

Adolescents Resisting Treatment: Exploring the Resistance in Eating Disorder Patients to Treatment Within the Family System

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Abstract: In the last three decades, the literature has supported the concept of conjoint family therapy for eating disorder patients. However, recently researchers have provided a more consistent focus on the individual in the context of seeing the family, turning to parent counseling and therapy especially when the patient resists therapy, at all ages. This development has come about due to the separation issues, the repetitive patterns of interaction about food and the need to understand the unconscious dialogue between parents and child as expressed through the eating disorder symptom. The aim of this paper is to present a family therapy model for eating disorder patients developed at the Davidson Clinic (Hanotrim). The model emphasizes the importance of separate treatment for the child and for her/his parents in the first stage of treatment. We shall discuss the importance of recruiting the parents into the therapeutic process, the powerful effect of parent group therapy and the father's crucial role in enabling the daughter's recovery. A case study that was conducted mostly with parents will illustrate the model.

Introduction

The complexity of treating patients who suffer from eating disorders stems primarily from their explicit and implicit resistance to treatment. Viewed from an intrapsychic perspective, the eating disorder symptoms of many adolescent patients, including their manner of eating as well as body image disturbances, can be seen as the expression of a "silent cry"; the symptoms manifest mostly the separation-individuation conflict (1), as the adolescent performs a desperate act of separation on the one hand, and generates behavior that requires mothering, as of a baby, on the other.

One of the keys to deciphering this unconscious process can be found in the dynamics between parents and the adolescent daughter, in her place within their relationship as a couple, and her unconscious meaning to each of them.

With children and adolescents, we are faced with the question of how parents should be involved in the treatment process. In the case of eating disorders, this issue is brought into an even sharper focus, as parental involvement is nearly always essential for the effective treatment of adolescents and young

adult patients. According to Colahan and Senior (2), "The existence of the eating disorder in most of the families seems to lead to fixed patterns of interaction around it. Just as an eating disorder becomes a baffling and impenetrable autonomous condition within the individual, so also the organization of the family around the individual and her behavior has a life of its own" (p. 256).

This article will discuss the following subjects:

- A. A brief literature review of the family patterns and family models in eating disorders, and the research comparing the effectiveness of conjoint family therapy, parent counseling and individual therapy in treating eating disorders.
- B. Presentation of a family model developed at the Davidson Clinic, with the rationale for the therapeutic model, which also includes a means of coping with resistant patients, i.e., difficult to treat patients, based on criteria of age, symptom severity and severity of psychopathology.
- C. A case study conducted mostly with parents will demonstrate the model described and illustrate the different stages of treatment. Through the

case study, we will discuss the following questions:

- Is the symptom-bearer necessarily the central patient?
- Can change in the eating disorder symptoms of the patient be effected when psychotherapeutic intervention is conducted mostly with the parents?

Literature Review

As early as the 19th century, Gull (3) and Lasegue (4) recognized the need to separate anorexics from their family environments in order for recovery to occur. When psychoanalytic theories concerning eating disorders became established in the 1960s, pathology of the mother-daughter dyad was emphasized. Bruch (5), one of the earliest and most important writers in the field of eating disorders, described the problem as the young girl's difficulty in separating from her mother.

Bruch's writings, largely based on Winnicott's (6) theory, were highly influential. Concerning family intervention,

- She recommended conjoint family sessions "...in fairly young patients who are relatively healthy emotionally.
- In those with severe deficiencies in personality development...the chief work needs to be done through individual psychotherapy. When parents are well informed and not too defensive, they will make treatment arrangements on their own decision" (7, p. 116).

Yet, we would suggest that Bruch did not emphasize the importance of recruiting the parents and motivating them to treatment in the same treatment setting. In addition, to our understanding, she underestimated the father's role in the family dynamics.

Later, the "absent father" came into the picture (8). Fathers were encouraged to intervene more directly, to make closer contact and to accept conflicts with their daughters in order to set and maintain limits.

In 1970s the system theory, and within it family dynamics, came to the fore. Selvini-Palazzoli (9) and

Minuchin et al. (10, 11) were among the most important family theorists who wrote about anorexia nervosa. They attempted to construct a comprehensive theory that would provide an answer to the familial etiology as well as explaining the role of family therapy. In the 1980s, Vandereycken (8), Humphrey (12) and others wrote of the "bulimic family."

"Certain types of therapy have always been associated with particular disorders that served as paradigms for the development of the therapeutic model. Anorexia nervosa was largely the paradigm for family therapy" (13, p. 333). Minuchin et al. (11) developed a model referring to "psychosomatic families," in which anorexia nervosa was thought to be a prime example. Selvini-Palazzoli (9) developed a model referring to "the three way matrimony," i.e., the daughter is trapped within the parents' relationship.

The "bulimic family" (8, 12) was later portrayed by many theorists as a family with multiple conflicts and excessive criticism. Humphrey (12) suggested that "holding environment in bulimic families fails them in nurturance, soothing and tension regulation, empathy and affirmation of separate identities. Parents and children alike are 'starving' for nurturance" (p. 324).

They suggested the need for the integration of the family system dynamics with the intra-psychic and interpersonal elements of each member of the family. The theorists above attempted to characterize the structure of families at risk of development of anorexia and of bulimia.

Over the last decade, researchers in the family therapy field, including Colahan and Senior (2), Dare and Eisler (13), Eisler (14), Vandereycken (8) and others, have agreed that no specific family structure can be cited as prone to develop one type of disorder or another. This is due partly to the fact that research and clinical observation bring us into contact with the families only after the symptoms appear. Due to the acuteness of the illness, family dynamics are strongly influenced by concerns for the patient's health, making it impossible to distinguish between antecedents of the illness and its consequences. In addition, the dichotomous separation between anorexic and bulimic family types cannot be valid, in view of the transition of patients from one state to another.

Between 1987 and 1994, four large controlled

treatment trials (Maudsley Hospital), compared the effectiveness of conjoint family therapy, parent counseling and individual therapy (reviewed in 13, 14).

The results indicated the effectiveness of conjoint family therapy in the treatment of anorexia nervosa in adolescents with a short history of illness (only three years). All the studies supported the need for parent counseling, either in a couple or a group setting. The researchers were surprised to find that parent counseling only was more effective than conjoint family therapy, regardless of the patient's age. This was especially true with patients with severe eating disorder symptomatology, as well as with parents who expressed a high level of criticism towards their ill daughter (15).

Therefore, in approaching the treatment of a family system, focus should be on recognizing the differences between families and between each individual within the family. It is vital to diagnose the dynamics of each particular family, and what resources this family needs in order to enable the patient to recover.

Thus, a prevalent finding is the apparent difficulty of some families, for various reasons, to provide the adolescent with the necessary impetus towards separateness, which also coincides with the adolescent's own fears of separateness (16, 17).

As noted above, according to current researchers, systems family therapy is most effective when the disorder is recent and mild, and the patient is young. In these cases, parent counseling can elicit dramatic changes. Also, conjoint family sessions can help with communication patterns that have not yet become fixed.

Most of the parents we meet in the first stage of treatment are experiencing a great deal of anxiety. Due to the distressing characteristics of the eating disorders, most will need intensive holding in order to become less preoccupied with their daughter's food habits and appearance. In cases in which the symptom is acute and arouses concern on both the physical and behavioral levels (sometimes to the point of endangering the patient's life), every day's events dominate the therapy's theme, just as they do at home. The patterns of interaction in the family, especially with the daughter, take on a dense, loaded character and are repeated over and over again, due to the unconscious attitude of each of the partici-

pants. This tendency precludes a dialogue that does not revolve around food, and prevents each participant from examining his or her characteristic attitude (including the unconscious aspects) in the interaction, and the way in which this attitude is responsible for maintaining the disorder. In order to enable each participant to understand this unconscious "dance," which is essential for recovery, a therapeutic space must be created. This space minimizes the everyday negative elements of the interaction.

Thus, beyond creating holding, the separate treatments create a space that enables each of the participants to examine his or her subjective position.

The Family Model Developed in the Davidson Clinic

The program is based on separate evaluation and treatment of the parents and daughter (even up to the age of 30) at the initial stage. It will develop into triad treatment when dialogue becomes possible. This phase can take between 3-6 months. The daughter receives psychotherapy, expressive therapy, dietary supervision and psychiatric care (medication) as necessary, while parents receive counseling and therapy from a therapist not involved in their daughter's therapy, preferably in group or in a couples setting.

Bruch (5) has argued that there is a need for weight restoration before commencement of therapy. Therefore, the therapy during the first stages of the treatment will be mainly supportive, helping the patient deal with the main goal, which is correcting her physical condition.

When an adolescent is strongly opposed to psychotherapy, she is only required to participate in physical and dietary supervision. As we stated in the title of this article, we understand her resistance as a sort of compass guiding us towards her parents. The parents will speak for her and for themselves, and through them we will attempt to understand "who" the child is for them, as well as the role of the "food-object" and the preoccupation with the body in her unconscious dialogue with the parents.

Once in six weeks, joint sessions are held with the parents and the child, and the staff involved in treating the family. The aim of this meeting is to discuss

the progress of the treatment and relevant treatment decisions. In cases in which the therapeutic choice is home hospitalization and mentorship, joint sessions with the parents and child are held more frequently.

Parent counseling

All parents are guided alone and in the first conjoint session, the daughter is informed about the new guidelines, as described below. The explanation given to the parents, as in Goodsitt's (18) terms, is that eating and the body have become a battleground for the separation-individuation conflict and that some adolescents view their body as the "battleground"; and the "battle" is about who controls the body.

Since our aims are to help the patient through therapy to facilitate the growth process which is not at the expense of her body, parents are asked to follow these guidelines: Parents prepare and serve food, they sit down at meals in the presence of their daughter. Eating is solely the patient's responsibility. The patient signs a written contract after the assessment is completed. If there is no change, in accordance with the contract agreed upon, the patient is aware of the consequences. If there is insufficient progress in the treatment, the treatment becomes more intensive, in the following order: moving from home hospitalization sometimes including mentoring, to day hospitalization, to full hospitalization. It is important to emphasize that the parents' perspective about the shape of the daughter's body and the way she eats will largely determine the way she feels about her body. Comments on these subjects should be avoided during meals and elsewhere.

The group model for parents

Group sessions are held with parents during the initial stages of their children's treatment and are used to provide information about eating disorders and their causes and the way the clinic operates, along with an opportunity to meet with parents in a similar situation, thus reducing anxiety and ambivalence towards the treatment. The power of a group can reduce feelings of shame and failure that parents may experience when faced with a single therapist (19). We explain from the very first moment the multidimensional etiology (20) in which families can play an important but unpredictable part. We give hope.

The group is composed of parents whose children suffer from all kinds of eating disorders, since heterogeneity has therapeutic power. The exclusion criteria can be for two reasons: strong objection to a group setting or from our clinical diagnosis. The children's age ranges from 13-30. The group is limited to 10 couples and meets for 25 sessions. Recruiting the fathers to the group is therapeutically valuable. We stress the need of empowering their authority function toward their daughters in following the treatment demands (21). The fathers' participation in the counseling group is a clear sign of their involvement and it is, practically always, much appreciated by their daughters as well as by their wives. We insist that both parents participate in the group, even if they are divorced.

In the first five sessions, information is provided by the staff about various aspects of the treatment their daughters are receiving and about eating disorders, along with practical advice. The need for advice from each other is central at first. Parents are encouraged to start living again, invite friends over, go back to having family meals, and to paying attention to the effect of the situation on the patient's siblings. The emphasis is on boundaries for chaotic families, and flexibility for rigid ones. Parents' experiences vary from emotional turmoil, with feelings ranging from guilt, to blame directed towards the child, society and the therapists, to the need for over-involvement, or a wish to abandon everything. We pay a great deal of attention to the role of the father and his importance for his daughter, with whom he seems to avoid an overtly emotional contact (21).

"The negative attitudes toward the father are frequently reported, sometimes to the extent that the patient will not stay in the same room with him. But the opposite may exist too: a more or less erotization of the contact between father and daughter. These parents are no longer able to impose any rules and set limits" (19, p. 356). Fathers are encouraged to intervene more directly, to make closer contact and to accept conflicts with their daughters in order to set and maintain limits (19, 22).

In the next 15 sessions, we gradually begin discussing what the girls were like before they got sick, what reactions they elicited in their parents, and dreams and disappointments they experienced through parenting. Group members begin to dis-

cover and to take responsibility for those aspects of the interaction that belonged to them and had been projected onto their daughters. This process enables the beginning of separateness. References to marital issues are limited, though we do highlight the point that sometimes the illness could be a symptom of the marital relationship and we encourage further couple therapy when group therapy ends.

The last five sessions are devoted to joint meetings with the parents and daughters. A recovered patient is invited to the first joint sessions. The recovered patient speaks about the process she has been through, including the process with her own parents and their contribution to her recovery, as well as answering to group members' questions. She functions as a bridge enabling the dialogue.

In the joint sessions, a dialogue is established among parents and daughters. At first they are organized into small groups of parents and children, not their own. Next an open discussion is held in the plenary group.

The parents' need to question other girls about their feelings towards their parents has been evident in all the groups we directed over the last eight years. They always share their search for a way to get through to their daughters, almost asking the other girls for advice on what to do.

The concluding session is held with the parents only, followed by separate meetings with each set of parents, in which decisions are made regarding the need for further individual or couples therapy for the parents, or further triad sessions with the daughter or all family members.

In our experience, this method of intervention brings about a change in parental functioning within a short time period. The main finding is the significant transition from overinvolvement or uninvolved involvement to more appropriate involvement levels, particularly by the fathers, who are able then to express greater empathy towards their daughters, no longer a "troublesome rival" (23), thereby sometimes releasing the mother and daughter from a symbiotic relationship. The group enables parents who are more reserved or passive to listen to others without being required to speak, and evokes motivation for subsequent individual, couples or group therapy, as needed. An issue that often arises concerns the effect on other siblings. In our experience,

when there is a change in parental functioning, the transformation will be felt in interactions with the other children as well.

In the last five sessions, the timing we choose for the therapeutic encounter between parents and daughters, dialogue has become more feasible and, by this time, it is easier to identify meanings such as "for whom" or "what" the girls are eating, and "who" the parents are feeding. When the daughter's symptoms remain resistant, we continue to work in an individual setting, as we did with Noa G., described in the case presentation.

Case Presentation

Noa was strongly opposed to treatment in general and psychotherapy in particular. She was brought to psychotherapy against her will and was steadfast in her silence. The case will demonstrate how her insistence on silence compelled us to confront the parents' resistance to any kind of counseling, as represented mainly by the father.

In presenting Noa's case, we will describe the full course of the family's experience at our clinic. The goal, in the first stage, was to enable Noa to begin eating and to attain more flexibility in her rigid eating habits. This family was unable to sit together and talk due to paralyzing anxiety, stemming from the father's domination. Noa was the only one "speaking" through her body.

When Noa arrived at our clinic she was 15 years old, the youngest of three children. Her sister suffered from bulimia nervosa. The parents belong to high socioeconomic status. Noa became anorexic at the age of ten. Noa was admitted to our clinic after six months of hospitalization with severe osteoporosis and had never menstruated. Her weight after discharge from hospital was: 45 kg, height: 1.58, BMI: 18. Target weight: 50 kg.

In the intake, her stubbornness was apparent. She put up a determined struggle to keep a particular number on the scale monitor — 45kg. Alongside her father's concern, his appreciation for the resolute side of her character could be discerned.

Noa, as mentioned, was the youngest child in her family. Mr. G. has very strict eating habits, acquired in his childhood, when his father's chronic illness led all members of the family to eat in the same way. He

is extremely strict about his appearance, criticizes his wife about her appearance and her sloppiness about order, organization and economy, and tends to interfere in every detail of life at home. Mrs. G. lived in his shadow throughout the years, never stood up for herself and often cried in response to his criticisms.

Against her will, Noa began psychotherapy, dietary supervision and psychiatric treatment. She was told that the goal was to restore menstruation. The parents did not cooperate at the first stage with parent counseling. During Noa's short therapy, the only issue bothering her was her mother's weakness. After two months, she refused to continue psychotherapy. As already noted, we released her from psychotherapy and required her to be in dietary supervision with the support of SSRIs only, and to participate in five sessions of the parent-child group. It was clear that no change could be attained without the involvement of her parents in the treatment. Noa, in her determined opposition, guided us to insist on engaging her father in treatment despite his own resistance.

Mr. G. joined the group against his will, saying, "I don't believe in this, but I'm willing to do anything to help her recover." Both parents barely spoke throughout the course of the group. In one of the joint sessions, Mr. G. had the opportunity to hear another girl talk about her relationship with her father, and responded with tears. Mrs. G. and Noa saw him express weakness for the first time. In response to one of the other parents' questions, Noa replied, "I know why I eat this way." Her father addressed her, a rare moment for this family, and asked, "What is the reason?" Noa answered, "I know the psychologists think it's because of you, but it's because I need everything to be under control." In her response she continued to protect her parents, but the change was the dialogue itself, which had become possible between them for the first time.

In the last session, with parents only, Mr. G. recalled this conversation with Noa and said that what frightened him was her determination and lack of doubts. Slowly, it became clear to him that he usually had no doubts either. "I always had clear ideas about what I was doing. Now I have to start asking myself questions." A conversation ensued in which the fathers could speak about their complex encounter with their daughters' maturation. This discussion

created the possibility for Mr. G. to participate and be present. It was hard for him to identify with the feelings of rejection that some of the fathers expressed towards their bulimic daughters. He said, "What I feel is helplessness. I see everything and notice every detail, and I say what I see. My children know that. But I haven't said a thing to Noa since she got sick." One of the fathers responded, in a humorous, gentle tone: "By shutting her mouth, Noa was the only one who managed to shut yours." In the final session, the decision was that the parents would continue couples therapy. Noa would not continue psychotherapy due to her continued refusal to talk, and, as mentioned, she would be required only to eat, with the help of SSRI medication, against which she also struggled.

Noa's symptoms were an expression of her parents' relationship. For her, the knowledge that they were coming in and talking was a release from the responsibility of maintaining their relationship. Mrs. G. could not speak in her husband's presence, and barely spoke in the group. However, she heard her husband speak, saw him cry for the first time in her life, in the group, and felt the softening in him.

About two months after the conclusion of the group, Mrs. G. began to speak in couples therapy and to assert herself. On one occasion, Noa heard her father telling her mother about a significant investment of time that had allowed him to save a minute sum of money. She turned to her mother and asked, "What do you say, would you have done that too?" Mrs. G. said, "No," and Noa said, "I agree." The therapeutic holding environment encouraged self-expression and tolerance of differences as first steps toward separation.

A genuine dialogue is still impossible between Noa and her parents, but there are several indications of a change in her: 1) Her question to her mother shows that she has doubts as to whether her father's way is always right. 2) Her behavior gradually became more flexible and less Spartan. She began to let herself enjoy leisure time, movies and parties that she had previously denied herself, bought new, flattering clothes and enjoyed the compliments she received. 3) Noa's sister, who suffered from bulimia nervosa, had told her father in the past, "You never hit us, but your looks were worse than beatings." She now told her mother there was a great

change in father. 4) After gaining 5 kg, with great suffering, she began to have regular menstrual periods for the first time in her life.

Noa's case provides a glimpse into the complex role of the dietician working with eating disorder patients. In cases bordering on a chronic condition, the dietician tries to minimize physical damage as much as possible. When the adolescent is not in psychotherapy and attends dietary supervision only, sessions will also include other issues such as the fear of food, the fear of being fat and the fear of losing control.

Despite the treatment's demands, it took Noa a year to achieve her target weight and to receive her first spontaneous period. At the first stage of treatment, she was allowed to choose the texture of her food, since she insisted on blending all of her food. Like an infant learning to eat, Noa went from soft food to chunky food and only later to regular food, in a long and exhausting process. Noa's rigid eating was experienced as identification with her father's Spartan patterns. When Noa began to expand her eating, she began "expanding" in other areas of life as well.

In a sense, Noa's fears of gaining weight were not groundless. As she expanded her repertoire of food and dared more, her appetite increased. In the last few months before her enlistment in the army she experienced binges, and because of the fear of being fat, she began to self-induce vomiting. The feeling of being out of control caused her severe anxiety. At this time, it was suggested to her to return to psychotherapy. Noa responded by crying, and said, "I don't want therapy, because I don't want to change my thoughts, I need to have everything under control!" Noa was told that what was happening to her was sometimes a stage in treatment, and the goal now was to help her regulate these urges (7).

Since she was not in psychotherapy, changes in her mood following weight gains led to depression and anger being expressed in the dietary sessions. The clinic setting of meetings with everyone concerned, every six weeks, helped in order to discuss her emotional condition, and determine whether we could continue to work according to a compromise of a contract, which was born out of Noa's refusal to participate in therapy.

Noa ended her treatment at the clinic when the

time came for her to begin her compulsory military service. She left the clinic still suffering from sporadic binges and vomiting. The treatment had not been completed yet. However, we believe Noa could easily have gone down in the statistics as a chronic anorexic in constant mortal danger had it not been for her parents' engagement in therapy and the convoluted path her dietician took with her. Noa's bulimia, as with many other girls, appears to be another step on the road to recovery (7). Even if partial bulimic symptoms remain with Noa in the future, we believe that after eight years of pre-pubertal anorexia nervosa her journey can be seen as an achievement.

Conclusion

Noa G.'s case illustrated the effects of intervention with the family system through a parents' group, and the contribution of the group to reducing the resistance of both the parents and the daughter to further treatment.

This case emphasized the importance, in the beginning, of separate treatment for parents and child, the contribution of the group process to the significant change in her father's attitude, through his exposure to dialogues of other parents and between daughters and parents, which occurred as a product of the group process. Later this change enabled the mother to gain increased strength through couples therapy and made Noa's recovery process possible.

Through Noa's case, we can answer the questions we asked at the introduction.

We have tried to point out the fact that the symptom bearer is not necessarily the central patient, and that change can indeed be effected when psychotherapeutic interventions are performed primarily with parents.

We exist as subjects even before birth. Parents have expectations, desires and wishes about each of their children, before they are born, related to the circumstances of each parent's life and their relationship with each other.

When we enable parents to talk about their daughters in our care they can identify through the therapeutic process "what" they nurtured this particular child with, even before her birth. Many times

the history of the symptom, the eating disorder, is bound up there.

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