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Parent Coaching Model for Adolescents With Emotional Eating

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A significant proportion of both healthy and treatment-seeking youth report eating for emotional reasons. Emotional eating (EE) is associated with medical and psychological sequelae including overeating and eating disorder symptoms. Youth with EE are thought to have a predisposition toward a high level of emotional sensitivity, with a tendency to experience emotions intensely, and for a long duration. Interventions are needed to address emotion dysregulation associated with EE. Parent-focused interventions that emphasize training parents to respond to emotion dysregulation in their children have the potential to reduce the incidence of EE. This article describes an emotion-focused parent training intervention for youth who engage in EE.

INTRODUCTION

A common dysfunctional eating behavior is emotional eating (EE), or eating in response to negative emotional states, as 15–43% (Jaaskelainen et al., 2014; Nguyen-Rodriguez, Unger, & Spruijt-Metz, 2009) of healthy adolescents and 63% (Shapiro et al., 2007) of treatment-seeking youth report EE. Youth who eat for emotional reasons may eat in response to feelings of anger, anxiety, frustration, or depression (Tanofsky-Kraff et al., 2007) and EE may function as an escape from negative affect (Heatherton & Baumeister, 1991). EE is associated with overeating (van Strien, Engels, Leeuwe, & Snoek, 2005), eating disorder symptoms (Goossens, Braet, Van Vlierberghs, & Mels, 2009), and depression, anxiety, and appearance overvaluation (Stice, Presnell, & Spangler, 2002).

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Based on the biosocial model (Linehan, 1993), youth with EE are thought to have a predisposition toward a high level of emotional sensitivity, with a tendency to experience emotions intensely, and for a long duration. Coupled with an environment that mismatches responses to emotional experiences, an adolescent with a high level of emotional sensitivity may not effectively learn how to regulate emotions, increasing the likelihood of EE. Consequently, when experiencing negative emotions, adolescents who do not have adaptive emotion regulation skills may resort to EE as a way of reducing negative affect.

Parents are considered central to the treatment of adolescent eating disorders (Le Grange, Lock, Loeb, & Nicholls, 2010). In terms of the treatment of youth with EE, parental involvement has the capacity to increase the efficacy of interventions for EE. To date, no parent-focused treatments have been studied specifically for youth who emotionally eat. The role of parents in the treatment of youth with EE should be considered within the biosocial framework of emotion dysregulation, which describes emotion regulation difficulties as occurring because of both biological and social influences (Linehan, 1993). Parents may simply lack an understanding of their child's emotional vulnerability and as a result, fail to adopt a response set that is appropriate for someone with high emotional sensitivity. Thus, this unique biosocial vulnerability predisposes an adolescent to experience emotional arousal that can lead to maladaptive coping behaviors such as EE. Considering these findings, it is possible that a unique interpersonal skill set may be necessary to successfully interact with adolescents who are vulnerable to emotion dysregulation and EE.

Parents of youth with EE may require education on underlying causes of EE and more importantly, training on appropriate emotional responding. A parent intervention focused on teaching parents to successfully respond to and interact with their child's emotional experiences could potentially mitigate emotion dysregulation and thereby decrease episodes of EE. Promoting parenting practices that facilitate appropriate emotional processing may enhance an adolescent's ability to cope with future emotional challenges in constructive ways rather than through dysfunctional behaviors such as EE (Greenberg, 2002). Furthermore, an intervention focused on tailoring emotional responding to prevent EE episodes, rather than intervening directly on EE episodes may more appropriate for adolescents, where direct intervention may pose negative consequences or be rejected (Liddle, Rowe, Dakof, & Lyke, 1998).

Thus, we have developed an intervention based on underlying theoretical principles of emotion-focused therapy (EFT) and adapted from emotion-focused family therapy (EFFT) (Greenberg, 2004; Lafrance Robinson, Dolhanty, & Greenberg, 2013). EFT was originally designed for depression (Greenberg & Watson, 2006), and focuses on facilitating appropriate emotional processing by guiding individuals through emotional experiences

in a way that facilitates learning to interact with their emotional landscape in healthy ways (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg, Warwar, & Malcom, 2008; Greenberg & Pascual-Leone, 2006). Greenberg (2002) posits that in childhood development, caregivers can influence healthy emotional development by the way in which they respond to their child's emotions. Caregivers who are attuned to their child's emotions and who respond to the array of emotions in validating and corrective ways promote healthy emotional functioning through the lifespan. On the contrary, maladaptive or mismatched responses can lead to unhealthy emotional coping styles and dysregulation. EFFT, developed from this model, represents a family-focused intervention to improve emotional transactions between children and their caregivers. EFFT positions parents as their child's "emotion coach" and seeks to teach caregivers effective methods for recognizing and responding to emotional experiences (Lafrance Robinson et al., 2013). Models of EFFT show preliminary promise for use with eating disorders (Lafrance Robinson et al., 2013; Lafrance Robinson, Dolhanty, Stillar, Henderson, & Mayman, 2014). This model may be particularly suitable for parents of youth with EE, where appropriate parental responses could prevent or reduce emotion dysregulation and thereby decrease vulnerability to EE.

TREATMENT

Overview

Emotion-focused parent training for youth with EE (EFPT-EE) facilitates the positioning of parents as their child's "emotion coach." Parents are guided to understand overeating episodes as a function of emotion dysregulation. The aim of the parent intervention is to learn to successfully intervene with overwhelming emotional experiences (considering the unique biological and social vulnerabilities of children with emotion regulation difficulties), to mitigate EE episodes. Parents are empowered to view their role as pivotal in preventing and intervening on emotion dysregulation by reciprocating with corrective responses that serve to "down-regulate" or "re-regulate" emotion dysregulation. This process is explained as a primary and critical method for preventing the use of maladaptive behaviors, in this case EE, to control or thwart emotional experiences.

This rationale positions parents to adopt the stance that children with emotion regulation difficulties require "emotion coaching" and that they must become an emotion coach by learning a unique emotional skill set to assist their child. In EFPT-EE, parents are led through progressive steps to becoming an emotion coach based on Greenberg's model (2002, 2004) of emotion coaching, which includes (a) attending to emotional experiences by acknowledging their presence, (b) labeling the emotion, (c) validating

the emotional experience, and (d) meeting the emotional need. Parents are taught the multiple roles that they must play in coaching adolescents, which include using corrective emotional responding, modeling, problem solving, and facilitating skills usage. Most importantly, the role of emotion coach is framed as a method for responding to a dysregulated emotional style explained using the biosocial model.

Structure

EFPT-EE consists of eight sessions and is conducted in a parent-only format. EFPT-EE can be delivered to parents in either a group or individual format. Group interventions have the benefit of making use of potent group effects including parent-to-parent consultation, comradery, and the ability to observe and learn from others. An individually delivered treatment allows for more opportunity for tailoring the interventions to each particular participant. Our clinical laboratory has delivered the interventions in both formats, and to date, adherence and retention rates suggest that both treatments are feasible and acceptable. The program can be run as a stand-alone treatment, or alongside adolescent-focused interventions of interest of this population, such as dialectical behavior therapy (DBT) or behavioral weight loss. Indeed, due to focus on emotion dysregulation, EFPT-EE is highly suitable to be run in conjunction with adolescent-only or multi-family DBT skills training. When run in tandem (EFPT-EE and DBT), the treatments represent a comprehensive model where adolescents learn positive coping skills to self-intervene and simultaneously, parents learn skilled ways of intervening with their adolescent to further reduce the risk of EE.

Target Population

EFPT-EE is appropriate for parents of adolescents between the ages of 13 and 17 years old who engage in maladaptive coping behaviors in an effort to control or manage emotions. Although the protocol was developed to address EE specifically, because of the emphasis on emotion dysregulation as the underlying theoretical cause and primary point of intervention, the protocol can be easily adapted to address other issues of emotion dysregulation that present in adolescence such as self-harm, substance use, and suicidality. Since EE occurs as a result of emotion dysregulation, it is likely that adolescents of participating parents will also present with other comorbid issues stemming from emotion dysregulation difficulties. Due to the focus on intervening on emotional arousal in general, comorbidities do not preclude the participation of a parent-adolescent dyad with multiple presenting issues. Participating caregivers can be any adult in a caregiver role who is present to assist with emotional episodes, and preferably one that is living in the same household.

Treatment Description

The focus on EFPT-EE is on positioning parents as their child's emotion coach. In the first two sessions, the focus is on providing a theoretical rationale for learning a unique skill set for emotional responding using the biosocial framework. Parents are oriented to potential biological and social vulnerabilities that predispose their child to become emotionally aroused, and EE is explained as a maladaptive response to being emotionally overwhelmed. This is done to mobilize parents to take action in a nonjudgmental and empathic manner.

With this rationale, parents are presented with a step-by-step model to becoming an effective emotion coach. Each session is focused around one sequential step to becoming an emotion coach. Steps include: (a) understanding the multiple roles involved in caregiving an adolescent and their function in intervening on EE's; (b) self-assessing emotional response tendencies; (c) identifying and attuning to adolescents' emotions; (d) using empathy and validation; and (e) using specific corrective responses for each emotion.

Parents are taught a method for emotional responding by "attuning, intervening, assessing, and re-intervening." In this model, parents learn the importance of recognizing slight behavioral and cognitive indicators of emotion so that they are attuned to the initiation of even a low-level emotional experience within their child. They use learned response sets (specific to particular emotions) to attend and respond to emotional reactions, and are taught to self-assess their efficacy in down-regulating emotional experiences, and lastly, to continue to intervene if necessary. Parents are taught effective ways to respond to specific emotional experiences, with an emphasis on the primary emotional triggers of overeating which can be a wide array of emotions, but most often include anxiety, sadness, loneliness, tiredness, and anger (Masheb & Grilo, 2006). Additionally, they are taught empathy and validation and encouraged to use these skill sets as a ubiquitous foundation for emotional responding. Lastly, lessons focus on teaching parents how to anticipate the emotional needs of their child through the use of sincere empathy and then to choose a response that appropriately matches their child's emotion. Specific skills sets that serve as antidotes to negative emotions are then taught and practiced as a way to facilitate a corrective emotional experience, such as responding to sadness through soothing, or anxiety through the demonstration of safety. Skills sets include training on appropriate verbal, nonverbal, and behavioral response sets for each particular emotion. In parallel, parents are led through activities that build awareness of their particular emotional response tendencies that are rooted in their own biosocial history and past emotional experiences (Lafrance Robinson et al., 2013). Additionally, this traditional model of emotion coaching is bolstered by teaching parents to (a) problem-solve with their child (Lafrance Robinson

et al., 2014), (b) model usage of appropriate methods of managing emotional experiences in their own lives in the presence of their child, and (c) use regular family meetings and reflective questioning after unsuccessful episodes to guide improvements in emotion coaching (See [Table 1](#) for list of sessions).

CASE EXAMPLE

Mia was a 16-year old female of Samoan origin. Mia and her biological aunt Grace, who was her primary guardian, signed up for EFPT-EE after her aunt noticed extreme episodes of binge eating that seemed to be triggered by familial and social stress. Mia was obese, with a BMI in the 99th percentile for girls her height and age. Grace reported that Mia had gained over 30 pounds in the past 2 years. She reported that the weight gain occurred as a result of “stress eating,” which began when Mia’s mother was placed in jail for theft. Grace assumed legal custody of Mia due to parental neglect resulting from her mother’s issues with substance use. Mia met criteria for major depressive disorder and binge eating disorder, and reported that she ate in response to feeling sad and anxious. Prior to EFPT-EE, Grace had made attempts at helping Mia control her eating by ensuring a healthy home environment and minimal access to unhealthy foods. Despite this, she reported that Mia continued to gain weight and engaged in binge eating at school. Grace was unsure how to help Mia, and furthermore, was accustomed to her new role as a parent figure for Mia. She stated that Mia was erratic in her emotions, often irritable or alternatively “shut-down,” where she isolated herself and refused to speak about what she was feeling.

During initial sessions of EFPT, Grace learned that Mia was likely engaging in binge eating as a way to manage her emotions. She learned that social experiences, such as Mia’s history of familial stress including extreme neglect by her mother, likely contributed to her lack of ability to manage or tolerate emotions. Grace reported often that Mia self-proclaimed that she “doesn’t do emotions” and appeared to be very uncomfortable expressing any emotional experiences. Likewise, throughout EFPT sessions, Grace also learned and reflected on her difficulty in tolerating Mia’s emotions due to her propensity to be someone more comfortable with reason and logic, rather than the emotional realm. Throughout the time in the program, Grace reflected on how she was often not able to identify what Mia was feeling, and further how uncomfortable she felt when Mia expressed emotion due to her lack of experience with parenting a teen, as well as her own upbringing. By reflecting on this, Grace realized that her discomfort often led her to avoid or escape when she felt Mia was experiencing a negative emotion. Initially, Grace was led through skills to learn to more accurately use the signs that Mia was showing to identify specific emotional experiences that she was having. Through this practice, she learned that Mia was often sad, and that her primary ways of

TABLE 1 List of Sessions in the Emotion Focused Parent Training for Emotional Eating (EFPT-EE) Program

#	Topic	Primary objectives
1	Parenting a teen with emotion dysregulation	<ul style="list-style-type: none"> • The biosocial model of emotion dysregulation • Review implications for parenting • Introduce model of emotion coaching to prevent EE (via emotion regulation)
2	Parenting an adolescent with EE: The multiple roles of caregivers	<ul style="list-style-type: none"> • Review primary parenting roles (teammate, facilitator, psychologist, enforcer, role model) • Discuss specific interventions for EE related to multiple roles • Facilitate parent reflection on ways use each role effectively
3	Know your own response tendency	<ul style="list-style-type: none"> • Review common models of parent response tendencies to adolescent emotional arousal using metaphorical animal models • Facilitate reflection on typical response tendencies and desired change • Present an ideal model of emotion intervention (using metaphorical animal model)
4	Staying attuned: Becoming an emotional detective	<ul style="list-style-type: none"> • Identify emotions that trigger EE • Learn cognitive, verbal, facial, and behavioral characteristics associated with specific emotional experiences • Practice recognizing low level emotional experiences and common triggers
5	Empathy: Seeing your child's emotions from his/her shoes	<ul style="list-style-type: none"> • Frame negative emotions as an opportunity for intimacy and teaching • Review function of responding empathically • Facilitate an imaginal exercise to build empathy • Direct parents to use empathy to guide their response sets to emotional experiences
6	Using validation to down-regulate emotion experiences	<ul style="list-style-type: none"> • Explain validation as the behavioral expression of empathy • Frame validation as the core universal response to emotional experiences • Review levels of validation • Practice validation
7	What does my teen need? Corrective responses to specific emotions	<ul style="list-style-type: none"> • Introduce a parent response class for each emotional trigger of EE (cognitive, behavioral, nonverbal, verbal) • Review validation as common element • Teach specific response class for each emotion (anxiety, sadness, boredom, guilt, shame)
8	Being an effective emotion coach	<ul style="list-style-type: none"> • Provide an integrative model of emotion coaching by combining all steps • Review comprehensive emotion coaching model • Facilitate continued practice of integrative model

showing sadness were by becoming quiet and isolating. Grace was surprised to learn that this was in fact sadness, having previously assumed that Mia was angry when she displayed this type of behavior. Next, Grace practiced using more validating responses to Mia's sadness after recognizing that her escape tendencies were likely very invalidating to Mia. Grace was taught appropriate ways to respond to sadness through soothing. She learned that in fact Mia craved physical affection and that her presence during Mia's episodes of sadness significantly reduced her negative emotionality. In addition to Grace attending EFPT-EE sessions, Mia participated in a coping skills training group and one-on-one behavioral monitoring sessions with a therapist. Throughout the time she was in treatment and through Grace's continuous practice and application of these skills, Mia lost 15 pounds without any specific dietary intervention. Mia reported using skills independently, but maintained that the most effective tool was being able to rely on her aunt for emotional support.

CONCLUSION

EFPT-EE is a parent-focused model which targets parents effectively responding to their child's emotions to avoid emotional over-arousal that leads to maladaptive eating behaviors. EFPT-EE considers the biological and social vulnerabilities that predispose particular youth to eat in response to emotion and positions parents as critical agents of change in reducing not only EE, but emotion dysregulation in general. EFPT-EE is adapted from EFFT, which has demonstrated preliminary promise in youth with eating disorders. However, despite a robust clinical and theoretical rationale for emotion-focused training as a point of intervention for youth with EE, more research is needed to determine the effectiveness of this approach. A clinical trial led by our group is currently underway to assess the feasibility and efficacy of a family treatment intervention for overweight adolescents with EE (13–17 years old) and their parents. Primary outcomes include EE episodes and weight loss. Data will be collected on 30 parent-adolescent dyads receiving EFPT-EE in conjunction with parent-child skills training and behavioral monitoring. We hypothesize that EFPT-EE will assist parents in supporting their adolescents in managing their emotional dysregulation, and thus will reduce their EE over time. Reducing EE may result in greater overall functioning and well-being, as well as weight loss. Future directions for research include trials comparing EFPT to other parent-focused interventions, and trials examining whether EFPT enhances outcomes compared to adolescent-only interventions. Furthermore, this model should be explored in relation to other adolescent issues of emotion dysregulation.

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