mizes (Eds.), Comparative Treatments for Eating Disorders (pp. 283–308). New York, NY: Springer Publishing.

Vitousek, K., Watson, S., & Wilson, G.T. (1998). Enhancing motivation for change in treatment-resistant eating disorders. *Clinical Psychology Review, 18*(4), 391–420.

Wildes, J.E., & Marcus, M.D. (2011). Development of emotion acceptance behavior therapy for anorexia nervosa: A case series. *International Journal of Eating Disorders*, *44*(5), 421–427.