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Reflecting Team Family Therapy for Eating Disorders

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“What happens when the barriers between therapists and clients are removed, when they all participate in a dialogue about change, and when therapists and clients even trade places? Operating within the reflecting team format, professionals meet clients without pre-existing hypotheses. Together, they engage in a conversation that becomes a search for the not-yet-seen and the not-yet-thought-of, as well as for alternate understandings of what has become problematic. As clients and therapists trade places and various members of the entire group participate in conversations, the possibilities for change open wide.”¹

In 1985, Dr. Tom Andersen was supervising a young therapist who struggled to bring a sense of optimism to a family who had suffered for many years. During one of

the therapy sessions, Dr. Andersen and his colleague, who were watching the session, called in the therapist to share ideas that might be useful in interrupting the very negative family cycle that seemed never-ending. The therapist returned to the session but nothing seemed to work – in fact, the therapist seemed to get drawn in to the cycle’s negativity. Minutes later, Dr. Andersen noticed that both rooms were equipped for sound. He quickly interrupted the family session and asked the family whether they wanted to listen to the therapists as they discussed the case. The family agreed. The lighting and sound were switched, and the group of therapists talked for a few minutes, and reflected on the family’s dynamics, with a particular focus on the positive aspects of the family’s functioning that could be observed within the session. The lighting and

sound were again switched, the therapist returned to the family, and the family responded in a much more positive way. In fact, all involved were amazed at the powerful impact on the family of this process of reflecting, and reflecting on reflections. The new format was further developed, and became what is known as Reflecting Team Family Therapy (RTFT).

In addition to using this type of therapy as a training tool, clinicians continue to use reflecting teams all over the world when the family and/or therapist feel like progress has halted, or when one or more parties feel hopeless or disempowered. For example, through observation and reflection, a team of “reflectors” can help a family construct a new understanding of a particular family member’s behaviour more easily. This treatment modality is based on a

philosophy of being transparent, collaborative, inclusive, and focused on the needs of the family, as opposed to those of the therapist or clinical team. Currently, different variations of RTFT now exist, and are used with a variety of presenting problems, including emotional and behaviour problems, and more recently eating disorders.

Family-based therapy and reflecting teams

As highlighted in previous *Bulletins*, family-based therapy is currently the only treatment for adolescent anorexia nervosa studied through research that shows efficacy in restoring weight, reducing eating disorder thoughts, and improving relationships. However, while 50% or more of adolescents and their families recover with this model, the remaining 50% are left still struggling. A reflecting team model may serve as an adjunct to family-based therapy for at least some of these families.

As long as the philosophy is respected, RTFT can be delivered in several ways. For example, some reflecting teams may see a family only once, while in other cases, a team may meet with a family once a month over the course of 6 months to a year. With our model, developed within a

family-based treatment program for children and adolescents with eating disorders, families are seen by the team once a month, over the course of three months. The reflecting team approach is regarded as “a piece of work”, in the sense that it is used only when therapists feel stuck while engaging families in family-based therapy. This means that families continue to engage in family based therapy before, during and at the end of the RTFT sessions. As a result, it is critical for the referring therapist requesting a reflecting team approach to identify in which stage of family-based treatment the therapist/family feels stuck in order to incorporate the principles of that stage in the reflecting team approach.

First session of RTFT

Within each series of RTFT, there is an interviewer, a reflecting team and a family. Once the process of RTFT has been explained to the family, and they have met all members of the reflecting team, the interviewer usually begins the session with questions that allow each family member to describe and rate the severity of the problems in the family, with a focus on solutions. At the same time, a group of three to four trained reflectors quietly observe the family’s conversation and patterns of interaction through a one-way mirror. Once the problems

are defined, the therapist together with the family and reflecting team exchange positions – the therapist and the family sits behind the one-way mirror, and listen to the group of reflectors as they share their observations and reflections with one another. Reflections are presented as curious, speculative, and as tentative possibilities, e.g., “I wonder if...”, “What struck me was...”. They are also focused on the issues described as most important by the family. The conversation among reflectors typically lasts up to ten minutes, and then the roles are switched again. The interviewer encourages each family member to identify the points of reflection that resonated with them, as well as the comments that seemed inappropriate to, or inconsistent with, their views or experience of the issue raised. At this point, the interviewer may also share observations and reflections with the family. The family again has the opportunity to comment on the observations and reflections shared by the team. This process allows the family to have “the last word.” Once the reflections are discussed, the interviewer invites all family members to independently identify one small goal (preferably an observable behaviour) that they are willing to work on between sessions. The completion of the identified goal should potentially have a

positive impact on the problems defined earlier in the session.

Second session of RTFT

Upon their return, the family is invited to share with the team how they have been managing since the first session. Time is also spent reviewing the status of the family's goals, including the individual goals that were set by each family member. This session is often the most challenging, and most representative of the "stuck" system. Family members often express frustration at the lack of progress over the last month, and other issues interfering with the family's functioning tend to surface. Throughout, the interviewer is careful to adopt an interviewing stance that allows for solutions and creates room for optimism. The therapist and family switch places with the reflecting team, and the reflectors share their observations and reflections. Once again, the family is invited to have the "last word," and goals are set in anticipation of the last session.

Third session of RTFT

This session starts with a review of the goals and status of the family functioning. The interviewer then invites the family to participate in an experiential activity called a

"family sculpt." In this activity, the adolescent with the eating disorder is invited to be the 'sculptor,' and is asked to place family members in the positions that best reflect family relationships prior to the "arrival" of the eating disorder. Other family members are asked to comment on, and possibly adjust, the placements until there is consensus that the sculpt reflects how things were. The adolescent is then asked to "sculpt" the family dynamics as they are today, placing a reflecting team member who represents the eating disorder among them. Finally, the adolescent sculpts the future - once the eating disorder has lost its grip on the family- and represents the emotional relationships in the family as she or he hopes they will become. This process is often used to externalize the eating disorder with the intention that the family recognizes the impact of "the common enemy," as well as sees ways in which family members can change their reactions to the illness. After this series of sculpts, the reflectors are invited to share their observations and reflections with the family, followed by the family having the opportunity to do the same. In each series of RTFT that we have lead, this therapy activity along with the reflections, creates the most optimism as reported by the families. The session closes

with a review of the three sessions, including initial goals, and next steps. By the end of the third session, it is most often the case that the family and reflecting team identify concrete and obvious changes within the family system that are viewed as positive for all.

Feedback from families

The following are comments from family members who have participated in RTFT:

"I found it more helpful to sit back from my life, and to be an audience to the team, rather than sitting in my life in direct discussion with the team."

"When it was my turn to listen to the team, I felt that I was somewhere else, not with the problem. I could see how I didn't have to be with the problem. This didn't happen the time when I was talking with the team. It's not that I didn't enjoy talking with the team, but it just wasn't the same as listening to them."

"There is something that is so much more powerful about listening to a conversation about your life that is acknowledging and respectful of who you are."²

Preliminary research findings in Ontario

Some preliminary research has been conducted to look at

the impact of RTFT as an adjunct to family-based therapy. Over the course of one year, seven families were provided with the opportunity to participate in a series of RTFT (once a month over the course of three months). The teens and their families were asked to complete a questionnaire measuring different areas of family functioning at the beginning and end of treatment. Over time, despite a small sample size, significant differences were noted in a positive direction on questions relating to the teens' perception of the family, in particular those related to communication, emotional involvement and responsiveness. Similarly, positive shifts were noted with

respect to the parents' perception of overall family functioning, including emotional involvement.

While further research needs to be done, as we have noted throughout our series of *Bulletins* related to child and adolescent treatment, it is imperative that family approaches showing promise are considered as additional options for those families who require more intensive treatment, or who do not respond as easily to standard family-based therapy. In conclusion, in light of the complexity of eating disorder treatment, therapists should continue to look for other family-based modalities to enhance the therapy process,

for families who need them. We believe that RTFT can be one of those adjunctive therapies.

References

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