Engaging Patients with Eating Disorder to Treatment via Collaborative Understanding of their Emotional Issues Across Lifespan

Moria Golan*
Tel Hai Academic College and the Hebrew University of Jerusalem, Israel

Abstract

Most patients with eating disorder (ED) are ambivalent regarding change. The more severe the eating disorder, symptoms are perceived as being preferable to the alternative distresses and patients present negative coping mechanisms such as denial and/or opposition to treatment.

This report describes clinically driven strategy for engaging patients with eating disorders to therapeutic process. It describes a structured procedure for the preliminary meeting with the patient focusing on developmental tasks, difficulties and coping mechanisms.

There is an emphasis on the process of achieving collaboratively narration of the context in which the eating disorder invaded and how it relates to the patients’ emotional issues across the life span, as well as the etiological theories in which it is rooted. We review the patients’ history from childhood through adolescence or adulthood, exploring the nature of emotional and developmental difficulties in the different ages. We track how they impacted the person’s behaviors, personality and coping mechanisms, as well as the reasons he/she was tempted to the eating disorders’ ‘shelter’. A dynamic understanding, motivational interviewing, and engagement in externalizing conversation are the means used to reveal the prices and motivate the patient to take control of his/her life and choose to be treated.

Keywords: Eating disorders; Motivational interviewing intake; Developmental narration

Introduction

Patients with eating disorders (ED) often resist treatment. Denial and resistance to change are prominent features in most patients with ED [1]. The ego syntonic quality of symptoms can contribute to ambivalence and avoidance of treatment, difficulties in establishing a therapeutic relationship and high rates of attrition and relapse [2,3].

Ambivalence regarding recovery has been understood as expression of selfless souls with difficulties in achieving self-regulation, calming, soothing, and vitalizing [4,5]. Symptoms are perceived as being preferable to the alternative distresses since they present a coping mechanism against ego weakness, anxiety, and interpersonal factors [6,7] as well as high-reward dependence, arrested self-development [8-10]. Awareness of ambivalence seemed to encompass two aspects: inner struggle and fear of recovery. On one hand, the desire for recovery and on the other hand, the desire to resist themselves and struggle for thinness. Inner struggle may reinforce the fear of recovery and vice versa [11].

This manuscript describes clinically driven developmental narration in the first session, aimed to engage patients in the therapeutic process. This session has been named as the ‘preliminary phase’ in our model published recently and as “intake” by others [12].

The life story can serve to unify contextual and diachronic elements of the self, while also distinguishing this self from others. Due to the conceptual overlap between self-continuity and identity it is perhaps unsurprising that the life story and identity have often been equated [13]. The purpose of developmental narration is to deconstruct ‘problem saturated identity conclusions’ and understand them in the context of the biological and psychological characteristics in the person’s life [13].

First steps towards patients engagement

The evaluation and engagement session aims at getting to know the client, his/her problem, achieving mutual understanding of the context in which the ED invades his life and how it relates to the patients’ emotional issues along lifespan. Revealing the prices of having ED, frequently motivates the patient to take control of his/her life and choose to be treated. Such understanding often assists patients to retain the sense of control on their lives, which echoes the need for control that characterizes individuals with ED [14].

Part of the “therapeutic partnership” is achieved via collaborative review of the patients’ developmental narrative in respect to affect, fears and impulsivity features. It is done using a dynamic understanding, motivational interviewing [15] and engaging in an externalizing conversation (position the illness external to the patient) [16] contradicting most patients’ perceptions that they themselves are the essence of the problem. The patients are reassured that the vital, compensatory aspects of the psychopathology are deeply understood and that their apprehensions will be carefully appraised in shaping the interventions undertaken. Furthermore, changes sought will be measured against their tolerance to the anxieties that may be triggered [17,18].

Case illustration

Noa, a 20 years old female who had struggled with bulimia nervosa for the past three years. She had been referred to us by the eating disorders department where she was hospitalized for the last 3 months and had been discharge due to lack of collaboration. Noa came into the room with the filled demographic and personal details questionnaire. After a brief glance, I reflected that she had been through many interventions and I wondered what will be a success treatment for

*Corresponding author: Prof. Golan Moria, Tel Hai Academic College and the Hebrew University of Jerusalem, Israel, Tel: 972-547240330; Fax: 972-89348796; E-mail: moria.golan@mail.huji.ac.il
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The anamnesis features explored in each life period, the personal perceptions derived and the theoretical orientation explaining its relation to the eating disorder.

Table 1: The anamnesis features explored in each life period, the personal perceptions derived and the theoretical orientation explaining its relation to the eating disorder.
### Infancy
- **Temper:** Restless, low sleep
- **Sensitivity:** Intense cry

### Childhood
- **Regulation axis**
  - **Affective axis:** Emotionally
  - **Impulse axis:** Outbursts, passionate eating
  - **Anxiety axis:** Fear from strangers, fear from pictures, avoids sleep out
- **Personal**
  - Achievements: Good student, ADHD
  - Social issues: Many friends
  - Self-image: Hard for parents, the bad one

### Special events/trauma
- *Her brother's birth is considered as a special negative event for her*

### Identity conclusions
- Less liked than my brothers

### Adolescence
- **Regulation axis**
  - **Affective axis:** Extreme mood fluctuation
  - **Impulse axis:** Becomes morbid obese, passionate eating
  - **Anxiety axis:** Avoids out-home sleep
- **Personal features**
  - Achievements: Good marks but has behavioral issues at school
  - Social issues: Tyrannical behavior towards friends and family, extremely competitive
  - Self-image: Too fat, too intense, too much
- **Maturation**
  - Physically: Normal
  - Body image: Very negative, full of hostility
  - Emotionally: High performance winner when mother had cancer, she presented high resilience

### Special events/trauma
- None (from her point of view)

### Identity conclusions
- The black sheep of the family, not good enough, defective, no uniqueness

### Family dynamics
- Hard relationship with father, mother is overprotective, impulsive and aggressive family communication with intense outbursts by father and Noa.

### Coping Mechanisms
- Anxious avoidance and escape (concentrating on performance and 'doing' rather than on introspection and positive coping strategies), projections denial and splitting.

### ED provides a sense of:
- Self-regulation, control on self and others, mechanism for improving self-esteem and body image, legitimisation for the ‘status of sick’ and thus lack of progress in future

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**Figure 1:** The Problem Narration.

**Figure 2:** Noa’s Problem Narration.
Engaging ED patients in treatment is a challenging task. The described process of engaging patients and parents to the developmental context in which the eating disorder invaded, has been developed in the context of working with people with eating disorders and their families.

Asking for permissions as well as sharing reflections with the patients and get their approval for the therapists understanding, provide them with a sense of control and self-agency on the narrative created, sense of being understood and not isolated as well as becoming less defensive because their ambivalence is explored.


Discussion

The combination of developmental, narrative and motivational approach has formed the basis for many therapeutic models over the years [18,20,21]. Each of these models approach the patients with different strategies but with similar spirit: emphasizing partnership, honoring patient’s expertise and perspectives, affirming of patient’s right and capacity for understanding the context of the illness development as well as ways to cope with it.

Although such an intake is time consuming, it is theory based, can be delivered by therapists from different professional backgrounds and the potential for change is enhanced through a sense of collaborative understanding and empowerment of the patients who frequently present a sense of inferiority [22].

Conclusions

The described tool is a useful heuristic to help patients and their families understand the many factors that contribute to the illness and what plays a role in its persistence, as well as suggest how treatment can challenge them.

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References


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