

WHY ARE PARENTS IGNORED IN FAMILY THERAPY?

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INTRODUCTION

It is well documented that individuals with anorexia nervosa are difficult to engage in therapeutic work (Vitousek 2000). This can be particularly so in the case of children and young people with anorexia nervosa, who are often brought to professionals by their parents, rather than choosing to attend as adults do.

Experience has told us that, in order to engage the child or young person with anorexia nervosa in therapeutic work, we must engage their parent(s). Little has been written about engaging the parents of children and young people with anorexia nervosa in therapeutic work, although research (Maudsley 1987, Locke et al 2001) has suggested that family therapy can be a useful intervention for the younger age group when there is an early detection of the illness.

Parents can often be reluctant to be involved in therapy as they may often feel blamed, and indeed in the past may have been blamed, for their child's illness by professionals either explicitly or implicitly. Parents often feel that they are involved in treatment only because there is change that needs to occur in order to help their child become well. This they can feel indicates that professionals consider that what they did previously was wrong and contributed to or indeed caused their child's illness.

This paper is presented within a systemic framework and highlights some of the principles in engaging parents as well as some of the potential obstacles. It will also explore beliefs about the role of the therapist in aiding or inhibiting engagement by parents and in promoting the young person's recovery.

FAMILY THERAPY APPROACH

A first basic principle of this approach is that family therapy is a treatment with families not of families, a principle that would apply regardless of the specific family therapy school.

The earliest writings about family therapy used with children and young people with eating disorders, and specifically anorexia nervosa, go back to the 1970s when Palazzoli and her colleagues in Milan were the first to write up their clinical use of family therapy in the treatment of anorexia nervosa. The common thread found in the earlier writings was one of blame directed towards the parents. Since then the research work of the London Maudsley group in the 1980s and 1990s indicated family therapy as 'treatment of choice' for patients with early onset (under 19 years) and short duration (less than 2 years) anorexia nervosa. More recently a manual (Locke 2001) uses family therapy alone to treat adolescents with anorexia nervosa, specifically taking the whole family through sequential prescribed phases of treatment.

The main reasons that family therapy can be effective and therefore is often the chosen therapy particularly in young patients include:

- parents and families have experience and expertise with their children, though they may sometimes doubt this particularly when a child is diagnosed with an eating disorder;
- whether or not parents/families had a part in the onset of the illness, they have a vital part to play in therapy and in the recovery and it is therefore essential that the family is utilized as a resource in helping the young person to recover;
- exploration with the family of the environment in which the illness began (and took hold), to note any problems or issues within the family that may help or hinder recovery;
- a specific focus on how the family strengths can help the patient's recovery.

This paper concentrates on the role of the therapist as guide and support to parents and families throughout a treatment, which builds on the strengths and successes of parents and avoids highlighting weaknesses and setbacks.

Eating disorder Development

Lask & Bryant-Waugh (1998?) have outlined some of the factors present in the development of an eating disorder under three groups:

- predisposing factors such as genes, biology and personality, which more vulnerable than others to the development of an eating disorder in the context of

- precipitating factors which are circumstances of a life stress/trauma such as bereavement, bullying at school or separation of parents at home, and which may or may not be different from
- perpetuating events which can contribute to the continuation of the eating disorder when the original trigger is no longer present, such events might include bullying or parental separation, as above, or may include the well-intentioned but possibly ineffective response of parents to the eating disorder.

The eating disorder disrupts the healthy developmental progress into adolescence:

- it requires that the young person postpones the stage of taking greater responsibility for decisions,
- the young person through necessity moves back toward the family with increasing dependence again on the parents: the balance moves away from greater autonomy back to increased dependence and accountability to others specifically parents,
- the development of peer relationships is delayed,
- the eating disorder delays sexual development through low weight.

Delay or regression in all these areas is an inevitable consequence of an eating disorder in childhood or adolescence.

Working co-operatively and collaboratively with parents

This approach regards parents as essential members of the treating team along with the professionals. A co-operative and collaborative way of working with parents requires that parents are always kept informed and involved in discussions and decisions about the treatment and care of the young people.

This way of working is advocated, as this age group of patients is dependent on parents and their care. It is believed that their parents together with the treating team are best placed to enable and support the patients' sustained recovery.

This way of working means:

1. providing information that will best enable the young people and parents to understand their situation, contribute to decisions and fully take part in planning and treatment;

2. checking with the young people and their parents about any worries, fears, questions that they may have, and being sure to address their current issues alongside those of the treating team;
3. involving the young people and parents as much as possible in decisions;
4. supporting manageable tasks using the young people's and parents' own strengths and building on successes;
5. working with the present motivational stage reached by the young people and parents in order to support change and progress. (Millner & Rollnick) the motivational approach is where the young person involved is able to identify her areas of motivation and can feel in charge of her own treatment and what resources she has available to her. With motivational therapy the aim is for change to emerge from within.

A collaborative way of working with young people and their parents is a whole philosophy and committed approach to therapy and is not a politically correct technique which can be applied or not "if remembered".

Parents as a valuable resource in treatment and in patient's recovery

There is significantly better prognostic outlook for children and young people with eating disorders, especially anorexia nervosa, than for adults. For children and young people with short duration anorexia nervosa there is a positive finding on the helpfulness of family therapy on five-year follow-up (Maudsley group).

The significant variation may be attributable to obvious differences, such as relatively shorter duration of illness in children as well as the undermining effect and treatment fatigue that may be found in adults where the illness has persisted and been shown to be resistant to a succession of treatments. Another noteworthy difference is that children and young people have the added invaluable resource of their parents in the therapy, whereas adults may well have no family members or carers involved in a similar position of care and authority.

Indeed the young people's parents are a vital part of the treatment team. They are responsible for feeding and supporting the young person at home, as they struggle to recover from the illness and may resist all attempts by their parents to help them. That parents have experience and expertise with their child and are crucially important in the young person's recovery implies no blame or part in the onset and development of the illness. It simply means that without them to take responsibility

for re-feeding their child and containing and resisting her anxieties in this process, the work of the outpatient treatment team would not be possible.

[Case example: Em: at home c.1 year and still almost 100% dependent on parents to feed her, a task previously they were unable to do, now she will let them, despite being v. clear 1 year ago that she would stop eating again in order to die.]

It is therefore crucial that the treating team support and build on the strengths of the parents, and resist any temptation to present themselves as the experts or to undermine the work and progress of the parents by pointing out or indeed focussing on their inevitable shortcomings or periodic lapses, either in their work with feeding the child or in their own relationship or family dynamics. Strengths and stresses in the family can be identified and noted by the treating team without the young person's illness or struggle in recovery being attributed to these family factors.

OBSTACLES TO ENGAGEMENT

Blame

As parents often present with a child with an eating disorder with "baggage" of blame from previous experiences with professionals, it is important that the specialist eating disorders service works to eradicate or at least minimise these feelings, which are unhelpful to the work of helping their child to recover. The treating team may need to make direct explicit statements of "no blame" as well as communicating this more indirectly, for example through the respect shown to the expertise of the parents and the attention paid to keeping parents well informed and consistently seeking out their views.

Parents will feel that they and their expertise are validated by a clear acknowledgement from professionals that it is likely to be most helpful to their child if we and they pool together our resources and expertise and try to puzzle out together difficult issues and decisions.

Over-involvement

Over-involvement may refer to two different processes.

Firstly, the over-involvement and over-efficiency of the professional team to the exclusion of the parents may marginalise the parents and compound their sense of hopelessness and failure, in comparison to the team who feed their daughter while

they cannot. The treating team must work to resist taking over from the parents but to join alongside them as they face the task, now well supported, of re-feeding their daughter.

It is important to consider the relationship between the ward staff and the patient as well as the relationship between the ward staff and the parents. Most parents have feelings of failure or inadequacy, as well as feeling blamed or to blame, when they bring their child for admission. This is mixed with anger towards the child for being ill and the ward staff for being able to get their child to eat when they had failed to do so. Inexperienced and inadequately trained staff are rarely able to process this experience without becoming angry and blaming towards the parents. This can often mean that the conflict within the family becomes the conflict between the parents and the ward staff. Excluding the parents from the essential components to the inpatient treatment can compound these feelings; perpetuate this conflict and the symptomatology of the patient. This would then make it a more complex process for the parents to acknowledge that they had experienced any difficulty when eating the meal with their child.

Secondly, historically mothers of a young person with a mental health difficulty, and particularly with anorexia nervosa, have been identified as dysfunctional - either "too" involved or "not enough" involved. This "mother blaming" underpins many therapies and psychotherapies. These beliefs are not being challenged but examined for their effect both in family therapy and on the therapeutic process. When a mother feels blamed or to blame she may be unable or less able to work effectively towards change, as she may take a defensive or protective position, less available to the therapeutic process looking for change - a position that may retreat from the possibility of difference. Recently fathers too have been criticised, blamed if not available to their sick daughter but also blamed if they are perceived to be "too" involved or too close to her.

Ward vs. home re. feeding

A very brief story may suffice to illustrate this point.

A specialist eating disorders service for children in London received two visitors from a unit in the north of England where they sometimes see children with eating disorders and their families. During a break the visitors told of a little boy they were treating who came with his mother to their unit during the day and returned home in the evenings and for weekends. They told, with apparent surprise but also some

pride that they had no problem with the boy at the centre where he ate all his meals, but that he then returned home and refused to eat for his mother. For them, they emphasised, he was no problem and his mother knew that - with the implication that the problem lay with his mother and/or within the home, where they had completely failed to promote better eating. When asked how they had been able to help the mother achieve some success at home, how they had helped her to feel positive about her abilities and less of a failure, it seemed that that piece of work had not begun. In this incidence the professionals had shown themselves to be competent where the mother had failed and it was to be feared that the treatment at the centre may well have increased and compounded the mother's sense of failure and blame and thus had not been helpful to the child.

If it is unavoidable that a patient leaves hospital and/or returns home at weekends, it is important initially to keep this leave as short as possible and to predict the inevitable difficulties and weight loss and to plan for these as much as possible, so that this is not understood by the parents as their failure and hopelessness.

?????(Case example: issues and dynamics from inpatient setting/outpatient team, where hierarchy, use of power by senior staff, relative position of junior staff play a powerful part. Junior staff may feel unrecognised/unvalued within the professional team, may be most directly involved in patient's re-feeding - they can show what they can do/assert themselves, sometimes at the expense of hapless parents. Senior staff may enter battle with parents as a way of demonstrating authority and expertise to their team - again the parents are in a position of "no win".)

Indeed, some professionals may have their own personal beliefs about the role of parents in childhood eating disorders, which may lead them to show the parents to be lacking in competence or indeed to blame for the illness. The real danger of professionals entering into battle with parents finally is that everyone loses. The professionals may briefly show and assert their expertise and authority, but when parents take refuge with the patient and the eating disorder, no-one wins and the situation becomes very stuck. The cycle may become compounded by the parents being more blamed.

On the other hand, those who are experienced in treating eating disorders know that the re-feeding is the first and most straightforward part of the work - the more challenging and often much longer part of the treatment is establishing with the patient and her parents how the patient can be fed at home. They know the importance of working alongside the parents, ensuring their success in tasks, however small, and building always on their successes and strengths. Getting into battle with parents often pushes them into a stronger linking up with the patient and with the anorexia nervosa.

SUMMARY

In a cooperative and collaborative model of treatment of anorexia nervosa in young people within the context of the family, clinicians will focus with the parents on:

- the family and its context as a whole
- how the eating disorder fits into the whole
- family relationships and strengths and acknowledgement of stresses
- parents as a resource and an important part of the treatment team.

The focus of the family therapy sessions will include not only the eating difficulties of the young person but also relationships within the family and development of more open verbal communication. The sessions will also focus on the empowerment of the parents who will be seen as a resource and part of the team, who will feel valued by the professional team.

In conclusion, readers are invited to ponder the complex, multi-factorial causes of an early onset eating disorder and specifically the P's of predisposing, precipitating and perpetuating factors, and to banish the B's of blame, bully and battle in relationship to families and parents who would be weakened by these power battles. When parents have their strengths recognized and developed alongside the professionals in a cooperative fight against the eating disorder, their child is far more likely to enjoy a full recovery.