

SKILLS BASED TRAINING FOR CARERS OF PEOPLE WITH EATING DISORDERS

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The following brief notes are extracts from a book which is about to be published describing how to work with the families of people with eating disorders (1) . They can help you get started working with families .

Introduction

Living with a loved one with an eating disorder can have a significant impact on the mental and physical health of individual family members. The National Institute for Clinical Excellence (2004) guidelines recommend that most people with anorexia nervosa (AN) should be managed on an outpatient basis, a policy that places primary responsibility for care onto family members. Carers frequently report that they often lack the skills and resources required to care for their offspring with an eating disorder. Frequently, however, families of patients have high levels of unmet needs and stress (2;3). There is evidence to suggest that living with someone with an eating disorder can have a significant impact on both the mental and physical health of individual family members. The resulting transformation of family life is all too readily perceived as a direct demonstration of dysfunctional relationships within the family, a factor perceived to have a causal role in the development of the eating disorder.

Nevertheless, understanding the family context is important due to the impact of the illness on the family. The manner in which the family attempt to reduce the symptoms may inadvertently play a role in maintaining the problem with families becoming stuck in unhelpful interactions, whilst losing sight of their own strengths and resources. Consequently, there is increasing recognition that carers of someone with an eating disorder (ED) can be valuable resources in the process of recovery.

Treatment implications

A primary developmental challenge for a family is to create a meaning for the illness experience that promotes a sense of competency and mastery and that families adapt best when their representation of the illness is empowering, sustains hope and affirms their relationships. Thus, in order to equip the family with feelings of empowerment and efficacy, professionals should regard the family as a resource within the treatment in helping the family to feel included and valued. The assessment of the families needs to be handled with care and sensitivity (4). Carers may be very sensitive with their own feelings of guilt, blame and inadequacy and any actions made by professionals that reinforce these beliefs may be devastating for the family. Promoting beliefs that sustain hope and empower families, and encouraging families to take “safe risks” may be an important step in reducing carers’ feelings of helplessness and interrupting unhelpful interactions within the family (5)

Disseminating skills sharing techniques with families

The aim of the new Maudsley model of working families is to build an alliance between the carers, the service user and the team and to educate service users and

carers about the illness. The sharing of feelings and problems is encouraged in order to facilitate the exploration of possible solutions and to reinforce coping behaviours reducing the negative emotional climate and increasing overall positivity. The underlying philosophy of all elements of the programme is to foster understanding, respect, warmth, consistency and non-critical responses between all users. The collaborative caring skills training programme is administered under various formats.

Workshops

Collaborative care workshops were designed to equip carers with the skills and knowledge required to be a 'coach' and help the person with the eating disorder break free from the traps that block recovery (6). Training methods include role-play demonstrations on how to implement those skills required to instigate behaviour change using the trans-theoretical model of change and the principles of motivational interviewing.

The workshops discuss the principles of behaviour change in the context of people who may be ambivalent about change and use a two step format. First, they concentrate on how, why and in what way the behaviour of the carer may have to change. By thinking about, experiencing and implementing change in themselves, carers come to understand the process of behaviour change that will be needed for the second step, which is guiding change for the individual with an eating disorder herself. The group leaders use motivational interviewing (MI) techniques in order to facilitate change. The workshops are framed as an opportunity for those taking part to develop the skills to become an 'expert carer', the content being similar to that offered to specialist health professions. Information is given on how to improve coping strategies. Techniques on how to side step high expressed emotion responses to symptoms are taught. The process of training includes demonstrations using the principles of the transtheoretical model and motivational interviewing, with the aim of implementing these skills in helping their loved one change their behaviour. The preliminary findings are encouraging (7). More detail about the workshops is given later.

Self help interventions for Carers

Self help interventions overcome some of the problems of accessibility and time management. A variety of methods have developed been using technology such as books (8), the web and DVDs in order to reach out to a wider audience and to address issues of high demand, scarce resources and geographical and time constraints. The web-based and DVD programmes include role-play scenarios, which illustrate communication, assessment and motivational skills. The impact of these is under investigation(9).

A form of guided self-help that has been developed to compliment the DVDs/manual materials is telephone coaching. Whilst the DVD and manual provides psychoeducational information and knowledge, it is hoped that the telephone coaching sessions offer the interpersonal element provided by attending the on-site workshops. Carers receive a specified number of coaching sessions, whereby they are encouraged to use their own creativity and resources in identifying manageable target behaviours, using the strategies and techniques illustrated in the intervention materials. The coach essentially uses the same principles in guiding the carers as those taught to carers in the materials. More detail about this is given later.

A training programme is currently being devised, the aim of which is to teach 'expert' carers to become coaches themselves. The programme is part of a larger research project, Carer Assessment Skills and Information Sharing (CASIS). The primary aim of the training will be to recruit and train 'expert carers' to work as coaches with other carers, in using the principles of motivational interviewing to instigate behaviour change. In addition a manual for professionals describing this intervention will be available shortly(1).

Conclusion

In general, carers of people with eating disorders are highly motivated in participating in collaborative caring programmes. It is important, therefore, that carers are equipped with the necessary skills and resources required to support their loved one with an eating disorder, in an approach that includes both professionals *and* family members. This should include sharing information and teaching carers the same basic skills as those taught to professionals, to help them recognize those behaviours that may be maintaining or accommodating to the symptoms. The common enemy is the eating disorder. It is vital that the approach to treatment reflect this.

The goals of including the family in the assessment process

The goals of the family assessment are, first of all, to offer carers the opportunity to obtain information. Secondly, the family are a resource to complete the case conceptualisation with the different perspective they have to offer about the lifetime context in which the illness emerged. This includes an assessment of how interpersonal features might play a role in maintaining the disorder by reinforcing the illness behaviours. The preliminary discussion covers the concept of expressed emotion using the animal metaphors (see appendix 1) and then an assessment of how the family have organised themselves around the eating disorder. This is particularly relevant to those cases in which the individual still lives at home or is in receipt of continuing parenting because of the overt signs of the illness. The aim of this joint assessment is to ensure that the family are not pulling in a different direction to the therapeutic team. Finally, carers may be offered specific extra help with practical skills to adapt own their behaviours and manage the eating disorder symptoms.

In addition to the standard description of the illness, the following is a list of information sharing aims and skills that are useful for carers. The latter can also be demonstrated by the therapist within the session:

Information

- Strengthen the family's belief in the importance of their contribution in facilitating change. Families can play a large part in giving help and support and can help to ensure that any maintaining factor is kept to the minimum.
- Develop a shared evidence based model (which give the family the opportunity to express their concerns about the causes and effects of the anorexia nervosa and moderate their level of guilt etc). We do not know what causes anorexia nervosa and it is wrong to pinpoint one factor as the cause.

- Understand that untreated, eating disorders can lead to a chronic and destructive illness. The individual with the eating disorder may not be able to help herself as she is trapped and confused by the illness.
- Understand the basic elements of health behaviour change, i.e. stage and dimensional based models of stage of change.
- Discuss the basic principles of behaviour change, i.e. reinforcement to foster positive behaviours and a functional analysis to identify the triggers to problematic behaviours.

Skills

- Modelling, affirmation, coaching, and a solution focused approach.
- Model the use of externalising to reduce the level of criticism.
- Develop a functional analysis of family interactions.
- Teach good communication skills (the ability to listen and to elicit, express and process emotions).
- Promote respect, cohesiveness and satisfaction within the family relationship.
- Learn the skills of facilitating problem solving with their offspring.
- Maximise parenting skills (warmth with limits and boundaries, i.e. authoritative, compassionate parenting).
- Produce a shift in the environmental context to attenuate factors, which maintain the problem such as confrontation, collusion, high expressed emotion, criticism, hostility, or a dieting culture.
- Help the family manage OCD and anxiety behaviours so that they do not enable them.
- Help the family when they need to make a firm stance against illness behaviour.

It can be helpful to go through the accommodation and enabling scale (see appendix) with the family to focus the discussion on possible ways that these behaviours may be maintaining the illness . Sometimes it is helpful when the family recognise that they are not the only ones to have these problems.

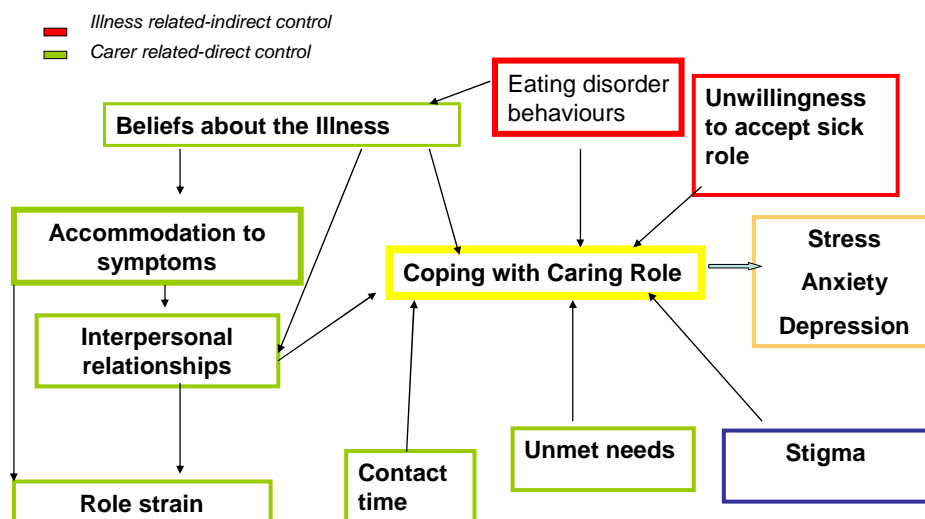
The Protocol for running Carer Workshops

The following is a brief outline of how we managed the carer workshops. We ran 6 sessions but many people came back for repeat training or ensured that their husband came back for later sessions. There is therefore great flexibility in how this is run. Remember that we are expecting the families to get the gist in 6 weeks in what we may have taken over 6 years to learn.

Session 1: Changing maladaptive interpersonal behaviours with the eating disorder

This session introduces the model of carer coping. First, we ask carers to think about whether they can make changes in the areas on the diagram in the worksheet in which they have a direct contribution. These include:

- Spending less contact time,
- Getting an optimal balance with other roles
- Balancing the relationship



First of all, we explain how to develop a balanced relationship avoiding the traps of extreme emotions or over directiveness. The animal metaphors are a playful way of introducing these maladaptive relationship patterns. A light-hearted discussion follows on from their observations and reflections of how these patterns emerge in their own day-to-day interactions. Carers often fall into extreme patterns of emotional responding, either taking too intense an emotional reaction with anguish or anger (jellyfish), or denying that they have any emotions (ostrich) and withdrawing. In terms of directedness carers can be overly protective (kangaroo) – taking over all roles - or overly directive (rhinoceros), invalidating the eating disorder symptoms. Most carers recognise that their relationship pattern may often fall into one of these animal roles.

Carers work in small groups discussing their default patterns of interaction. The aim is for carers to gently recognise and reflect on the possibility that they may play a role in maintaining the eating disorder symptoms. We teach about issues such as ‘readiness to change’ and how to increase motivation to change, by asking the carers to reflect on whether they might be willing and or able to work on changing *their* role in these patterns of interaction. The realisation that it is not just their daughter, son, relative or partner who might have to change, but that they too share a role, is an interesting milestone in the process. In other settings, this can be a road-block for some parents, especially if they feel they have to commit to family “therapy” when they do not see the family as part of the problem. The process of commitment to change within the workshops is more gradual and also more clear, structured and contained.

Session 1: Compassion and Emotional Intelligence

To be an effective mentor for their relative with an eating disorder, carers have to hone their emotional intelligence skills. This involves being able to be reflective about their own emotional reaction, using it as a guide decision making rather than becoming captured and swept up by the emotion. Thus, advice to remain calm and compassionate (all the C’s) and yet warm, is a constant refrain within the workshops. The parents need to change from high expressed emotion into a compassionate stance so that the person with the eating disorder can model how to be compassionate to themselves, the skills of motivational interviewing help with this process.

Enhancing compassion is associated with the following set of skills:

- Sensitivity to the need and distress of self and others
- Tolerant of the distress of self and others
- Able to care for the needs of self and others
- Shows sympathy and empathy for self and others.
- Is non judgmental of self and others
- Is able to see the goodness in self and others
- Slow to chide and swift to bless

The ability to reflect on their own emotions is a core skill, that can usefully be transferred to their offspring. People with eating disorders find this difficult, preferring to avoid and dismiss emotions altogether. We suggest, therefore, that a useful role for any carer is to serve as an emotional coach, modelling emotional intelligence. All too often, carers react to eating disorders by denying or invalidating

their own emotional reaction. If they are suspicious that their daughter has skipped a meal or thrown it away, for example, they may challenge their daughter who, in turn, responds angrily and may accuse her carers of not trusting her. Carers will often deny that this is the case, even although they do not trust her. Alternatively, they may deny being angry or irritated when provoked. They may give up spending time alone with their partner, saying they do not mind, when they do.

This is all done in an effort to keep the peace. Dishonesty or avoidance of emotions, however, is harmful as it invalidates emotions. This inhibits the person with an eating disorder from developing and feeling confident about her own emotional intelligence. Peacemaking should not be at the cost of truth. Walking on eggshells may only serve to maintain the illness.

We end the session by small group discussions about the carers' coping model and whether they recognise that demands of this model are relevant to them.

Session 2

In the beginning we review what it is about their own situation that contributes to high stress levels. The small group work focuses on their needs, and how to increase their coping skills. In many cases, this involves taking a step back with less of an intensive, full on response. The workshops give carers both the opportunity and permission to think of themselves as individuals with their own needs. Professionals and other carers provide a safe context to consider taking time off from the caring role, and to fit in activities that are rewarding and pleasurable. We emphasise that a distressed carer is a less effective carer. Furthermore, they need to model self nurturing behaviours for their offspring.

This early phase allows for re-evaluation of their caring behaviour and whether they might want to change. This process of thinking about the importance of changing to a different pattern of interaction with anorexia nervosa and whether they can be confident that they can do so, is a paradigm which also helps them to understand the process that their relative may undergo to change anorexia nervosa behaviours.

At the beginning of every session the facilitators elicit feedback from the previous session to enhance reflection and integrate meaningful information. We may, for example, ask participants to tell us one thing they learnt from the last session or one new behaviour that they had to put in place after the last session.

The next session starts with a discussion of the array of possibilities about how they might set about changing their relationship with the eating disorder. We teach and practice the technique of externalising the illness. This serves to correct some of the common misattributions about the illness such as "she is just doing it to annoy" or "because she is stubborn and naughty etc". We then discuss possible ways in which the eating disorder might control the family, by discussing how some families accommodate their behaviour to allow or maintain OCD rituals, or become controlled by the eating disorder. We then discuss and validate the splits, hostility and anger that commonly arise. Finally we end with a description of the trans-theoretical model of change.

Carers are then split into small groups to reflect on their readiness to change, using the readiness ruler, a tool designed to elicit change talk. They are often surprised to become aware of their own mixed feelings. Often they recognise the disparity between their ratings of importance to change and confidence in their ability to instigate change. They might, for example, recognise that by accommodating their daughter's rigidity about what she will eat, (e.g. only Waitrose's tinned celery), they may not be helping her fight the anorexia nervosa. Nevertheless, they are terrified of rocking the boat and whether they will be able to cope with the backlash.

We close the session by having carers undertake small group work, in which they reflect on their readiness to change some of their behaviours in relationship to the eating disorder, considering the pros and cons of change. This involves thinking about the two constructs of importance and readiness to change.

Session 3

In this session the focus is on developing good communication skills including, listening skills, the ability to understand non-verbal aspects of communication and developing the skill of making understanding statements in reflective listening. We use demonstrations and role plays based on carers' own experiences, to facilitate this key aspect of the workshops. We also analyse transcripts of carer/eating disorder interactions, as it can be easier to read and plan this new language of listening and reflection before being competent at speaking it.

Carers practise using elements of positive communication, such as solution focused questioning, within the safety of small groups. We teach reflective listening skills, using the principles enshrined in OARS - open questioning, affirmation, reflection and summaries. Many carers find that this new pattern of interaction is extremely liberating, albeit not always easy to master. Carers use these techniques to explore their own mixed feelings about changing the way they interact with the eating disorder. Carers reflect on both their own and their offspring's readiness to change and what any discrepancy means for the relationship regarding how they manage anorexia nervosa. This third workshop session ends with a discussion about how to match interventions with the stage of change. Again, we use the principles of adult learning, in that once a concept has been defined, carers examine how this fits with experiments in their own environment. Observations are reflected back to the group. A step to change their own behaviour is made on an experimental basis and they analyse and reflect on the implications. We introduce the concept of expressive writing as a means of deepening and tracking their progress. The narratives can help them step back, take an overview and see things from a different perspective.

Session 4

The aim of this session is to develop more advanced motivational interviewing skills. Thus, carers are introduced to the skills of tracking micro emotions and using complex reflections to deepen the meaning and increase the valence of their emotional reflection which, in turn, improves empathy. Another important skill is how to roll with resistance by sidestepping eating disorder talk and not entering into arguments. We teach carers how to move from the detail of the eating disorder into a bigger picture by framing the conversation within the context of the life course and core values. Carers learn to use the skills embodied in the acronym DARN (eliciting the desire, ability, reasons and need for change). The final aim is for carers to expose any

ambivalence their offspring might have about the eating disorder and increase the discrepancy between the current position and bigger ideals. By the end of this session, we hope that carers have started to commit themselves to some plan to change their own behaviours.

Session 5

In this session we move carers on from thinking about changing their own behaviours and interactions with the eating disorder onto tackling how they can foster change in eating disorder behaviours themselves. The theory underpinning behaviour change is explained. Carers are taught to observe the conditions that increase or decrease the likelihood of an unwanted behaviour. They move from this to undertake a functional analysis; in other words, to examine the antecedents and consequences of the behaviour. The functional analysis of problematic eating disorder scenarios leads into discussion about problem solving. In small groups, carers apply the skills of motivational listening by using OARS and DARN, in order to encourage a commitment to setting goals towards some small behaviour change. Group work focuses on negotiating these changes in eating behaviours, increasing the importance and confidence that change can take place as well as making a plan for an “experiment”. Coaching is used to set, implement and review goals.

Session 6

In the final session, we rehearse changing some of the other eating disorder behaviours such as obsessive compulsive behaviours, temper tantrums, self harm etc. Obsessive compulsive symptoms have consistently been found to impact on the outcome of anorexia nervosa. Consequently, it is important that we help parents modify this key maintaining symptom.

We teach parents key elements of change in obsessive-compulsive disorder (OCD). First, we explain how extremely difficult it is for people with OCD not to undertake their compulsions as any attempt to interrupt them, results in high levels of anxiety. Following any change in behaviour, there needs to be enough time to habituate to the feared situation so that the levels of anxiety can tail off. Part of the problem with working with people with OCD and AN, is that it seems to be very difficult to unlearn some of these reactions. People who have successfully gone through this process describe it as “going through hell” needing “blood, sweat and tears”. Carers may find it difficult to tolerate such distress and they will be tempted to cave in and interrupt the process. Carers, therefore, need to understand the rationale and the expected effects of treatment.

It is important that parents know that reassurance seeking is counter-productive. Often it can be helpful to have a formal written contract, which gets signed before the implementation of a plan to tackle OCD behaviour. A key point must be that the task is not changed at all. There will be pressure from the person with OCD, who will find loopholes to avoid doing the task in order to escape from the severe anxiety. Carers need to be able to accept some of the weird thoughts and not try to argue against them by saying that they are stupid, unreasonable or irrational etc. A gradual step-by-step approach with small goals is usually effective. Finally, this session also includes a basic review and quiz.

Coaching protocols

This intervention has been used as a form of guided self care to supplement self help material. The guidance can be used in face to face or telephone setting.

Session 1

The aim of the first session is to focus on the carer's self-reflection on their current behavioural and emotional responses to the illness. The coach broaches the possibility that carer responses can sometimes play a role in maintaining or aggravating the illness. The carer is then asked for their feelings on this. Through the use of motivational techniques the carer is then encouraged to use this information to reflect on their own responses in guiding their goal setting and action planning. The session follows a semi-structured format but generally the main objective of the session is for the carer to think about the animal(s) he/she best reflects, along with any useful strategies for behaviour change utilizing the techniques and tools in the materials. Towards the end of the session, the carer is asked what goals he/she can think of that they can experiment with for next session. Carers are encouraged to set specific, achievable and realistic goals that can be attempted in a timely manner, i.e. ones that are not likely to set them up for possible failure but those that can also challenge the behaviours in an appropriate manner. Examples of questions for the first session include:

- Thinking about the animal model, which animal would you choose for yourself?
- Have you noticed in what way this seems to help or hinder your relationship with Edi ?
- What do you need to change in your behaviour?
- Can you give me an example of your rhinoceros/ostrich/jellyfish behaviour?
- How important do you think it is that you change?

The following transcript exemplifies a typical excerpt from the first session where the coach and the carer engage in 'change talk'. We have illustrated the process elements that are being used which in this vignette case is all open questions. It would be better practice to have reflections interspersed with open questions. A rule of thumb in motivational interviewing is not to ask more than 3 questions in a row.:

Coach: What were your feelings on the animal analogies? (Open question)

Carer: Well, I can see very much, em where I fit in and I'm overly protective and em, you know, that I need to change my approach to be more like the dolphin and less like, is it the kangaroo?

Coach: The kangaroo. Can you give me any examples of kangaroo behaviour? (Open question)

Carer: Well always sort of fretting, always em always making her feel that she can't make decisions of her own back any more, about all sorts of things, not just about food but particularly about food, you know? I have to be the one who decides what she's going to eat. If, on the rare occasion, we do go out and she's faced with a menu, she can't make a choice of her own back. She has to ask me. I

have to, you know, decide for her and I think what I've got to do is try and stop doing that sort of say to her, 'well you've got to decide for yourself'...

Coach: Leaving the food talk to the side for a moment, can you think of any ways you can allow her to make decisions outwith the ... outwith the eating? You said you tend to make decisions in all areas of her life. (Open question)

Carer: Well because she's not really doing very much, its quite hard to sort of see how I can but I suppose really its just a way of encouraging her to try and get more involved in things outside of home and the illness and try and make arrangements to actually go out and see people and do things... I mean the exercising thing is a big problem for us because she goes mad with it and that's all she really wants to do so I need to try and encourage her to do other things

Coach: How important do you think it is for you to stop the kangaroo behaviours? (Open question)

Carer: Well I can see that if I want her to change her attitude then I probably need to change mine...

Session 2

The second session begins with the coach asking for a brief outline of how things have been going since the previous session. Goals are discussed and whether or not they were achieved. If they were not achieved, the coach will then ask what has been going well. In most cases, there are some green shoots ! If the carer finds it difficult to name any, then the coach will help out by reiterating the positives from last session. The motivational spirit is maintained at all times.

Meanwhile, the aim of the second session is to establish that the carer understands the concept of change in relation to whatever particular stage of change their son or daughter is in. If the carer has difficulty coming up with their own ideas to promote change in their loved one, then the coach asks permission to offer a list of strategies in whichever stage of change applies to their specific situation (precontemplation/contemplation strategies etc). Examples of questions and reflections from a typical second session include the following:

- What strategies or action plans can you make to help encourage your daughter to (further) contemplate change thoughts?
- Does the model of tailoring what you do to match her stage of change make sense?
- Were you able to use open questions? If so, can you give me an example?
- Sounds like you're saying that you feel your unassertive behaviour is interfering with your ability to try out some of the techniques.
- It sounds like you've gone out of your way again and again to try and make things work for your son. What are the green shoots that make you feel a little bit confident?

In the following two excerpts we can see the coach using open questions and reflections in addressing problematic communication (#1) and encouraging change talk #2:

EXCERPT #1: PROBLEMATIC COMMUNICATION

- Carer:* she wants to pack up her job and do a diploma in art which I don't see as a problem but she's never done art, you know and I'm thinking, 'well I don't see how you're going to get on an art course if you've not got a portfolio or anything like that' because me as a person I'm very ...I like to have all the facts I can to make a decision on. I would never just think 'oh I'm going to just pack my job up and do it. I'd have to look at all the pro's and con's and she said 'well you are never ever enthusiastic about anything I do and she really got really nasty.....really nasty and I just sort of said 'well I'm sorry but you know by now, I have to have all the facts ...and she was very nasty....'oh it's all your fault'....
- Coach:* The last time we spoke you described yourself as a pessimistic person by nature..... (**Complex reflection**)
- Carer:* Well I wouldn't do anything rash and I have to say I'm torn because if that's what she wants to do and its going to be good for her then yes, she ought to do it but on the other hand, the organized part of me says how's she actually going to do it, how's she going to fund it, if she gives up her job where's the money coming from.. you have to think of the practicalities but I can't say that because she then accuses me of being negative....
- Coach:* What would happen if you said 'fair enough that sounds like a fantastic idea'.....how do you think she would respond? (**Open question**)
- Carer:* She'd probably turn around and then She'd probably be OK probably..... She would have probably looked at it em ...but that's just me, its probably my fault but I can't be because I wouldn't be for anything. Its just not my nature to be like that...

EXCERPT #2: ENCOURAGING CHANGE TALK

- Carer:* so if I go back to work after her exams, I'm just concerned that she's got the whole of the summer on her own in the house. She has already said 'I know I'm not good on my own, I want to be as busy as possible and see as many people as possible' but when she wakes up and she's feeling low and subdued, the last things she's sort of thinking about is motivating herself to get out. Its sort of me saying 'well go on....you're going to go out, lets go for a walk....'
- Coach:* The statement, 'I don't do well on my own, I want to keep myself as busy as possible' sounds interesting. What open question could you use to pass a certain amount of responsibility and control for her well-being back to her again? (**Open question**)
- Carer:* Well I suppose I could have asked her what sort of ways did she have

that she could keep herself busy

Coach: That sounds like a fantastic open question (Affirmation)

Carer: and start planning for that really – I think we need to start thinking about that really...some action planning...

Session 3

The third session again starts with a brief summary of the situation, positives, difficulties encountered and how these were dealt with. The main aims of this session is to, first of all, clarify basic psychological rules and strategies that can be used in thinking about behaviour change using the ABC (antecedent-behaviour-consequence) functional model of analysis and to recap on understanding of previous DVDs. Carers sometimes find the ABC model difficult to implement in the home, so with the help of the role play scenarios from the DVD, the coach and carer may use this session to discuss the triggers that lead to problematic behaviours. These may be “high risk” environmental factors, such as people, places and other occasions that spark off a certain behaviour. Triggers can also be internal, the sufferer’s thoughts and feelings that can precede, for example, a binge. It can be beneficial to explore the antecedents because in doing so, it can help carers and sufferers realize that the problem behaviour is influenced by reasonably predictable external and internal factors. The consequences of colluding with or attending to a problematic behaviour may also be discussed. Examples from the third session could include the following:

- What do you think your daughter is *thinking* about right before a binge?
- What do you think she is usually *feeling* right before a binge?
- Can you think of any ideas as to how you can nudge your daughter forwards in any of these areas?
- If you were advising a friend, what would you tell her?
- What consequences are *you* avoiding?
- How do you feel about making those changes?

In the final extract, we look at setting boundaries for unacceptable behaviour and how the coach works with the carer through the use of reflective listening and open questions, to encourage her to come up with her own solutions and plan of action to address the unacceptable or maladaptive behaviour:

EXCERPT #3: SETTING BOUNDARIES FOR UNACCEPTABLE BEHAVIOUR

Carer: I don't see how to get over this hurdle of her pacing up and down when I visit her in hospital

Coach: Right...so this is the behaviour you would like to tackle (Closed question)

Carer: Certainly that one...I mean I guess she could have a heart attack at any moment but it's not just that – she's in a dangerous place... which is why she's supposed to be on bed rest

Coach: So what are your choices? (long pause)..... (Open question) You sound to me frightened that she's doing all this pacing, because there's the risk to her heart (Complex reflection)

Carer:and also it's the travesty of the relationship we've had up until now. Its like that 'naughty toddler' and the way to deal with a naughty toddler is to draw the boundaries and yesterday I was allowing it to continue and I felt I shouldn't have done...we were doing a crossword which we both enjoy and it was a case of colluding with em ...she was pacing up and down and I asked her not to and she just ignored me and I felt, you know, I'm colluding in it

Coach: and you left (Closed question)-A more MI adherent response would be: I am impressed that you are reflecting on interactions in terms of the ABC framework- this is an affirmation and a complex reflection

Carer: No I didn't

Coach: OK You didn't leave. (Closed question)

Carer: The first time I did but I'm not putting up with it any more...I think that's what I've decided ...I'm not putting up with it any more...I suppose I can go and just leave

Coach: The problem is when we tolerate difficult behaviours, it makes it easier to keep doing the same behaviour (complex reflection)- it would have been preferable if the coach had added more affirmation and highlighted the lesson to be learnt -eg You have reflected on interactions using the ABC framework and you plan to change some of the consequences as an experiment to examine if it will help change the behaviour you find unacceptable.

Carer: Exactly yeah...I've decided I'm not putting up with it...so that's my choice. I'm going to write to her and say that I find it unacceptable. I will come to visit but if you do that then I will leave immediately. I think that's what I'll do. That feels right.....

Coach. It is a really good idea to give some warning about how your behaviour will change and what you will and will not accept- a letter can help make it clear. (affirmative complex reflection)

These vignettes illustrate how the coach can use MI principles to coach the parent through behaviour change.

The following section includes accommodating and enabling scale and the eating disorder specific problem scale. These can be used as prompts to structure a discussion of the families reaction to the ED

Appendix A: Accommodation and Enabling Scale

Name:.....Date.....

The following items contain a number of statements that commonly apply to the family members who live with a relatives or friends with an eating disorder. We would like you to read each one and decide how often it has applied to your family members over the **past one month**. It is important to note that there are no right or

Items -During the past month how often have you thought about:

0 = never
1 = rarely
2 = sometimes
3 = often
4 = every day

Factor 4: Control of Family

Does your relative with eating disorder control:

PLEASE

CIRCLE

1.	the choices of food that you buy?	0	1	2	3	4
2.	what other family members do and for how long in the kitchen?	0	1	2	3	4
3.	cooking practice and ingredients you use?	0	1	2	3	4
4.	what other family members eat?	0	1	2	3	4

Factor 2: Reassurance Seeking

Does your relative engage any family member in repeated conversations:

5.	asking for reassurance about whether she/he will get fat?	0	1	2	3	4
6.	about whether it is safe or acceptable to eat a certain food?	0	1	2	3	4
7.	asking for reassurance about whether she/he look fat in certain clothes?	0	1	2	3	4
8.	their ingredients and amounts, possible substitutes for ingredients?	0	1	2	3	4
9.	about negative thoughts and feelings	0	1	2	3	4
10.	about self-harm	0	1	2	3	4

Factor 3: Meal Context Ritual

Do any family members have to accommodate to the following:

11.	what crockery is used?	0	1	2	3	4
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12.	how crockery is cleaned?	0	1	2	3	4
13.	what time food is eaten?	0	1	2	3	4
14.	what place food is eaten?	0	1	2	3	4
15.	how the kitchen is cleaned?	0	1	2	3	4
16.	how food is stored?	0	1	2	3	4
17.	the exercise routine of the relative with an ED?	0	1	2	3	4
18.	your relative's checking their body shape or weight?	0	1	2	3	4
19.	how the house is cleaned and tidied?	0	1	2	3	4

Factor 5: Blind Eye

Do you choose to ignore aspects of your relative's eating disorder that impinge your family's life in an effort to reconcile or make it tolerable for the rest of the family such as if:

20.	food disappears?	0	1	2	3	4
21.	money is taken?	0	1	2	3	4
22.	the kitchen is left a mess?	0	1	2	3	4
23.	the bathroom is left a mess?	0	1	2	3	4

Factor 1: Avoidance & Modifying Routine

24. In general, to what extent would you say that the relative with an eating disorders controls family life and activities?

None at All *About Half*
Completely

0 1 2 3 4 5 6 7 8 9 10

To continue answering the questionnaire, please bear in mind the following:

4. Over the past one month.

<p>0 = never 1 = 1-3 times/month 2 = 1-2 times/week 3 = 3-6 times/week 4 = daily</p>
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25. How often did you participate in behaviours related to the your relative's compulsions? 0 1 2 3 4

26. How often did you assist your relative in avoiding things that might make her/him more anxious? 0 1 2 3 4

Over the past one month.

<p>0 = no 1 = mild 2 = moderate 3 = severe 4 = extreme</p>
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27. Have you avoided doing things, going places, or being with people because of the your relative's disorder? 0 1 2 3 4

28. Have you modified your family routine because of the 0 1 2 3 4

	your relative's symptoms?					
29.	Have you modified your work schedule because of the your relative's needs?	0	1	2	3	4
30.	Have you modified your leisure activities because of the your relative's needs?	0	1	2	3	4
31.	Has helping your relative in the before mentioned ways cause you distress?	0	1	2	3	4
32.	Has your relative with an eating disorder become distressed/anxious when you have not provided assistance?	0	1	2	3	4
33.	Has your relative become angry/abusive when you have not provided assistance?	0	1	2	3	4

Accommodation and Enabling Scale (AESED) OVERALL score(0-132)

Avoidance& Modifying R. (0-40)= Items 24 + 25 + 26 + 27+ 28+29+30+31+32+33

Reassure Seeking (0-32)= Items 5 + 6 + 7 + 8 +9+ 10 + 17 + 18

Meal Context Ritual (0-28)= Items 11+ 12+ 13+ 14+ 15+ 16+ 19

Control of Family (0-16)= Items 1 + 2 + 3 +4

Blind Eye (0-16) = Items 20+ 21+ 22+23

Appendix A: Eating Disorders Symptom Impact Scale (EDSIS)

Name:.....Date.....

The following pages contain a number of statements that commonly apply to persons who care for relatives or friends with an eating disorder. In some stems we use the word EDI as a short hand for the individual with an eating disorder We would like you to read each one and decide how often it has applied to you over the **past one month**. It is important to note that there are no right or wrong answers. Also, it is best not to spend too long on any one statement. Your first reaction will usually provide the best answer.

Items	Never	Rarely	Some - times	Often	Nearly Always
<i>-During the past month how often have you thought about:</i>					
1. How your friends/relatives have stopped visiting.....	0	1	2	3	4
2. Losing your friends.....	0	1	2	3	4
3. Feeling unable to go out for evenings, weekends or on holiday.....	0	1	2	3	4
4. Cancelling or refusing plans to see friends or relatives.....	0	1	2	3	4
5. Regret that I did not act before it became so bad.....	0	1	2	3	4
6. Feeling that I have let her/him down.....	0	1	2	3	4
7. Feeling that there could have been something that I should have done.....	0	1	2	3	4
8. Thinking that perhaps I wasn't strict enough.....	0	1	2	3	4
9. Thinking about where I went wrong.....	0	1	2	3	4
10. Edi being physically and/or verbally aggressive....	0	1	2	3	4
11. Edi being controlling/manipulative.....	0	1	2	3	4
12. Edi lying/stealing.....	0	1	2	3	4
13. Edi exhibiting an out of control temper.....	0	1	2	3	4
<i>- When the sufferer was living with you at home during the past month, how often:</i> (if the sufferer was not living at home with you during the past month, please refer to					

19 Janet Treasure Notes on Working with the Families of adult eating disorder patients 22/10/2008

the last time she/he was living at home)					
14. Did you experience difficulties preparing meals (i.e. making separate meals for family members, not having correct ingredients)?	0	1	2	3	4
15. Were there arguments with other family members about how to handle mealtimes?	0	1	2	3	4
16. Were there arguments or tension during mealtimes?	0	1	2	3	4
17. Did food disappear from the cupboards?	0	1	2	3	4
18. Did you spend long periods of time shopping for food?	0	1	2	3	4
19. Did you have difficulties with blocked drains, plumbing?	0	1	2	3	4
20. Were there bad smells and hygiene in the bathroom?	0	1	2	3	4
21. Did you have to turn up the heat due to her/him feeling cold?	0	1	2	3	4
22. Did you check on her/him to ensure that she/he was "okay"?	0	1	2	3	4
23. Did you notice or think about how the illness was effecting her/him physically (i.e. see her/him fall, faint, struggle up the stairs)?	0	1	2	3	4
24. Did you notice or think about how the illness was affecting her/him mentally?	0	1	2	3	4

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