Compulsory treatment in eating disorders – the role of control and provocation. The coercion paradox

Ferenc Túry, Tamás Szalai, Irena Szumska

Institute of Behavioural Sciences
Semmelweis University
Budapest
H-1089 Budapest, Nagyvárad tér 4

Abstract

In the most severe forms of eating disorders (especially in anorexia nervosa), when the patient do not have insight and refuses life-saving treatment, compulsory treatment can be necessary. However, there are strategies which diminish the resistance and enhance motivation. The therapist can reframe the compulsion, or turn the vector of it, or with the technique of splitting can form an alliance with the healthy part of the patient. The involvement of the families is always essential during the treatment of eating disordered patients.

The issue of control is a central phenomenon in eating disorders. The anorexic overcontrol can sometimes be observed paradoxically, this is the control paradox. Other paradoxes are also described in anorexia, i.e., the body weight paradox and competency paradox. In this study the importance of provocative behaviour of anorexic patients in the family is discussed. The provocation has a positive message with challenging important family issues, and in this aspect a coercion paradox can be conceptualized.

Key words: eating disorders, anorexia nervosa, bulimia nervosa, compulsory treatment, provocation, coercion paradox

Introduction

Eating disorders are serious, many times life threatening conditions, with a high mortality rate of anorexia nervosa (AN). The treatment of these disorders is a difficult task for the practitioners. During the treatment one of the major problems is the denial of the illness, mostly in AN. Bulimia nervosa (BN) can also be a dangerous condition, and is frequently hidden. About 80% of the bulimic patients do not seek help. It is a major challenge in the psychiatry to detect hidden disorders (not only BN, but also some anxiety disorders and affective disorders).

Denial of the illness

There are several psychiatric disorders which can be characterized by the lack of insight (e.g., schizophrenia). AN is a typical disorder of the denial, and about three-quarter of the anorexic patients can be characterized by the denial of illness in the first years of treatment (Noordenbos, 1992). The denial is not a constant relationship, but a dynamic process with many functions – there are adaptive aspects as well (Vandereycken, 2006). There is a continuum from total denial through non-compliance and change after persuasion to insight and total compliance. During the treatment the transitions between these forms can be observed. At the beginning of the therapy, when the most intensive denial is in the foreground, the patient's resistance may be a powerful message to the parents, reflecting certain family dysfunctions. In line with the continuum of denial, a similar continuum relates to compulsion.

Compulsory treatment

In severe AN, when the patient do not have insight and refuses life-saving treatment, compulsory treatment can be necessary, e.g. in direct suicidal risk (Elzakkers et al, 2014). As full recovery is possible in life-threatening AN, detention is sometimes justifiable (Thiels, 2008). One of the forms of compulsion is the tube feeding, which should be applied only in the most dangerous situations. The degree of the compulsion is the most important topic of the debate about the compulsory treatment. If the patient denies the illness, subjectively every therapeutical interventions become compulsory. Because of the lacking insight some kind of coercion is an almost necessary part of AN treatments. Some authors argue that compulsory treatments are effective only in the short term (Ramsay et al, 1999).

In the severe cases of AN the compulsory treatment regularly mean hospitalization. This is the most important step in the realization of the external compulsion. In the hospital there are strong forms of compulsion, e.g. tube feeding in extreme emaciation. The soft forms of compulsion

include the pseudo-contracts: the patient has to sign it, but practically there is no choice. These are not real contracts, but dictates. In the honest and congruent patient-therapist relationship the communication should be clear: tha patient always has to know whether (s)he has choice or not. Contracts are used in many therapeutical regimes, but we have to differentiate between prescription and contract. The latter means a responsible decision: I, the patient accept what is proposed.

Strategies which can diminish the resistance and enhance motivation

Do we need compulsory treatment in the difficult cases routinely, or do we have other opportunities? There are strategies which can diminish the resistance and enhance motivation. In all cases the positive attitude of the therapist is a prerequisite. Sometimes confrontation is inevitable, but it should be used with support. Paternalism doesn't help the establishment of a trustful relationship. It is crucial how therapists "offer", and how patients perceive compulsion and coercion in the course of the treatment. The perception of coercion is complex, and it is not necessarily associated only with the degree of restriction of the patient's freedom – it is moderated by the nature of relationships with their parents and mental health professionals (Tan et al, 2010). This also means that the good therapeutical relationship and congruent, motivating communication with parents and therapists are crucial to lower the level of coercion.

The therapist may *reframe* this conflict: "it is not the treatment, which is compulsory, but staying alive – or improving health – is compulsory". In a serious physical and psychological situation the treatment can be regarded not a coercion, but an act of compassion towards the patient (Tiller et al, 1993). Therapists have a compulsion to save life and improve its quality, but patients have a compulsion to demolish their life.

There are several proposals, how to diminish the resistance in the case of treatment refusal (Goldner et al, 1997):

- Seek to engage in a sincere and voluntary alliance.
- Identify the reasons for refusal.
- Provide careful explanations of treatment recommendations.
- Be prepared for negotiation.
- Promote autonomy.
- Weigh the risks versus benefits of treatment imposition.

- Avoid battles and scare tactics.
- Convey a balance of control versus noncontrol.
- Ensure that methods of treatment are not inherently punitive.
- Obtain ethical and legal clarification and support.
- Consider legal means of treatment imposition only when refusal is judged to constitute a serious risk.
- Consider differential treatment in chronic AN.

There are *motivational strategies* across different treatment methods of eating disorders (Vitousek et al, 1998). Therapists are recommended to understand the patients' personal experience of the disorder with an emphasis on distress from weight gain and acknowledgement of difficulty of change. A Socratic approach towards resistant patients can be very useful, based on doctor-patients collaboration, curiosity towards their experience, and patience. The main and especially fruitful motivational themes are for reluctant patients: psychoeducation about the disorder; examination of the advantages and disadvantages of symptoms; utilizing experimental strategies in the treatment (objective fact-finding including models about the disorder); exploration of the patients' personal values.

There are questionnaires to detect the motivation of the patients. The Readiness and Motivation Interview for Eating Disorders is a semi-structured assessment tool about the patients' experience of their symptoms, which helps clarifying the extent of readiness and motivation for change including internal versus external reasons (Geller & Drab, 1999).

The therapist can *turn back the vector of the compulsion*: not the patient is under pressure, but the parents – and last, the therapist. The parents have to do steps for the sake of their child in a life threatening situation. The therapist is also forced to do the rules of a serious situation. Who can propose better solution in a serious situation? The therapists are committed and assigned to heal and save lives so *they* are also under the compulsion to deal with serious situations.

The *therapeutical splitting and forming an alliance with the healthy part of the patient* is also an effective tool to involve the patient to a certain level of collaboration. Splitting is a defense mechanism characterized by polarization of feelings and objects such as love and hate, good or bad, attachment or rejection. In contrast with that, therapeutical splitting can be intentionally

utilized by the therapist in order to form a better compliance with the patient. We can say to the aggressive patient e.g.: "*I see the positive side of you, and I know that your eating disorder has a serious psychological message. You are OK in 95%, the family is important for you, you are clever and learn well. But in 5% a small devil lives inside you, which causes problems, and I would like to make alliance with your healthy 95%. Let's fight together against this little devil."* After this proposal the patients keep silent, which is a good sign. There is no protestation or objection – nobody said that I don't want to make any alliances.

The *involvement of the families* during the treatment of eating disordered patients is always crucial to deal with the resistance, even if individual therapy is the focal therapeutical strategy, or even if the patient is adult. Of course, there are sometimes circumstances when no family member can be involved in the therapy. The family is the interface between the patient and the therapist – the parents have to take over the responsibility in severe situations. It is important to stress, that a certain amount of responsibility remains always at the patient – even in the directly life-threatening situations. E.g., only the patient can regulate the amount of consumed food (in the case of tube feeding many patients do tricks to get rid of the fluid or calories). On the other side, the responsibility of the parents is to check the body weight, and to limit burning calories (hyperactivity). In hospital, when the hyperactivity or self-harm behavior is extreme, the staff assures continuous control. The parents have to take the responsibility with concrete actions relating the health status of the child. This implicates that the patents are "forced" to make challenging actions (Swensson et al, 2013).

An extreme situation can occur when the patient do not want to consult the doctor, and she is not in a serious condition, so the parents cannot force her to undertake the family therapy. In this situation we can do *family counselling – treatment without patient.* If only the parents visit the therapist, it can be helpful, because the parents learn how to deal with the anorexic child, how the control the pathological behavior.

Case vignette

One of the authors (TF) consulted the parents of a 17-year-old anorexic girl, who did not want to come to family therapy. Her height was 170 cm, and the body weight was 47 kgs (BMI: 16.26). The parents showed photos of the girl, who never came personally to the consultations. The most important points of the anorexic behavior were discussed, the parents changed their communication, even their marital relationship improved. After five session the body weight of

the girl increased four kgs. It was not a completed therapy, but a significant change could have been observed.

Another possibility to treat the resistance is the *home visit* (if the mountain won't come to Muhammad…). It is a very useful (and rarely used) therapeutical technique. Family visits can help to reduce resistance. The theoretical basis is the environmental psychology and the structural family therapy – the former deals with the informative aspect of personal environment. These visits have several advantages (Túry et al, 2008):

- Environmental psychological information can help in understanding family functions and dysfunctions.
- The visit shows the physical and the psychological boundaries, and the structural characteristics of families.
- The therapists have the opportunity of giving home tasks on site.
- The visit is a special opportunity for an intimate encounter with the family and for deepening of the therapeutic relationship. Moreover, it has a strong confidence-boosting role.

Sometimes the therapist have to consider not to treat the patient for positive reasons. There are situations, when *no treatment is the prescription of choice* (Frances and Clarkin, 1981): to save the patient from iatrogenic harms, to postpone the therapy for a better period, to save the results of a former therapy, to avoid pseudo-treatment, or to give the patient the opportunity for spontaneous remission.

In chronic and serious cases the patient should not be forced to be hospitalized, e.g. after many inpatient treatment. In these situations the palliative care can be the strategy. The therapist can offer the opportunity of visiting the hospital only for one day, and the patient can come back any time.

The control in eating disorders – the anorexic control paradox

The issue of control is a central problem of eating disorders. Patients with AN are overcontrolled, those with BN confront lack of control from time to time. So, eating disorders can be conceptualized as *dyscontrol syndromes*. Therapeutic strategies also aim to develop an

internal control, rather than forcing external coercive tools. Control and compulsion have a simultaneous and complementary nature in treatment of eating disorders.

However, the anorexic overcontrol emerges paradoxically in three aspects, this is the control paradox in AN (Lawrence, 1979). First, the obsessive control of the body weight replaces the control of the real issues of the life for the patient. The AN can be regarded as a rebellion against the parents, an exaggerated form of protestation. In this serious situation the parental messages are often controversial. They experience that the autonomy and obedience of the child is simultaneously lacking. The patients want to be autonomous, but their severe medical symptoms lead to a parental control (often overcontrol). Second, the control paradox can be found in the self-image. The perfectionism can mask the low self-esteem, the self-starvation raises the sense of self-control. However, this sense of control turns soon, because the physiological processes lead on a severe state. Third, there is a controversial relationship between the AN and the slimness ideal. The patient feels that she has to lose weight to become more attractive (many times it is a question that she wants to be slim and nice for herself, or for others). However, the exaggerated weight loss results in a socially disadvantegous emaciation. Sometimes it is difficult to say, whether the patient wants to rebel against the attractive appearance, or to fulfil the requirements of the fashion in the culture of slimness. The controversy relates to the female beauty and the denial of sexuality as well.

Other anorexic paradoxes

The controversial nature of the AN can be found in some other paradox features of the disorder. The *body weight paradox* means that during the treatment there is many times an over-emphasis on body weight. This attitude of the professionals can be inappropriate and misleading, because one of the core symptoms of the disorder is the morbid preoccupation with weight (Lask and Frampton, 2009). On the other side of this problem we can see that insisting to a healthy nutritional state (and normal body weight) is a positive endeavor towards the recovery. Otherwise, if the therapist doesn't care about the weight, it can lead to a hidden coalition with the anorexic part of the patient. This may be the reason of long-lasting and unsuccessful therapies.

Another paradox is the so-called *competency paradox*: the severely anorexic patients may be mentally competent to refuse care, in spite of their serious somatic condition. It may be a problem how to initiate the compulsory treatment (Wall, 2017).

The concept of the coercion paradox

As the denial, the issue of compulsion is also a spectrum, not a dichotomous feature. Regarding to the compulsory treatment we can suppose a *coercion paradox* in AN. It is similar to the control paradox. The coercion is not a simple phenomenon, not the linear causality is valid in this respect. It is rather a relational problem. In the next paragraphs we will focus on the usual family setting: the anorexic child and the parents. Of course, in the case of older patients, when the relationship to the parents is not strong, and the patient lives alone, the situation can be totally different.

The incompetence and inconsequence of the parents, which can often be observed in anorexic families, causes insecurity in the child. There is no clear guideline in the difficult situations of life. The rebellion of the anorexic children often reflects to the lack of definite guidance. Social psychological experiments produced evidences that the different groups need leader, otherwise anarchy will be the consequence. In the family the situation is similar: if there is no clear hierarchy, the life will be unpredictable, and insecurity takes place.

The exploratory behaviour of the child means that the child tries to step through the boundaries, and the consequences will help him/her to navigate in the situations. The child addresses challenges towards the parents, and their reaction will be the basis of orientation. This is the phenomenon of the everyday provocation – in a positive sense, because it serves the better orientation in the life. The child knows the environment not only passively, but also endeavors to influence it, to challenge it, to try the reach (radius of operation).

The unconscious aim of the child's provocations is generally to elicit the clear-cut behaviour of the parents. The provocation is not a misconduct, but a necessary step in the personality development. The anorexic child found a very powerful tool in the dangerous symptoms of AN to push the parents to be determinate, e.g., to undertake hospitalization. It is natural that the child will show opposition, sometimes in a cruel manner – the earnest standpoint of the parents can be best seen against resistance. The child feels that the parents will be obliged to seek help and treatment. There is a certain double-entry bookkeeping. A paradox manifests itself: *the child coerces her parents to coerce her* towards the right direction. The positive aim of the provocation is obvious in these situations. So, the secret message of this anorexic behaviour

often is: please force me to choose the right direction, because it helps me to recognize the boundaries in the life.

We can interpret this intrafamiliar pattern on the basis of transaction analysis and game theory. The child will have long-term gains, if her parents will be more definite, learn to say no to her, and set the boundaries in the life, signing the dangers as well.

One of the reasons of the lack of therapeutical success can be that the positive message of the provocative behaviour of the anorexic child is unrecognized. In these situation the parents and the therapists become stuck in the simple operant conditioning. The pattern of the provocation can be best understood in family therapy. In the individual therapy the influence of the parents is not in the focus.

Case vignette

A 16-year-old anorexic girl showed strong resistance against outpatient psychotherapy, she was passive during family therapeutical sessions, kept looking at her watch, and was sometimes verbally aggressive to her parents. The parents felt themselves helpless, especially her father, who expressed frequently that he is only a mathematician, who is incapable in the psychological matters. After several kilograms weight loss hospitalization was decided. It was the father's duty to bring her to the hospital. He was so afraid of his own incapacity, that he booked an ambulance. Surprisingly, the girl got into their car quietly, and the ambulance became unnecessary. So the girl forced her father to make a definite step towards the more intensive treatment form.

Fights of control and provocation

The relational strains often come from control issues, emotional pressure and blackmailing. The reproach, the snuff, the martyr behaviour are more or less hidden forms of aggression. These are frequent manifestations of parental manipulations. Moreover, the child can also blackmail her parents. The eating disordered children used to ask their parents: why don't you trust in me? It is important to believe in the real changes than in promises – it is a well-known trap in the course of eating disorders.

Many parents feel that they are not good enough parents if they do not trust in the child. If the parent do not dare to criticize the child, because (s)he is afraid of losing the love of the child,

this is the antechamber of the blackmailing. This behaviour goes generally hand in hand with the provocation. To avoid this, the parents should learn some kind of twoness: the consistence embedded in love. If needed, to say no – for the sake of the child.

The will, the stubbornness, and the defiance are closely interrelated characteristics. Their formation is one of the central parts of the personality development. This process is primarily realized in the parent–child relationship, with a basically positive aim, i.e., that the child learn to prove his/her will. Of course, there are wrong tracks as well. The defiance is a form of passive resistance, while the provocation is a more active mean of the regulation of relationship. In the background several unconscious aims can play a role. One of them may be the precipitation of the necessary parental control, which means security, and the milestones of orientation. Another aim may be that the child wants to elicit real emotions from the parents, which means intimity, not a mannered role playing. Children consider real feelings an honour: so they are real partners of the parents. Neutrality would be much worse, and it would mean that the child is not important enough for the parent. A further aim may be to raise the attention of the family members. The child wants to place his/her personality in the focus, so to increase the self-efficacy and sense of competence.

Provocations become dominant in the family life, when the necessary parental guidance is lacking, and the parents feel themselves helpless and incompetent. In the family history of parents the influence of old stories can generally be found in the background of this parental attitude. E.g., after a past abortion the couple vow that they will be good parents. Mapping the family history by setting a genogram may be crucial in the course of the family therapy.

Many family stresses reflect the hierarchy: who decides what in the family. If the family cannot decide in an important situation, the uncertainty will be stressful for the children. The leading role should be undertaken in the family, because the incapacity in decisions will lead to chaos.

In eating disorders provocative behaviours occur very frequently, because eating and food have numerous emotional meaning in the family: who prepares the meals, are there common meals or not etc. The parents can be easily provoked with eating and refusal of food. The provocation is more or less unconscious. The patient knows (or rather feels) that there is something wrong with her, so the parents are forced to step forward. The provocations keep going until the controlling behaviour of the parents changes. It is essential in the course of the family therapy

that the parents would understand the positive meaning of the mechanism. The parents, and the helpers often regard the provocative behaviour a conduct disorder and punish it.

Responsibility as a central factor

The human responsibility can be the concept which dissolves the problem of compulsion, and is at central importance in the treatment of eating disorders (Lester, 2007). The life and the health are values, and we are responsible to maintain them. An ancient Indian proverb says: "Treat the earth well: it was not given to you by your parents; it was loaned to you by your children." So we can say about our body: Treat your body well – it was not only given to you by your parents, but you have to use it for the sake of your future children. One has to be responsible for his/her body and health.

The building of responsibility can be used at the hospitalization in seriously anorexic cases. E.g., we can say (Stierlin and Weber, 1989): "*You have to be admitted to the hospital in this serious situation. 80% of the patients accept this solution, 20% will be angry and may threaten with committing suicide. What group do you belong to, the 20% or the 80%?"* In this example the importance of responsibility is stressed. The opportunity is provided to choose consciously the resistance – it can be regarded a certain form of paradox.

In the opinion of eating disordered patients the role of genetics and personal responsibility in the development of eating disorders is controversial (Easter, 2012). Most patients found that introducing the role of genetic and other risk factors can reduce the shame and guilt coming from the sense of personal responsibility. However, even half of the patients worried, that relying on genetic and other external excuses can lead to fatalistic self-fulfilling prophecies and may reduce the sense of self-efficacy in defeating the eating disorders.

We may conclude that patients are not responsible for developing and suffering from eating disorders, but it is their primary responsibility to struggle against the illness. During the motivation therapists shall reduce shame and guilt, reframe the eating disorder as the coercive phenomenon over the patients' lives, then enhance the patients' responsibility for their own health.

In some cases both the patients and their families are relieved to hand over responsibility to the therapist. However, the responsibility for eating shall be gradually handed back to the patient.

It also means that the patient is responsible for her own health. So she shall make steps for her own health, and the parents help her with being consistent in keeping agreements, while a trustful relationship with a secure and consequent therapist assures a better guidance. This may hold a balance of responsibility and freedom.

References

1. Easter, M. M. (2012): “Not all my fault”: Genetics, stigma, and personal responsibility for women with eating disorders. Social Science & Medicine 75:1408-1416.
2. Elzakkers IF, Danner UN, Hoek HW, Schmidt U, van Elburg AA (2014): Compulsory treatment in anorexia nervosa: a review. International Journal of Eating Disorders 47:845-852.
3. Frances, A., Clarkin, J.F. (1981): No treatment as the prescription of choice. Arch. Gen. Psychiatry 38:542-545.
4. Geller, J., Drab, D. L. (1999): The readiness and motivation interview: a symptom-specific measure of readiness for change in the eating disorders. European Eating Disorders Review 7:259-278.
5. Goldner EM, Birmingham CL, Smye V (1997): Addressing treatment refusal in anorexia nervosa: clinical, ethical, and legal considerations. In: Handbook of treatment for eating disorders. Ed. Garner DM, Garfinkel PE. Guilford, New York, pp. 450-461.
6. Lask, B., Frampton, I. (2009): Anorexia nervosa – irony, misnomer and paradox. European Eating Disorders Review 17:165–168.
7. Lawrence M (1979): Anorexia nervosa - the control paradox. Women's Studies International Quarterly 2:93-101.
8. Lester, R. J. (2007): Critical therapeutics: Cultural politics and clinical reality in two eating disorder treatment centers. Medical Anthropology Quarterly 21:369-387.
9. Noordenbos, G. (1992): Important factors in the process of recovery according to patients with anorexia nervosa. In Herzog, W., Deter, H.C., Vandereycken, W.: The course of eating disorders: long-term follow-up studies of anorexia and bulimia nervosa. Springer, Berlin-New York, 304–322.
10. Ramsay, R., Ward, A., Treasure, J., Russell, G. (1999): Compulsory treatment in anorexia nervosa: Short-term benefits and long-term mortality. The British Journal of Psychiatry 175:147-153.

11. Stierlin, H., Weber, G. (1989): Unlocking the family door. A systemic approach to the understanding and treatment of anorexia nervosa. Brunner and Mazel, New York.
12. Svensson, E., Nilsson, K., Levi, R., Suarez, N. C. (2013): Parents' experiences of having and caring for a child with an eating disorder. Eating Disorders, 21:395−407.
13. Tan, J. O. A., Stewart, A., Fitzpatrick, R., Tony, H. (2010): Attitudes of patients with anorexia nervosa to compulsory treatment and coercion. International Journal of Law and Psychiatry 33:13-19.
14. Thiels, C, (2008): Forced treatment of patients with anorexia. Current Opinion in Psychiatry 21:495-498.
15. Tiller, J., Schmidt, U., Treasure, J. (1993): Compulsory treatment for anorexia nervosa: Compassion or coercion? British Journal of Psychiatry 162:679-680.
16. Túry, F., Wildmann, M., László, Zs., Dúll A. (2008): Environmental psychology and home visits in the family therapy of eating disorders. Int. J. Psychotherapy 123:36-44.
17. Vandereycken, W. (2006): Denial of illness in anorexia nervosa – a conceptual review I-II. European Eating Disorders Review 14:341-368.
18. Vitousek, K., Watson, S., Wilson, T. G. (1998): Enhancing motivation for change in treatment-resistant eating disorders. Clinical Psychology Review 18:391-420.
19. Wall, B.W. (2017): The competency paradox in somatic disease. J Am Acad Psychiatry Law 45:426–8.