
Long-Term Outcomes of a Brief Emotion-Focused Family Therapy Intervention for Eating Disorders Across the Lifespan: A Mixed-Methods Study

Les effets à long terme d'une brève intervention de thérapie familiale centrée sur l'émotion en lien avec des troubles alimentaires au cours de la vie : une étude à méthodes mixtes

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ABSTRACT

Emotion-focused family therapy (EFFT) empowers caregivers to support their loved one's eating disorder (ED) recovery. Data were collected over time from 74 caregivers who participated in a 2-day EFFT workshop. Results revealed positive outcomes related to self-efficacy, treatment engagement fears, and the accommodation and enabling of behaviours. A thematic analysis of interviews conducted with eight caregivers identified the following themes: (a) increasing self-efficacy with emotion, (b) working through emotion blocks, (c) strengthening interpersonal relationships, (d) experiencing togetherness among participants, and (e) benefiting from experiential practice via role-play. Results suggest this brief intervention is associated with positive caregiver outcomes that can be maintained over time.

RÉSUMÉ

La thérapie familiale centrée sur l'émotion (TFCE) permet aux aidants de soutenir la guérison d'un être cher aux prises avec un trouble alimentaire (TA). Les données furent recueillies au fil du temps auprès de 74 aidantes et aidants qui participèrent à un atelier de deux jours sur la TFCE. Les résultats ont révélé des effets positifs relativement à l'auto-efficacité, aux craintes de s'engager dans un traitement et à l'accommodement et l'habilitation des comportements. Une analyse thématique des

entrevues menées auprès de huit aidants a permis de dégager les thèmes suivants : (a) auto-efficacité accrue en ce qui concerne l'émotion, (b) travail de gestion des blocages émotifs, (c) redressement des relations interpersonnelles, (d) sentiment de solidarité entre les participants, et (e) capacité de profiter de la pratique expérientielle grâce au jeu de rôle. Les résultats semblent indiquer que cette brève intervention est associée à des effets positifs chez les aidantes et les aidants et que ceux-ci peuvent perdurer.

Eating disorders (EDs) are serious mental disorders that have a negative impact on quality of life, including physical, emotional, cognitive, and social well-being (Klump et al., 2009). Additionally, EDs have high comorbidity with mood, anxiety, and substance use disorders (Hudson et al., 2007). They are notoriously challenging to treat, and the course of the illness can be chronic, with a high risk of premature death (Steinhausen, 2009). To prevent or limit potentially severe consequences of an ED, effective treatments are needed to provide the best recovery outcomes.

Current models of ED treatment acknowledge the therapeutic value of including parents and caregivers as active agents of healing (Lafrance Robinson, Dolhanty & Greenberg, 2013; Le Grange et al., 2010; Treasure et al., 2010) and point to the salutary effects of such involvement for both the caregiver and the affected individual (Byrne et al., 2015; Goddard, Macdonald, & Treasure, 2011; Lafrance Robinson, Strahan, et al., 2013; Macdonald et al., 2011). Emotion-focused family therapy (EFFT) is one such model whereby caregivers are empowered to increase their role in their loved one's eating disorder recovery, with respect to (a) nutritional rehabilitation and symptom interruption, (b) emotion processing, and (c) the facilitation of therapeutic apologies to heal individual or family wounds if relevant (Lafrance Robinson, Dolhanty, & Greenberg 2013). There is also a focus on processing caregiver "emotion blocks" (e.g., criticism, accommodation, and enabling behaviours) that can interfere with supportive efforts. For example, when caregivers purchase diet foods for their loved one or support patterns of excessive exercise, these behaviours are regarded within the EFFT framework as manifestations of fear ("I buy her diet foods because I'm afraid that otherwise, she won't eat anything"), or other powerful emotional states that can thwart the caregiver's access to their instincts and lead to engagement in problematic behaviours (Stillar et al., 2016). As such, problematic emotional states are targeted to support caregivers in regaining access to their intuition and skills and engaging with their loved one as positive agents of change.

Early in its development, this treatment model was manualized for delivery in the context of a 2-day workshop for parents and caregivers of a loved one with an eating disorder. The intervention was designed to be accessible to caregivers of loved ones of various ages and regardless of symptom profile, involvement in treatment, or motivation for change. The workshop includes modules related to (a) behavioural support, referring to skills related to increasing the caregiver's

role in the renourishment process and with symptom interruption; (b) emotional support, referring to skills related to increasing the caregiver's role in supporting their loved one with emotion processing (in response to behavioural interventions or more broadly); and (c) the facilitation of therapeutic apologies to aid in the release of anger, resentment, self-blame, or other emotional processes in the loved one that could interfere with the acceptance of caregiver support. Throughout the workshop, attention is also paid to caregiver treatment-engagement fears as well as concerns relating to blame that could impact negatively their supportive efforts (for additional information on the details of this intervention, see Lafrance Robinson et al., 2014).

Research studies have revealed that participation in this brief EFFT intervention leads to positive short-term outcomes for caregivers that are directly related to their supportive role in their loved one's therapy in the context of treatment for eating disorders (Lafrance Robinson et al., 2014) as well as in the context of treatment for general mental health issues (Foroughe et al., 2019; Wilhelmsen-Langeland et al., 2019). Specifically, caregivers benefit from healthier attitudes concerning their loved one's emotions and their role as emotion coaches. They also report decreased fears and increased confidence concerning their role as agents of change (Foroughe et al., 2019; Lafrance Robinson et al., 2014; Wilhelmsen-Langeland et al., 2019). Perhaps best of all, they experienced a decrease in self-blame as well (Lafrance Robinson et al., 2014).

Process research using structural equation modelling has also been conducted to explore the theoretical foundations of the therapeutic model. Results from a multi-site study revealed that the intervention was effective in decreasing caregiver treatment-engagement fears and self-blame, which then predicted an increase in confidence in their role, which in turn predicted an increase in positive intentions to support their loved one with symptoms, meals, and emotion processing (Strahan et al., 2017). These results underscore the importance of skills training in tandem with attention paid to processing caregiver fear and self-blame to support self-efficacy concerning caregivers' active role as agents of healing in their loved one's treatment.

The Present Study

The current study sought to expand upon previous findings to examine long-term caregiver benefits following participation in a 2-day EFFT workshop for caregivers of loved ones with an eating disorder. The workshop is both transdiagnostic and lifespan-focused, in that caregivers can attend in support of their loved one whether they are an adolescent or an adult and whether they suffer from symptoms of restriction, bingeing, and/or purging. This study also employed a mixed-methods design, the first in the context of EFFT for ED, to allow for a more comprehensive understanding of parent and caregiver experiences during

and following the workshop. Participants in this study completed a set of quantitative questionnaires used in the previous studies, and a subset of this sample participated in a semi-structured interview to expand upon the findings.

Methods

This study employed a two-phase, mixed-method approach. Quantitative analysis of caregiver responses on individual questionnaire items was conducted before, after, and 6 months following the intervention. These data were then supported with qualitative themes from interviews conducted approximately 2 to 3 years later. Ethical approval for this study was obtained from the Health Research Ethics Authority in the province where the study took place.

Participants

A total of 74 caregivers (54 women, 20 men) participated in a 2-day EFFT workshop provided by a not-for-profit eating disorder foundation in Canada. Participants were informed of the workshop as a result of word of mouth, posters and brochures, social media (e.g., Facebook), and the foundation website. Of the 74 participants, 58 were parents (43 mothers, 15 fathers), while the remaining 16 were alternate caregivers (relative or partner). They were attending in support of their loved one whose age ranged from 13 to 46 years ($M = 20.88$ years, $SD = 6.74$). The majority (70.3%) of caregiver-participants had a loved one involved in active treatment for an ED, while 17.6% of individuals were not currently seeking or involved in treatment, 5.4% were on a wait-list for ED treatment, 4.1% had recently completed an ED treatment program, and 2.7% chose not to specify. Participants reported that their loved one first displayed ED symptoms an average of 14.47 years previously (range from less than one month to 18 years). Caregivers reported that their loved one's primary symptoms of current concern included restricting (90.5%), bingeing (35.1%), purging (32.4%), over-exercising (45.9%), and using laxatives (16.2%). Eight caregivers (seven parents, one adult sibling) participated in the semi-structured interview. Seven of the eight caregivers interviewed were female. These caregivers participated in the workshops held in 2014 ($n = 6$) and 2015 ($n = 2$), and follow-up phone interviews were conducted in the spring of 2017. The average elapsed time between the workshop and the interview date was approximately 2 years and 7 months or 33.4 months ($SD = 6.3$).

Materials and Procedure

Phase 1

During the first phase of the study, participants engaged in the 2-day workshop administered according to standard EFFT guidelines (see Lafrance Robinson et al., 2014) by two trained facilitators, one of whom was a counsellor, the other

a caregiver advocate. The workshop occurred in a group format, with eight to 12 caregivers at a time. Participants were provided with psychoeducation about eating disorders and their impact on families. They were also taught skills to support their loved ones' behavioural and emotional recovery from the illness. Parents and caregivers had opportunities to practise these skills in the context of role-plays, where one of the facilitators took the role of their loved one. Throughout, caregiver fears and self-blame were also targeted to lessen their impact on supportive efforts, and participants were encouraged to set relevant goals. Caregivers were administered quantitative self-report measures (described below) before and after the workshop and again 6 months following the intervention. All participants completed the paper and pencil measures in the same order. The duration of each data collection period lasted approximately 45 minutes.

Phase 2

Following the completion of the 6-month data collection, participants were invited by email to participate in a semi-structured interview. A single researcher conducted each of the interviews. The semi-structured interview included questions related to caregivers' subjective evaluations of the EFFT workshop, including the value of specific interventions and perceived outcomes. Sample questions included "How would you describe the differences in the ways you support your loved one in the recovery from an ED as a result of the group, if any?" and "What elements if any of the group process were helpful?" When appropriate, participants were asked follow-up questions. Therefore, while questions were standardized, follow-up questions often differed based on the information shared by the participant. Participants were also asked to provide suggestions and recommendations based on their experience. The interviews ranged from 35 to 90 minutes. Approximately 8 hours (483 minutes) of interview data were collected. A second researcher transcribed the recordings verbatim and verified their accuracy. They then coded the data units, engaging in consultations with the lead investigator when necessary.

Measures Used in Phase 1

Caregiver Self-Efficacy

Caregiver empowerment was assessed using a revised version of the Parent Versus Anorexia scale (PVA; Rhodes et al., 2005). The PVA scale was designed to measure parental self-efficacy in the context of treatment for anorexia nervosa, that is to say, the "ability of a [caregiver] to adopt a primary role in taking charge of the [ED] in the home setting" (Rhodes et al., 2005, p. 401). Minor revisions were made to reflect parent and caregiver experiences of loved ones with varied symptom profiles. Sample items include "I don't have the knowledge to take a leadership role when it comes to achieving a total victory over the eating disorder" and "I feel equipped with specific practical strategies for the task of bringing

about the complete recovery of my loved one in the home setting.” There are 7 items in the scale, and each item is rated on a 5-point Likert scale from *strongly disagree* to *strongly agree*. Scale total scores range from 7 to 35, with a lower scale score indicating a lower level of self-efficacy ($\alpha = .42$).

Caregiver Traps Scale (CTS)

This 15-item scale was developed in order to assess treatment-engagement fears among caregivers recruited as collaborative partners in care over their loved one’s treatment for an ED. The scale was developed over the course of 2 years on the basis of common concerns expressed by parents and caregivers of children and adolescents in the context of family-oriented therapies (Lafrance et al., 2019). Caregivers completing the measure are introduced to the items with the following prompt: “We have found it is a very normal process for caregivers to struggle with concerns that surface while engaging in the tasks of recovery. How likely are you to feel vulnerable to the following concerns when supporting your loved one’s refeeding/interruption of symptoms?” Example items from the CTS include “Fear of putting strain on my couple relationship,” “Fear of pushing my loved one ‘too far’ with treatment (leading to depression/running away/suicide),” and “Fear of being blamed or being to blame.” Each item is accompanied by 7-point Likert scales. Scores range from 15 to 105, with higher scores reflecting a greater level of concern regarding the active involvement in supporting their loved one in the behavioural treatment of their loved one’s ED ($\alpha = .92$).

Accommodation and Enabling Scale for Eating Disorders

The Accommodation and Enabling Scale for Eating Disorders (AESED; Sepulveda et al., 2009) is a 33-item self-report scale developed to measure the degree to which carers engage in behaviours that may accommodate and enable the symptomology of a relative with an ED. Sample items include “Does your loved one’s eating disorder control the choices of food that you buy?” and “Does your loved one engage any family member in repeated conversations about whether it is safe or acceptable to eat a certain food?” The total scale score can range from 0 to 138. A higher score indicates a higher level of accommodating and enabling of ED symptoms ($\alpha = .93$). This measure was only administered pre-intervention and at the 6-month follow-up, given that there would be no expectation for change from the morning of the first day of the workshop to the end of the day on the second day of the workshop.

Analysis

The self-report measures were analyzed using IBM Statistical Package for the Social Sciences (SPSS; v22). Descriptive statistics, missing data analyses, and repeated measures ANOVA were utilized to examine the data. A thematic analysis (Braun & Clarke, 2006) was utilized to analyze the semi-structured interviews

Table 1
Means, Standard Deviations, P-Values, and Effect Sizes for Caregiver Measures

Caregiver Measure	Pre-Treatment		Post-Treatment		6-Month Follow-up		n	p
	M	SD	M	SD	M	SD		
PVA-R total	16.19	3.39	22.90	3.08	18.94	4.33	31	<.001
CTS total	61.41	18.32	49.10	18.37	54.48	20.36	29	<.001
AESED	56.13	23.72	n/a	n/a	41.71	22.27	24	.003

and to identify themes at a semantic level within the data set. Transcripts were read and reread for the researchers to become familiar with the data. Initial codes were generated based on recurring patterns, and the codes were sorted into themes that represented the data accurately. A theme was defined as a patterned response that occurred in at least 50% of the transcripts.

Results

Descriptive Statistics

From the total sample of 74 parents and caregivers, 44.6% ($n = 33$) completed follow-up measures at each time interval, while 55.4% ($n = 44$) did not. MANOVA analyses were conducted to determine whether participants who did and did not complete follow-up data differed significantly on the variables of interest in this study. The independent variable was data completion, with two levels, (1) post-data only and (2) post-data and follow-up data. The dependent variables were change scores (pre-treatment mean – post-treatment mean) on the variables of interest described above. The results showed that there were no significant differences between participants who completed follow-up data and those who did not ($F(4, 57) = 1.68, p = .167$). Given that no significant differences were found on the variables of interest in this study between participants who completed the follow-up and those who did not, the researchers proceeded with analyses using the sample of participants who completed follow-up data. Additional descriptive statistics can be found in Table 1.

The sample for the analyses included 33 caregivers (23 women, nine men), 26 of whom were parents (20 mothers, six fathers). The mean age of the affected individual was 21.30 years ($SD = 7.54$) and ranged from 14 to 46 years. The majority (69.7%) of caregiver-participants had a loved one involved in active treatment for an ED for an average of 8.80 months (range from 1 month to 32 months) while 15.1% were not currently involved in or seeking treatment, 6.1% were on a waitlist for ED treatment, 6.1% had recently finished an ED treatment program, and 3.0% chose not to specify. Participants reported that their loved one first displayed ED symptoms an average of 5 months previously (range from 1 month to 25 months). Caregivers reported that their loved one's

primary symptoms of concern included restricting (97%), bingeing (30.3%), purging (30.3%), over-exercising (48.5%), and laxative use (12.0%).

Caregiver Self-Efficacy

A repeated-measures ANOVA of caregiver self-efficacy using the PVA-R as the dependent variable and time as the independent variable, with three levels ($T1$ = pre-treatment, $T2$ = post-treatment, $T3$ = 6-month follow-up), was run to assess change over time. Mauchly's Test of Sphericity indicated that the assumption of sphericity was not violated, $X^2(2) = .692, p = .708$. Results determined that caregiver self-efficacy differed significantly between time points ($F(2, 29) = 52.38, p < .001$; $T1 M = 16.19, T2 M = 22.9, T3 M = 18.94$).

Post hoc tests using Bonferroni correction revealed that participation in the 2-day EFFT group led to a statistically significant improvement in caregiver self-efficacy, immediately following the group ($\Delta T1-T2 = -6.71, p < .001, d = 2.07$). Caregiver self-efficacy decreased significantly from post-group to 6-month follow-up ($T2-T3 = 3.97, p < .001, d = 1.05$); however, a statistically significant improvement in caregiver self-efficacy from pre-group was maintained at the 6-month follow-up ($\Delta T1-T3 = -2.74, p = .001, d = .71$).

Caregiver Traps Scale

A repeated-measures ANOVA using caregiver blocks (or treatment-engagement fears) related to supporting their loved one's recovery as the dependent variable and time as the independent variable, with three levels ($T1$ = pre-treatment, $T2$ = post-treatment, $T3$ = 6-month follow-up), was run to assess change over time. Mauchly's Test of Sphericity indicated that the assumption of sphericity was not violated, $X^2(2) = 3.287, p = .193$. Results determined that caregiver blocks related to supporting their loved one's recovery differed significantly between time points ($F(2, 27) = 15.35, p < .001$; $T1 M = 61.41, T2 M = 49.103, T3 M = 54.48$).

Post hoc tests using Bonferroni correction revealed that participants experienced a statistically significant decrease in fears related to supporting their loved one's recovery immediately following participation in the 2-day EFFT group ($\Delta T1-T2 = 12.31, p < .001, d = .67$). There was no significant difference in caregiver fears immediately following the group compared to the 6-month follow-up ($T2-T3 = -5.38, p = .26, d = .28$). However, a statistically significant decrease in treatment-engagement fears from pre-group was maintained at the 6-month follow-up ($\Delta T1-T3 = 6.93, p = .04, d = .36$).

Accommodating and Enabling Behaviour

A repeated-measures ANOVA using accommodating and enabling behaviour as the dependent variable and time as the independent variable, with two levels ($T1$ = pre-treatment, $T2$ = 6-month follow-up), was run to assess change in accommodating and enabling behaviours over time. Results determined that

Table 2
Themes, Sub-Themes, and Endorsement of Each Theme

Theme 1: Increasing Caregiver Self-Efficacy
Sub-Theme 1: Increased Ability to Recognize the Role of Emotion in ED (8/8)
Sub-Theme 2: Learning Techniques to Support Emotion Processing (8/8)
Theme 2: Working Through Emotion Blocks
Sub-Theme 1: Overcoming Fear (6/8)
Sub-Theme 2: Overcoming Self-Blame/Guilt/Shame (4/8)
Theme 3: Strengthening Interpersonal Relationships
Sub-Theme 1: Providing Better Quality Support (7/8)
Sub-Theme 2: Increasing Effective Communication (6/8)
Theme 4: Experiencing a Sense of Togetherness
Sub-Theme 1: Creating Meaningful Facilitator Relationships (8/8)
Sub-Theme 2: Connecting With the Experience of Other Caregivers (7/8)
Theme 5: Benefitting From Experiential Practice via Role-Play
Sub-Theme 1: Engaging in Experiential Practice (8/8)
Sub-Theme 2: Observing Experiential Practice (7/8)

accommodating and enabling behaviour differed significantly between time points ($F(1, 23) = 10.76, p = .003, T1 M = 56.13, T2 M = 41.71$). Participants experienced a statistically significant decrease in accommodating and enabling behaviour from pre-group to the 6-month follow-up ($\Delta T1-T2 = 14.42, p = .003, d = .63$).

Qualitative Analysis

The researcher who transcribed the interviews developed 16 initial codes, 10 of which were endorsed by at least 60% of the participants. A second researcher reviewed the data and the emergent themes with the primary coder and they agreed to combine two codes into a single sub-theme. Five central themes were identified with two sub-themes per central theme. Quotes most suitable to represent each of these sub-themes were then identified. Table 2 provides a summary of the themes and the sub-themes, along with the number of participants who endorsed each theme.

Five central themes were identified from the thematic analysis of eight semi-structured caregiver interviews exploring the impact of the workshop. Specifically, participants reported that the EFFT workshop led to outcomes relating to (1) increases in their self-efficacy with respect to emotions in treatment, (2) working through emotion blocks that could interfere with their supportive efforts, (3) strengthening interpersonal relationships with the family, (4) experiencing a sense of togetherness in the group, and (5) benefiting from experiential practice of emotion-focused skills through role-play.

Theme 1: Increasing Caregiver Self-Efficacy

Caregivers shared that the workshop provided them with overall feelings of empowerment that were related to emotional support in particular. Before the

workshop, the caregivers communicated that they had felt ill-equipped, even helpless, when it came to supporting their loved ones with food and feelings. After the workshop, many caregivers felt that they had a new sense of confidence in their ability to take on the role of recovery coach to promote their loved one's recovery from an ED. They felt that the skills gained in the workshop added to their "tool kit," in particular concerning supporting their loved one with emotions.

Sub-Theme 1.1: Increased Ability to Recognize the Role of Emotion in ED

Caregivers indicated that the workshop helped them to understand that one of the underlying factors of their loved one's ED was emotion-based. They felt as though the workshop aided them in developing the ability to recognize and respond to emotional cues in themselves and others. By developing the ability to identify emotion, they felt more capable of addressing their loved one's feelings in a way that would be beneficial, including during meals. A father described his new-found understanding of the role of emotion underlying his daughter's ED:

For me, really just getting to truly understand that the eating disorder was merely a symptom. And until we got our hands around the emotional side, we were really just going to go from one maladaptive coping strategy to another. If it wasn't an eating disorder it was going to be cutting or drugs or something we were just going to keep going around. I think that was the big one for me. I think the other big one for me was learning how to really watch out for the emotion and listen to what was being said. (P5)

Sub-Theme 1.2: Learning Techniques to Support Emotion Processing

Caregivers expressed that the workshop helped them to be accepting and supportive of emotion that emerged throughout recovery, rather than focus on trying to solve the "problem." One participant described this evolution in the following way:

Emotion is so important, and I used to always want to fix it. Make someone feel better. Now I let them talk about the emotion. You acknowledge the emotion and let them talk about it . . . , but I don't just always give off-the-cuff advice anymore. (P2)

Caregivers also expressed that the workshop helped them learn how to regulate their own emotions, which helped them to guide their loved ones in their emotional processes. As one participant explained,

It made me feel not as helpless, like there was actually something I could do. Even if it was only for myself to get a handle on my own emotions, to be able

to deal and feel my own emotions so that I could help her do that kind of thing, that's something I can do. (P6)

Theme 2: Working Through Emotion Blocks

Caregivers expressed that the workshop helped them to overcome a range of emotion blocks that could interfere with their ability to support their loved one. They commented most often on the role of fear and self-blame. They experienced great relief in working through these emotional states that were often described as previously overwhelming.

Sub-Theme 2.1: Overcoming Fear

Caregivers expressed that the fear of losing their loved one or making the situation worse interfered with their ability to help in their loved one's recovery. Participant 3 acknowledged the need to work through her sometimes overpowering fears and to cultivate trust in the process:

I had to put aside all of my fears. I had to put aside all my anxiety. I had to put all that aside and just support her in the moment and just say I've got to put faith in her. (P3)

Sub-Theme 2.2: Overcoming Shame/Self-Blame

The parents in the sample also expressed that their narratives of self-blame evolved concerning their loved one's ED, including the notion that they were "bad parents" because their child had developed this disorder. The workshop created space for them to work through these painful feelings, which helped them to assist in their child's recovery better. Participant 4, an alternate caregiver, shared her experience of resolution concerning her self-blame for her perceived role in her sister's illness:

I was always someone that held a lot of guilt and a lot of self-blame and that group kind of showed me, not only that it wasn't my fault, that I had nothing to be guilty about, but it showed me how to work with those emotions. And so, [EFFT] tamed them back a bit and it helped me better speak to my sister. (P4)

Theme 3: Strengthening Interpersonal Relationships

Caregivers expressed that the workshop had helped them to build, maintain, and heal relationships with their loved one with an ED. They also reported a strengthening of bonds with their other children, their spouse, and other family members and friends. This seemed to be related to their ability to support their loved ones in a way that felt more productive.

Sub-Theme 3.1: Providing Better Quality Support

Caregivers expressed that they felt as though the amount of support provided to their loved one did not necessarily change but that the quality of support that they could provide had increased significantly. Participant 7 described newfound insight into ways to support her daughter better through her ED recovery: “I did not feel differently about my daughter, but I think it made me feel differently about how I could support my daughter.”

Sub-Theme 3.2: Increasing Effective Communication

Caregivers added that they were able, after the workshop, to communicate better with their loved one with an ED as well as with other loved ones. This was deemed to be important given the effects of the diagnosis and treatment on others in the home. A caregiver shared the following:

It has given me a way to communicate with both my daughters. A new way, a better way, and it's general now and when I talk to people, I use it all the time . . . and in my marriage too. It certainly helped give me a greater insight into their feelings. (P2)

Theme 4: Experiencing a Sense of Togetherness

Caregivers felt as though the workshop had connected them to a great support network. They were able to relate to the facilitators and to other members of the group. They gained a sense of hope that other people understood and cared about what they were going through.

Sub-Theme 4.1: Creating Meaningful Facilitator Relationships

Caregivers expressed that the clinicians who led the workshop were instrumental in its success. They skilfully created an open, non-judgmental, empathetic, and safe environment. They seemed to relate to the caregivers on a deeper level because they had experiential knowledge of the subject matter and were open about some of their own challenging experiences as parents. One mother expressed, “I can sum it up in one word. Trust. . . . They get it. They understood where we were at. They . . . were empathetic and I trusted them” (P3).

Sub-Theme 4.2: Connecting with the Experience of Other Caregivers

Caregivers also reported experiencing a sense of comfort and support provided by the other members of the group. They shared a sense of common purpose, which was deemed meaningful in that they could share stories and support one another in moving forward. Participant 7 described the ways in which the social networks created at the workshop had provided an additional source of support and hope as well as a lessening of self-judgment:

We were all there seeking support and help and needing affirmation that we weren't the worst parents in the world. But more so than that needing affirmation, that our children were going to be okay, that we could help them get through this, we could stand by them if they got through it. (P7)

Theme 5: Benefitting From Experiential Practice via Role-Play

Caregivers expressed that they found the experiential practice of targeted skills to be the most beneficial aspect of the workshop. This aspect of the intervention provided an opportunity to practise the skills they had learned and helped them to make sense of their loved one's perspective. Experiential practice in this context refers to role-plays whereby caregivers, supported by the facilitators and with feedback from the group, would practise using the skills learned in the context of scenarios they predicted would present the greatest challenge (e.g., emotion coaching around meal support).

Sub-Theme 5.1: Engaging in Experiential Practice

Although caregivers expressed that these role-plays could be emotionally challenging, they expressed that the experiences were transformative. The experiences provided them with an opportunity to put themselves in the position of their loved one and to practise new ways of listening and communicating in a way that would lead to increased cooperation and engagement around symptom cessation. A caregiver described this process in the following way:

It's amazing how powerful the chair is because you're asked to take the role of your loved one and you really do try to immerse yourself in that and you're forced to do that. And you know it's not a natural thing. (P3)

Sub-Theme 5.2: Observing Experiential Practice

Caregivers expressed that observing others engage in these role-plays was also extremely helpful. They shared that the practice allowed them to learn new strategies and to experience some relief in the fact that they were not alone in feeling stuck at times. A mother described that this experiential practice gifted her with increased self-compassion via her experience of compassion for others participating in the process:

You have empathy for somebody else, then you kind of give yourself a little bit of empathy at the same time . . . cut yourself some slack, because you know you're not the only one suffering through this kind of thing and finding it hard. It was definitely reaffirming to kind of hear how somebody else would approach things. (P6)

Finally, although this is not a theme per se, it is worth noting that every one of the participants who were interviewed reported that they would recommend the EFFT workshop to other caregivers with a loved one struggling with an ED. They also provided recommendations for improvement that are described in the discussion to follow.

Discussion

This study is the first long-term, mixed-method examination of caregiver outcomes relating to the 2-day EFFT workshop for ED in adolescents and adult sufferers. Results suggest that this brief transdiagnostic intervention led to positive and lasting changes concerning caregivers' treatment-engagement fears as well as their confidence and skill as active agents of change in both behavioural and emotional domains. They also experienced reductions in their engagement in accommodating and enabling behaviours, an important finding given their potential as ED maintenance factors (Goddard, Macdonald, & Treasure, 2011). This is also the first study of the 2-day workshop to reveal sustained reductions concerning these problematic patterns of behaviour, suggesting that they are, in fact, amenable to change, highlighting the value of family-based support and skills training for caregivers of loved ones across the lifespan.

Overall, the quantitative results support the effectiveness of the brief EFFT intervention for caregivers of children with eating disorders across the lifespan in increasing caregiver self-efficacy, decreasing the intensity of treatment-engagement fears or emotion blocks, and decreasing accommodating and enabling behaviours. Outcomes were within the medium to large range post-intervention (Cohen's $d = .67-2.07$), which is consistent with effect sizes from other caregiver-focused interventions. For instance, Lafrance Robinson et al. (2014) evaluated the efficacy of a 2-day EFFT group-based intervention for parents of children with eating disorders across the lifespan. They reported large effect sizes for several measures, including caregiver traps (Cohen's $d = 1.72$) and parental self-efficacy (Cohen's $d = 3.39$). Similarly, when evaluating the efficacy of a 2-hour psychoeducation group for parents of youth with eating disorders, Spettigue et al. (2015) reported large effects for parental self-efficacy (partial $\eta^2 = .454$) and parental knowledge about eating disorders (partial $\eta^2 = .133$) as well as a small effect for the perceived impact of the eating disorder symptoms on the family (partial $\eta^2 = .010$). Also, Bruning Brown et al. (2004) evaluated the efficacy of an Internet-based eating disorder prevention program and results revealed effect sizes ranging from .48 to .61 concerning parental attitudes and criticism. In this study, the strength of outcomes at a 6-month follow-up decreased to within the small to medium range (Cohen's $d = .36-.71$), suggesting that a booster group following the main intervention may aid in maintaining the strength of the intervention as caregivers continue on the journey of supporting their loved one's recovery.

There was also a high level of concordance between the quantitative data and the qualitative data, strengthening our confidence in the results, in particular given the fact that our measure of caregiver self-efficacy yielded lower than expected scale reliability (PVA-R). Thankfully, there was little question—based on triangulation of anecdotal reports, analysis of means over time, and qualitative findings—that caregivers did, in fact, benefit from increased confidence concerning their role in their loved one's recovery concerning both behavioural and emotional support. However, as previously mentioned, the fact that the initial gain on this measure spiked and then declined at the 6-month follow-up suggests the clinical utility of a follow-up session to maintain higher levels of caregiver confidence. In fact, during the interviews, when asked about recommendations for improvement, most caregivers shared a need for a refresher course. Therefore, treatment programs interested in integrating this manualized intervention within their service should consider the addition of one or more booster sessions between the workshop and the 6-month mark. We were also encouraged by the fact that initial reductions in fear and self-blame as measured by the Caregiver Traps Scale were maintained for at least 6 months. Qualitative results also pointed to the benefit experienced by the participants from the attention paid to these emotional states. Rather than try to reassure parents, the EFFT clinician employs tools and strategies to process fears and self-blame, knowing that doing so will help caregivers regain access to their instincts and fund of knowledge. The interviews also brought attention to the importance of practising these new skills in a group setting where vicarious learning is also possible. Not surprisingly, participants also noted the value of the experience of universality, a common experience in therapeutic groups of any type (Yalom, 1995). Finally, the qualitative analyses revealed that, among other positive experiences, the emotional support skills acquired in the workshop generalized across relationships. We believe this new finding to be very important given the impact of an ED on close others, including partners and siblings (Ajulo, 2013; Anastasiadou et al., 2014; Anastasiadou et al., 2016; Highet et al., 2005; Sepulveda et al., 2010) and the need for advanced skills to temper its negative influence.

In addition to the outcomes described, the strengths of this workshop lie in the fact that it is low-cost and can be delivered to many caregivers at a time who are attending on behalf of their loved ones of varying ages and suffering from a range of symptom profiles. These features were especially important in the setting in which this study took place, which was a community-based not-for-profit organization in Canada. This means that clinicians in programs struggling to support caregivers (when the identified client is deemed most in need of limited resources) can offer the same intervention to parents, spouses, relatives, and adult siblings of loved ones young or old, regardless of ED diagnosis, and whether or not they have access to individual client information. That said, this intervention does require some specialized training due to its intensity. One of the additional

recommendations from the caregivers who were interviewed related to the intensity of the work, concerning both emotions and the volume of material covered. Specifically, they felt it could be helpful to meet with caregivers in advance so that they could be better prepared for the experience. As such, we recommend that an information session be offered to prospective participants, where they can be provided with an overview of the intervention and an opportunity to ask questions or to express concerns.

These results add to the growing literature supporting the use of this intensive EFFT intervention for caregivers of a loved one with ED across the lifespan. Given that, in these and other related studies (Lafrance Robinson et al., 2014; Strahan et al., 2017), many participants are attending the workshop on behalf of their adult loved one, the notion that caregiver involvement should be limited to clients who are children or adolescents is becoming less relevant. These caregivers are seeking assistance, benefiting from it, and seemingly eager for more. They can also access this support without the need for access to confidential information about the loved one's illness and without the loved one's expressed consent for caregiver involvement, offering hope to those caregivers whose loved one refuses service or who are themselves on the outskirts of the treatment process. We believe that treatment offerings for caregivers are vitally important, especially since there are high rates of caregiver burden among those who care for sufferers (Anastasiadou et al., 2014; Sepulveda et al., 2010), and problematic patterns of caregiving can emerge and become reinforced by the presence of the ED in the home (Goddard, Macdonald, Sepulveda, et al., 2011; Loeb et al., 2012; Schmidt & Treasure, 2006; Treasure et al., 2008). Caregivers are also best poised to support their loved one based on their availability and presence (which is far greater than a clinician or a therapist) as well as the greater impact of their supportive efforts due to strength of their neurobiological bond (Hughes & Baylin, 2012; Siegel, 2001).

Limitations

The findings of this study must be viewed in the context of important limitations. Firstly, although analyses did not reveal differences between those who had completed each of the measurement points and those who had not, it is still possible that the follow-up outcomes may not be representative of the entire group of caregivers, especially in light of the smaller sample size concerning the qualitative interviews. For example, it is possible that caregivers who experienced greater gains were more compelled to complete the measures when compared to their counterparts. It is also possible that those who had volunteered to complete the interviews were more motivated by a positive experience or were in a more advanced phase of recovery. Secondly, it was not possible to include a control group. As such, other variables not related to the EFFT workshop specifically (i.e., the time between pre- and post-workshop measures) may have influenced the positive outcomes observed at the 6-month mark, and these may have been

outside of interviewees' awareness. Thirdly, both quantitative (i.e., measures of ED symptomatology) and qualitative data were not collected from the individuals struggling with an ED to determine whether the gains reported by caregivers translated to better outcomes for their loved one. Although related research has demonstrated positive relationships between caregiver and child outcomes in the context of the 2-day EFFT workshop for general mental health (Foroughe et al., 2019), the inclusion of these data in this context will be an important next step. It may also have been advantageous to collect qualitative data at more than one interval. For example, interviews could have been conducted earlier when participants may have been easier to access and their memory of the program more vivid. For these reasons, we would encourage a tempering of the conclusions drawn and future research to understand further the unique impact of this intervention concerning chronicity, symptom profile, involvement with other supports, and nature of the caregiver relationship (parent of a child vs. adult vs. spouse or partner support). Despite these limitations, the field has been turning its attention to the role of caregivers in treatment, and this study provides additional evidence in support of the clinical utility of this brief, low-cost, and transdiagnostic intervention developed in the service of widening the therapeutic circle to support the recovery from an ED.

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