A psychological support group for the parents of patients with eating disorders

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Abstract

This article aims to describe the experience of conducting a psychotherapy group for parents of patients affected by eating disorders, took place in the General Hospital Sant'Orsola, in Bologna (Italy). The first part describes a theoretical analysis of the dynamics of families of patients who are affected by eating disorders. The second part describes sessions that show the special clinical dimension and therapeutic factors that characterize the homogeneous group setting.

Key-words: parenting , eating disorders, homogeneous group, transgenerational

Introduction

In this article I will describe the experience I had with a colleague while running a psychotherapy group for parents of patients afflicted with eating disorders. The group was held at the Sant'Orsola-Malpighi Hospital of Bologna.
This paper belongs to the issue of *Gamma Function* entitled "Adolescence, anorexia, and groups" in the section regarding parenting.
Believing that clinical practice can only be enriched and "strengthened" by theoretical reflection and by the epistemological approach which each clinician uses in his/her clinical work, I was lead to write this paper thanks to a need for further reflection on the work done.
Following a brief theoretical introduction to dynamics emerging among families wherein a member has an eating disorder, I will discuss some sessions held with our group, underlining group and individual progress which emerged during the psychotherapeutic work.

Theoretical considerations

Given that we are talking about a group made up of members of various families, I have highlighted how, from the literature, it is possible to find some common threads among families with an anorexic female child. Generally speaking, they are small families where the female figures dominate; often there are two daughters only, and frequently it is the first-born one to develop the disorder.
At the first meeting almost all the parents describe their daughter's childhood not as simply normal, but as extraordinarily happy and singularly trouble-free.

In fact, just as the parents often deny – especially at the beginning – the existence of conflict in their marital relationship (even if, in the last sessions they did talk about their conflicts), so do they refuse to admit that their child has a problem, other than the undeniable weight loss.

The theoretical-clinical perspective which has lead to the most significant development in the study of the anorexic family is the system-relational one. Selvini Palazzoli (1998) defined the peculiar situation of a family with an anorexic member as "a three-way marriage", because each component of the family is "secretly married" with two people, or in other words the mother with the husband and the daughter, the father with the wife and the daughter, and the daughter with the mother and the father. The girl is so wrapped up in this situation that she has no way or time to develop her own identity and the eating disorder emerges as a way of trying to affirm her own individuality.

Selvini Palazzoli's analysis of typical communication styles in these families is also interesting. Generally speaking, the family members express their own communication – both verbal and non-verbal – as consistent. Those families wherein the girl's anorexia is complicated by violent behavior or bulimic crises are an exception to this generality because, in this case, there is inconsistency. It is not inconsistency between verbal and non-verbal simultaneous communication, but rather between successive verbal communication acts. On the other hand, as far as communication with others is concerned, the common reaction is that of denial, not at the communicative intention level, but at the level of the message itself: it is as if each member of the family recognizes the right of the other to speak, but denies the validity of that which is said. It is worth noting that, in those cases where the anorexic disorder is more complicated, there are more psychotic communication styles characterized by confusion between the past and the present and the negation of possible improvements seen in the girl.

As far as the father is concerned, in general he comes from a family situation in which his infant needs for nurturing were not satisfied, even if he – unaware of it all – continues to idealize his parents. Such affective shortcomings created suffering for him, in any case, for which he put defense mechanisms to work. As a child he was a model son -- self-sufficient, independent, efficient; but that -- in the end – was really a way to avoid the need, which was not met, of an affectionate maternal presence. Then, as an adult he sought a maternal substitute which would not be of the symbiotic, infantile type, but rather of a caring, preadolescent one: he doesn't expect his wife to be dependent, but rather he expects her presence so that, for example, he loves to find her at home when he returns from work.

The family, as we know, is the quintessential environment in which a child has his/her first experiences. From a situation with maximal dependence, it evolves toward one of independence and the self-identification. In this sense the family can be considered a complex system, made up of multiple temporal levels, which move on both synchronic and diachronic planes. Given this, we can imagine how it is that relational difficulties

develop which have their roots in the family system. An anorexic's family is characterized, in fact by a deep sense of impotence which sets off the well-known triad of impotence-omnipotence-guilt (Corbella, 2003).
We can see how work done with the parents of adolescents with eating disorders makes up a particularly useful opportunity for observation to help move toward an understanding of the behavioral interactions in the family, within the dynamics of which we need then to assess the importance of "cultural" transgenerational transmission.
With this term I refer to the orientation of Anna Maria Nicolò (2000) wherein transgenerational, with its Latin prefix *trans*-, suggests a crossing, a passage between generations, between psychic spaces, the elaboration and transformation of whose content has not been possible. In *Totem and Taboo* Freud (1912) had already affirmed that consequences of actions can continue to be operant in successive generations which of the actions themselves have had no knowledge. The topic of transgenerational transmission has become a point of reference for understanding many pathologies, especially the most serious ones. Its existence presupposes the absence of a transitional space among family members – that space which allows for the transformation of content, and for their being made into metaphors. In transgenerational transmission that which is transmitted is not transformed, and so nor is it introjected; rather it is incorporated. It is well known, in fact, that introjection requires transformation and assimilation work.
According to Nicolò, in pathological dimensions (e.g. families with an eating disorder) the very act of creating or perpetuating a secret can translate into the active seizure of aspects or parts of the individual or familial emotional life, which gets passed on crossgenerationally. The pathological and pathogenic factor is found in the removal of something from a potential space where reciprocal elaboration between the Id and the other, and the Id and one's self can develop. In this way the traumatic repetition of the consequences of the first event is perpetuated, and time stops.

Clinical description

An important factor for our work with the group was the participants' motivation. In fact, given that none of their children were minors, the decision to participate in the group was entirely voluntary.
It was made clear to the parents that, via a shared process of reflection and exploration, the group would be consciously going back through the dynamics of their children's pathology starting with their own parental point of view.
A group dynamic which emerged from off the first meeting was the assumption of being basically dependent (Bion 1961). In fact, initially the parents would refer only to

the therapist, waiting for a "magic recipe" to solve their problems, without interacting the least among each other.
As a matter of fact, I had the impression that, one after the other, some were bothered if others took up too much space in their interaction with the therapist.
Often it was the parents who formulated a call for help, which took form in the request that their child go back to being the one he/she was before. The parents saw the cause of their desperation in their daughter's sickness, so much so that in their fantasies its resolution would mean the resolution to all their problems.
This is what Recalcati (1997) defines the paradox of the parental question. It is a question of care for themselves, founded in the child's symptoms, without taking on responsibility for themselves, thus a question which is substantially empty. But the reality is different, because one family member's symptom necessarily implies the involvement of all the family relationships. For this reason, the preliminary treatment for the family should be first of all to create some new discomfort in the parents' question, which is different from the daughter's one and which should then question the parents on their own role in regards to their daughter's suffering. In the end, the relatives should get to the point where they understand to what extent they were influential in the development of their daughter's pathology, which often masks their own personal and marital problems.
With time, the group moved away from their assumed dependence and a shared group field was created, where mirroring allowed for real sharing of emotional experiences.
Motivational factors are not the only obstacle, however, when group work is proposed to parents. In fact, once the group has been put together, it can get polarized almost purely on the question of "nutritional behavior", which is felt to be fundamental and urgent. This means avoiding topics which are much more at the center of their relationships with their children.
Focusing on eating behavior was a tendency our group showed also, especially by a few couples. Nonetheless, with time and with the creation of a shared "group field" which was characterized by trust and intimacy, it was also possible to talk about relational dynamics with their children which were much deeper and more painful.
A common characteristic of all groups, especially therapeutic ones, is the occurrence of the sacrificial lamb phenomenon. This is an archaic defense mechanism which consists of projecting parts of the self which are experienced as disturbing, painful, unthinkable onto some object other than the self (Corbella, 2003). The sacrificial lamb is often essential for adequate functioning of a group (whatever its type may be) in so far as it provides an area where aggressions can be directed and focalized without creating a threat for the psychic integrity of the individual or a threat to the stability and unity of the group itself (Toker, 1972). It is at times of transition and of crisis that we see on the group's part an attempt to find outside or inside of the group someone or something which will take on the sacrificial lamb role. When the sacrifical lamb is

found outside of the group, the group often puts itself into a position of fight-or-flight, with the bad feelings that go along with this protomental state. In these cases, however, the process is not particularly dangerous or destructive as long as it is kept under control by the therapist in a deliberate way. In some circumstances it can help restore, through emotional contamination, a kind of undifferentiated cohesion which – in the face of emerging separationist-individualization progress – attempts to recover the original fusionality. In our group, the role of the sacrifical lamb was held by the clinic, so by an institution. In fact, the parents complained constantly of the clinic's poor organization thanks to continual turn-over of doctors and psychologists, and that they (the parents) were never informed regarding their daughters' clinical situation, thus feeling a strong sense of impotence. The therapist tried, all the same, to explain the reasons for their strong anger with the clinic and to make it more manageable and tolerable.

Finally, the fact that the group was for the most part made up of parental couples allowed "couple dynamics" to emerge which were at times another obstacle to the group work. For example, in the sessions one couple in particular revealed their disagreement regarding the approach to take with their daughter: the father was more categorical and distancing when faced with requests from his daughter, which were at times oppressive and exaggerated; the mother on the other hand was more tolerant, complying with the daughter's requests, without however receiving any sort of thanks and developing for herself a strong sense of guilt and indecision about what to do. Furthermore this daughter, who had already changed three schools during the year, abandoning them after just a few weeks because she didn't like them, recently had expressed a desire to attend a private night school in order to avoid staying a year behind in school. Faced with this umpteenth request, the father was not willing to give her permission whereas the mother wanted to make her happy. From this point an argument began between the parents which got worked through and was made more manageable during some of the group sessions. As opposed to those aspects discussed earlier, this one persisted throughout the time of the group's activity.

Caring for their child is a difficult test for the parents who are forced to put up for discussion their own relational system and, where possible, to look back over aspects of their own personal histories regarding the phase which preceded the emergence of the disorder's symptoms. A "non-intrusive" clinical device is needed in order for them to maintain a stable connection with the Institution, and to do so for a long enough time.

It is intuitively clear how the intervention happens on delicate terrain whereon, through the creation of a climate of sharing and support aimed at clarifying relationships, one can encourage the parents to develop greater openness to reflection on specific aspects of family history. This approach proves to be fundamental for the development of the triangulation "parent-institution-child", perhaps the only one which is able to

reactivate emotional circulation, which is necessary for understanding and resizing the symptom.
This aspect proved to be especially true in our group. In fact two couples of parents participated in the hospital-based program even though their children had suspended the clinical check-ups. This could almost demonstrate that the institution can be a "sufficiently good and reassuring container" if the clinical device has not been intrusive. A particularly touching session, supporting that which was said up until now, was one of the ones just before the summer break. During the session the wife of the couple, whose daughter had not been followed by our service for more than a year and a half, said: "I have a lot of faith in these meetings and in you because I get a lot out of the group. My problem is that I don't like my daughter hardly at all anymore." The woman added later that her daughter asks her for rules so that she can then break them. Following on this woman's comments, other participants, evidently feeling that what she said had some resonance with themselves as well, talked about their "need" for the institution in order to be able to get closer emotionally and appropriately to their children.

Reflections

The basic question is: *what is the purpose of working in a group?* Undoubtedly this is a method which has notable advantages on the emotional front: in fact, we can notice that new possibilities for meaning, not thought of before, come out progressively. Comparing one's own experience with other people who live with the same problems on a daily basis, who have the same anxieties, or who ask themselves the same questions, allows them to reduce their feeling of isolation, thus opening them up to new emotional and relational ground. Sharing and telling about one's personal experience makes available many possible solutions which the individuals have already tested in their own families and which therefore are not characterized by an "infused" knowledge, top-down, but rather appear out of their life experience.
Mirroring (Foulkes, 1972) and reciprocal support simplify reflection about the origins of the child's suffering, moderating the pressure of guilt.
As time goes on basic assumptions are brought into question: the "indestructible" family beliefs which at times have been passed on transgenerationally, the same ones which at times do not allow for the perception of children's needs, obscured by the implicit idea of a stigmatized and chronic illness.
The group atmosphere promotes recognition of the other and his/her own emotions, reactions, and personal way of seeing things and thinking.
The crisis, the explicit pathological manifestation, will not be "read" exclusively anymore as an aggressive act by the sick family member on the nuclear family or, more directly, on a single parent. And so it will be ever less necessary to activate

punitive or expulsive mechanisms, but rather it will be possible to generate accepting responses, connoted by new and more adequate affective tones.
This is favored in large part by the group device which facilitates the emergence of fantastic representations which have conditioned both the parents' own relational modalities as those of their children. It becomes clear how often parents house the fantasy of being able to be perfect and how frustrating it is to give up such fantasy once the child's symptoms have become evident.
The child's pathology, in fact, forces them into constant examination of the reality of their own "failure" as parents, an exercise which creates feelings of guilt and anger.
Group work facilitates working through this anguish, and helps to return to parental functions which were lost or put into question after the narcissistic piece generated by having problematic children. As was said earlier, in the initial stages of group work the couples are completely focused on the symptom and this prevents them from looking at how they relate to one another. It is only with time and sharing that they come to understand the importance of the relationship with their daughters more than the one their daughters have with food. At this point we can observe true progress which opens up the road for the emergence of the first conflictual knots. And so we find quickly coming to the fore the children's difficulties, as well as those of the parents, with accepting reciprocal autonomy derived from growing up.
In this regard it comes to mind that in one of the last sessions the mother of an anorexic teenage boy, hospitalized for nearly two months in our ward and who is now following a program of family therapy, said that during a therapy session her son had talked about wanting to go live on his own.
The mother reported this incident with great stupefaction, as she had always wanted to see her son – with extreme ambivalence – as a "mamma's boy". In fact, from her words it was easy to see her suffering related to this desire.
After a few months of the group working together we were confronted with an obstacle: there are no words to express the complexity of emerging emotions. Having exhausted the supply of "stories" about their children, it was as if the parents didn't have anything more to say. The only couples who seemed to be able to come up with words, and to be able to verbalize, were those who find themselves in emergency situations. There was the risk of getting bogged down in the same pathology as the child's, thus stopping the evolving progress of the group. We moved into a period of boredom in which it became evident that we needed to move deliberately in a way which would allow the parents to re-appropriate their own positions.
Themes of parental function, and of the motivations for and goals of this experience weighed on the group panorama. The poles from which observations were made switched, from the children's perspective to that of the parents.
We can note, in fact, how these couples have a very hard time managing to observe their children's problem from a more adult point of view which could allow some

space between being parents and being children. It seems as if they are unable to distance themselves from the symptomatology and so it starts to represent their primary way of relating with the object. They are so stuck in the problem, they fear they will "lose" not only their own maternal/paternal role, but also their own individuality.
The evolution of Giuseppe, father of a girl who was treated in the ward earlier, proved to be an interesting aspect of the group.
This man had always had the role of *Genius loci*. The *Genius loci* (Neri 1996), in small groups with an analytic mission, has the job – of which he is thoroughly unaware – of animating or re-animating the group's identity, of connecting the group's progress with its affective base. The *Genius loci* therefore must also prevent the group from becoming sclerotic as well as from becoming excessively institutionalized. Its function is also that of preventing rifts or wounds in the members' identity, while at the same time allowing the group's development.
In any case, Giuseppe, in the group's last session which coincided with a psychotic episode of his daughter's, abandoned "his role" and entered more directly and in a more participatory way with the group, bringing his anxieties and his concerns to the group in a way that they could be shared and received.
Groups do in fact, being a protected microcosm (Corbella 2003) release one from these containment roles, almost like a mother's womb.
The group's work, as declared by its participants, was very "energetic" in the sense that "the repeated immersion in its grandiose self permitted them to achieve that archaic fusionality, which allows for the development of the self in a more authentic way" (Corbella, 2003). In this regard I think it is useful to report that which happened in the fifth session, that is at the half-way point of the program. On this occasion the parents, for the first time, sat very close one to the other. The group's conversations had revolved around the theme "you mustn't pull back from the table". In particular, one mother told about how her daughter expects her parents to stay with her at the table for the entire duration of the meal, which lasts about an hour and a half, thus exercising an omnipotent power over them. The parents felt that, in the face of this request, they could do nothing but "go away", refusing a request on the part of the daughter, which became for all a pseudo-sharing. In the parents' discussions the difficulty in separating themselves from their children took on a completely negative value (we can't pull back from the table), but in the here and now of the group it was clear that there was also from the point of view of the parents a search for fusionality which, if verbalized and thought through again together, could allow for access to positive aspects of fusionality, which in the parents' stories cannot be found. Being able to share positive aspects of a kind of adult "fusionality" took on a reparatory/constructive value.

On the part of the participants there was difficulty in integrating the double, positive-negative value of sharing and of movement toward identification. The group cannot allow for the acceptance of the most primitive needs and the most advanced needs of its members. Acceptance into a therapeutic group means that both needs are made thinkable, and interaction becomes the instrument which allows for individual growth within the group. There one can accept that which is usually, outside of the group, expelled (cut off and projected outward). Finally it becomes possible to give voice and meaning to thoughts never thought. In the group there is a moment of silence which underlines a temporary, constructive retreat from interaction. The chance to take on the responsibility of thought goes through two stages: a first unavoidable moment in which distance is taken from the group and so an acceptance of one's own solitude, and a following moment of renewed acceptance of your own belonging to the group, which allows and even stimulates exchange of that which is thought individually. At the beginning of group work the therapist who wants to build responsibly a group therapy culture must first of all take on the responsibility of thinking as a group and about the group exactly so that the participants are allowed to get to the group thought earlier and then to thinking as a group, and then later about group, and in group, in the alternating dialectic of becoming in the spiral of time. It is the therapist to promote this possibility at the beginning of the therapy, for example when he/she needs to help the group get over a fusional stall and stimulate movement toward identification, or when he/she needs to avoid or contain the group's potential for destruction such as the creation of a sacrificial lamb or the dominating of an "unsaid".

Conclusions

The group has resources which, if well run, can serve in moments of crisis.
It is important that we consider the uniqueness with which each person uses the group and how this develops as a whole and at the same time how it allows for the use of individual characteristics of the group's members. The processes which develop in a homogenous group (with which is meant a group whose members have one or a few directed objectives, goals or functions) bring into focus some peculiar clinical dimensions. The importance of the leader's role comes to the fore; the function of communication within the group in relation to the various phases which it has passed and in relation to the conscious communication processes and the unconscious ones; the function of "containing". In homogenous groups *transfert* toward the group as an entity is amplified to the maximum and in that case the therapist is considered an "outsider" (H.D. Kibel, 1998).
The therapist will have to promote the image of the group's identity as an object which "contains" and, in the same way, will have to accept his/her role as an "outsider"; it is

only with “the expulsion” of the therapist (in fantasy) that the members of the group bond with each other in the strongest way.
The group’s homogeneity has a function which regards the possibility of giving participants a sense of security in relation to the fear of beginning, belonging to and participating in a group (Friedman, 2004). The most important process is inherent to protection from differences/variations and the elaboration of anxieties which develop, as seen in our hospital experience, around the issues of inclusion, loss, control, and intimacy (Schutz, 1996) and the need for containment. Probably this type of defense works in both conscious and unconscious identification processes. Finally, another function is the hope of learning from those who have experienced the same problems and who deal with the same pain.

Personal considerations

The group is born initially and then becomes interiorized in the mind of the people and groups start to be understood also as a possibility to access understanding and sharing of moods and ways of thinking , which is something that goes well beyond simple, objective presence of many people (Speltini, 2002). In the group I observed, great satisfaction on the part of the participants was underlined many times, even if almost none of them had ever participated in a group experience before. New emotional openings and a new awareness of certain life experiences were possible thanks to mood which everyone shared.
Seeing anorexia as a style of life or as a sickness which develops within a relational group (familial, cultural, or social) means giving back vital complexity to a private, subjective experience. With attention given to social and primitive aspects of the mind one favors listening and working through within a group, succeeding in this way to give sense to the experiences, even extreme ones, which appear in eating disorders.
In this perspective, the group, as S. Marinelli (2004) argues, becomes a system which is able to receive and to furnish with cohesion those patients who are afflicted by modern pathologies connected to psychosomatic fragility and the fragility of identity.

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