

# **Eating disorders, Parent-child Conflicts and Family Therapy: A Qualitative Study in Shenzhen**

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# Background of The Study

- Eating disorders affecting 0.48% of adolescents age 12 to 18 in the USA (Lock et al., 2004)
- A rising mental health problem for adolescents and young women in China
  - Anorexia nervosa
  - Bulimia

# Background of the study

- The symptoms of ED (self-starvation, purging, bingeing and excessive exercising) have detrimental effects on health, psychological well-being, schooling, family relations, and social activities
- If not properly managed, resulted in high morbidity and mortality

# Background of the Study

- Drug treatment alone is ineffective
- Family therapy superior to individual psychotherapy
  - Emaciated adolescents aged 18 or below with a history of the illness shorter than 3 years (Russell, Szmukler, Dare & Eisler, 1987; Russell, Dare, Eisler & Le Grange, 1992)
- Assess the applicability of family therapy in Kong Kong 7-years ago
  - Outcome of the study encouraging and promising (Ma & Lai, 2006; Ma & Lai, in press)

# Background of The Study

- Development and maintenance of symptoms
  - Contextual dependent
- China is a rapidly transforming society after the 'open door' policy and economic reform

# Research Questions

- Characteristics of parent-child conflicts between Shenzhen young people suffering from ED and their parents
- Understand their contextual meanings within the socio-cultural context in Shenzhen

# Literature Review

- Clinical summaries and clinical reports (Sung & Fang, 1990; Chen, 1990; Wang, 1999; Tai, 2001; Ding & Hu, 2001)
- Assessment of psychometric measures developed and commonly used in the West for disordered eating namely EDI (Zhang & Kong, 2004; Chen, Leung, Wang & Tang, 2005)
- Study of psychological factors predicting dieting (Xiao, Gail & Aian, 2001)

# Literature Review

- 4 qualitative studies in Hong Kong on meanings of food and self-starvation (Ma et al. 2002; Chan & Ma, 2002a, b, & c)
  - Self-starvation as an expression of love and control, coalition of the AN daughter with the mother, family loyalty, powerlessness and helplessness of the mother

# Knowledge Gap

- Failed to inform mental health professionals in general and family therapists in particular on the effects of the disorders on parent-child relationships
- Knowledge helpful
  - Make emotional connections with the afflicted adolescents and parents
  - Assess problems and difficulties in refeeding
  - Design treatment strategies

# Micucci's Family Treatment Model

- Based on structural family therapy
- Conceptually feminist oriented
- Technically eclectic
- Focus on the stifling family context that may have maintained the symptoms, rather than on the symptoms
- Emphasize family's collective effort to resolve the covert and overt conflicts arising from the disorder (Micucci, 1998)

# Modification to Micucci's Model

- Enrichment of the cultural perspective
  - Chinese concept of family, jia, in family assessment
  - Use of culturally appropriate way to identify and resolve family conflicts
- Working with family problem/s or difficulty
  - Financial difficulty
  - Marital relationship of the parents
  - Mental health problem/s of parent/s (Ma, in press)

# Modification to Micucci's Model

- Motivate the emaciated young people to assume an active role in recovery

## Treatment format and duration

- Conducted in Putonghua, national language in Mainland China
- 90-minutes on a bi-weekly basis on an out-patient basis

# Objectives of the Study

- To identify the characteristics of parent-child conflicts between Chinese young people with ED and their parents
- To contextualize these intergenerational conflicts, that is, to understand the meanings of these intergenerational conflicts in Shenzhen

# Context of Study Shenzhen

- First Special Economic Zone in South China under the open-door policy and economic reform in the 1980s
- Successfully transformed
  - from a rural town to a vibrant city
  - from planned economy to market-oriented economy (GDP per capital = RMB\$7,483)

# Context of Study: Shenzhen

- Population predominantly young immigrants from different parts of China especially from the rural areas
  - 314,100 before 1980
  - Over 7 millions in 2005
- Lag behind in changes of socio-cultural values and development of social institutions
  - Agricultural-patriarchal family patterns of interaction persist

## Method of Study

- Qualitative in nature
- Multiple-case study (Yin, 1994) as the research design
- Ten families with a daughter suffering from eating disorders and seeking help from
  - Shen Gang Family Treatment Center, Department of Clinical Psychology, Nanshan Hospital, Shenzhen

# Criteria of Inclusion

- Young person and the family had given consent for videotaping the family treatment sessions for research purposes
- They had attended family treatment for at least three times

# Method of Study

- Peer reviews of family treatment sessions
- Transcribe for categorization and thematization
  - Went through the transcripts of the family interviews
  - Marked off units that were related to the same topic (e.g., parent-child conflicts)
  - Divided them into topics (e.g., mother-child conflicts; father-child conflicts) and sub-topics (e.g., mother-child conflicts in the lunch session)
  - Similarities and differences of the categories identified and examined
  - Open discussion on coding should there be disagreement

**Table 1: Patients' Profile in Shenzhen**

(n=20)	Percentage (n)
<b>Sex</b>	
Male	25% (5)
Female	75% (15)
<b>Age</b>	
10-14	20% (4)
15-19	55% (11)
20-24	20% (4)
25-29	5% (1)
<b>Education Level</b>	
Junior High School	45% (9)
Senior High School	25% (5)
University	15% (3)
<b>Occupation</b>	
Student	85% (17)
At Work	10% (2)
Stay at home	5% (1)
<b>Diagnosis</b>	
AN	75% (15)
BN	15% (5)
<b>No of Family Therapy Session attend</b>	
1-5	60% (12)
6-10	15% (3)
11-15	15% (3)
16-20	5% (1)
21-25	0%
26-30	0%
31-35	0%
36-40	5% (1)

**Table 1b: Father' Profile in Shenzhen**

<b>(n=20)</b>	<b>Percentage (n)</b>
<b>Age</b>	
35-39	15%(3)
40-44	10%(2)
45-49	25%(5)
50-54	15%(3)
55-59	10%(2)
Missing	25%(5)
<b>Occupation</b>	
Businessman	20%(4)
Doctor	5%(1)
Trading	5%(1)
Manager	20%(4)
Driver	10%(2)
Civil servant	25%(5)
Worker	5%(1)
Teacher	5%(1)
Missing	5%(1)
<b>Education level</b>	
Junior high school	5%(1)
Senior high school	15%(3)
Tertiary school or above	40%(8)
Missing	40%(8)

**Table 1c: Mothers' Profile in Shenzhen**

<b>(n=20)</b>	<b>Percentage (n)</b>
<b>Age</b>	
30-34	5%(1)
35-39	15%(3)
40-44	30%(6)
45-49	20%(4)
50-54	5%(1)
55-59	5%(1)
Missing	20%(4)
<b>Education level</b>	
Primary school	20%(4)
Junior high school	0%
Senior high school	5%(1)
Tertiary school or above	40%(8)
Missing	35%(7)
<b>No of sibling</b>	
Singleton	35%(7)
One	15%(3)
Two	10%(2)
Three	5%(1)
Missing	35%(7)

## Table 2: Patient's Body Mass Index (BMI) in the Pre-treatment Stage

**Mean (n=19)**

BMI	16.18
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Calculation of BMI = Body weight (kg)/Height (m<sup>2</sup>)

**Table 3 :Eating Disorder Inventory (EDI) scores of the Patients**

	Pre-treatment stage (n=18)
	<b>Mean (S.D.)</b>
Drive for Thinness	6.61 (7.20)*
Bulimia	5.50 (6.14)
Body Dissatisfaction	14.11 (6.77)
Ineffectiveness	17.56 (27.84)
Perfectionism	7.17 (5.18)
Interpersonal Distrust	7.17 (5.95)
Interoceptive Awareness	8.28 (7.27)
Maturity Fear	10.28 (5.92)

\*Higher scores denote more symptomatic; 0 score denotes non-symptomatic

**Table 4 : McMaster Model of Family Functioning (FAD) Scores of the Patients, Fathers and Mothers**

Pre-treatment stage	
	Mean (S.D)
<b><i>Patients</i></b>	(n=17)
Problem Solving	2.22 (.44)*
Communication	2.44 (.59)
Roles	2.48 (.28)
Affective Responsiveness	2.13 (.38)
Affective Involvement	2.18 (.33)
Behavior Control	2.57 (.31)
General Functioning	2.31 (.59)
<b><i>Fathers</i></b>	(n=14)
Problem Solving	2.03 (.28)
Communication	2.24 (.21)
Roles	2.38 (.20)
Affective Responsiveness	2.27 (.25)
Affective Involvement	2.30 (.32)
Behavior Control	2.44 (.28)
General Functioning	2.12 (.27)
<b><i>Mothers</i></b>	(n=17)
Problem Solving	2.06 (.39)
Communication	2.24 (.37)
Roles	2.51 (.28)
Affective Responsiveness	2.17 (.36)
Affective Involvement	2.25 (.53)
Behavior Control	2.41 (.28)
General Functioning	2.06 (.36)

\*Lower scores denote healthy family functioning

**Table 5 : Dyadic Adjustment Scale (DAS) Scores of the Parents**

	Pre-treatment stage
	Mean (S.D)
<i>Fathers</i>	(n=14)
Dyadic Consensus	50.36 (8.90)*
Affectional Expression	8.46 (2.47)
Dyadic Satisfaction	36.18 (5.06)
Dyadic Cohesion	15.92 (3.34)
<i>Mothers</i>	(n=17)
Dyadic Consensus	52.64 (8.79)
Affectional Expression	8.92 (2.54)
Dyadic Satisfaction	35.00 (8.39)
Dyadic Cohesion	14.87 (5.45)

\*Higher scores denote better marital quality

**Table 6: Symptom Check-List-90R(SCL-90-R) scores of Patients**

	Pre-treatment stage
	Mean (S.D.)
<i>Patients</i>	<b>(n=17)</b>
Somatization	.95 (.80)*
Obsessive-Compulsive	1.55 (1.12)
Interpersonal Sensitivity	1.72 (1.26)
Depression	1.72 (1.19)
Anxiety	1.42 (1.17)
Hostility	1.37 (.91)
Phobic Anxiety	1.06 (1.12)
Paranoid Ideation	1.41 (1.05)
Psychoticism	1.21 (1.11)

\*Lower scores denote less symptomatic

**Table 7 : Symptom Check-List-90R(SCL-90-R) scores of Parents**

	Pre-treatment stage
	Mean (S.D.)
<b><i>Fathers</i></b>	<b>(n=14)</b>
Somatization	.46 (.45)*
Obsessive-Compulsive	.54 (.61)
Interpersonal Sensitivity	.43 (.51)
Depression	.48 (.53)
Anxiety	.39 (.58)
Hostility	.89 (.99)
Phobic Anxiety	.23 (.31)
Paranoid Ideation	.51 (.56)
Psychoticism	.36 (.54)
<b><i>Mothers</i></b>	<b>(n=16)</b>
Somatization	.99 (.69)
Obsessive-Compulsive	.99 (.56)
Interpersonal Sensitivity	.67 (.50)
Depression	1.13 (.80)
Anxiety	1.10 (.81)
Hostility	.95 (.59)
Phobic Anxiety	.45 (.49)
Paranoid Ideation	.75 (.66)
Psychoticism	.49 (.55)

\*Lower scores denote less symptomatic

# Profile of participants

Table 1: Patients' Profile

Case	Age	Weight (kg)	Height (cm)	BMI	Diagnosis	No of sessions she presented	Father's occupation	Mother's occupation
Case 1	17	31.0	153	13.24	AN	1	Businessman	Deserted
Case 15	20	52.2	161	20.14	BN	5	Officer	Official
Case 11	16	30.8	153	13.16	AN	10	Official	Driver
Case 23	18	46.4	168	16.44	AM/BN	5	Senior manager	Teacher
Case 2	19	48.2	168	17.49	BN	5	Senior manager	Housewife
Case 3	15	30.0	158	12.02	AN	10	Teacher	Teacher
Case 4	13	29.4	155	12.24	AN	7	Chinese herbalist	Medical assistant
Case 9	20	41.5	166	15.06	AN	4	Businessman	Housewife
Case 10	19	53.0	168	18.78	NB	6	Businessman	Housewife
Case 16	26	49.0	167	17.5	BN	7	Government official	Teacher

BMI refers to Body Mass Index = Weight/Height (M<sup>2</sup>)

# Table 1: Patients' Profile

(n=20)	No. of patients
<b>Age</b>	
10-14	1
15-19	6
20-24	2
25-29	1
<b>Diagnosis</b>	
AN	5
BN	3
NB	1
<b>No of Family Therapy Session attend</b>	
1-5	5
6-10	5
<b>Father's occupation</b>	
Businessman	3
Senior manager	2
Officer	2
Government officer	1
Teacher	1
Chinese herbalist	1
<b>Mother's occupation</b>	
Housewife	3
Teacher	3
Officer	1
Driver	1
Medical assistant	1

# Profile of The Participants

- Five young people suffering from anorexia nervosa (AN)
- Five from bulimia nervosa (BN)
- Year of onset ranged from 1 to 5 years
- Body mass index of the young people with AN (mean = 13.10)
- Body mass index of the young people with BN (mean = 16.27)

# Profile of The Participants

- 8 were students; 1 working as a part-time language teacher and 1 remained idle and unemployed
- 5 single child in the family; 2 with 2 siblings; 2 with 3 siblings and 1 had 4 siblings
- Academic performance before the onset is conspicuously good
- 9 not married and 1 divorced

# Profile of The Participants

- 7 nuclear families; 1 single-parent families; 1 three-generational family
- Another one on the verge of breakdown due to the parents' severe conflicts and the father request to divorce
- 6 came from rural parts of South China; 4 families from northern and southwestern China

## Results of the Study

- Three themes identified related to parent-child conflicts
  - Issue of control and power struggle evolving around eating versus non-eating
  - Adolescents' maturity fear of growing up versus staying young
  - Personal autonomy versus living up to parental expectations

## **Don't Force Me to Eat Even Though I Am Starving to Death**

- Parent-child interaction entangled in a continual power struggle at the dinner table during mealtime
- Severe and intense between the mother and the emaciated daughter
- Mother blamed by her spouse, relatives and even mental health professionals for the daughter's failing health

## Parent-child Conflicts Discerned in the Lunch Session

- Upon the request of the therapist, Mrs. M. begged her 15-year old daughter to take a mouthful of food. Patient M screamed hysterically at her mother: “Let’s go home. I like to go home now. I don’t like eating here and maybe I’ll listen to your advise at home.” Tearful and hopeless, the mother retreated immediately. She turned to the therapist and said: “I can’t do it at all. That is what has been actually happening at home. Please hospitalize her.” The therapist suggested the father to take over the task from the mother. Slowly and patiently the father persuaded the daughter to take a mouthful of food.”

# Parent-child Conflicts Discerned in the Lunch Session

- Patient X, the 13-year old emaciated adolescent, kept shaking her head forcefully when the therapist asked her to start the lunch. She remained sullen and motionless. Mr. X, the father, was perplexed, shook his head and sighed helplessly. Apparently he had given up doing anything to rescue the fragile daughter. The mother, as anxious and helpless as the father, picked up the lunch box, leaned forward and began persuading her daughter to eat using a warm and firm voice: “Eat some; otherwise you will die quickly.” Her daughter protested by moaning

## Parent-child Conflicts Discerned in the Lunch Session

- A few unintelligible words and sounds. Mrs. X hesitated but pursued several times with the encouragement of the therapist. After a long struggle, Mrs. X finally succeeded. (Patient X in treatment session two)

## Don't Treat Me As Young Though I Dislike Growing Up

- The 26-year old daughter talked directly to her mother: “I have my own way and please leave me alone.” Then she turned to the therapist and narrated: “They don't know that I have grown up and they always treat me as a young child.”

## Don't Treat Me As Young Though I Dislike Growing Up

- The mother explained apologetically: “I hope that you can take care of yourself. If I don't remind you to eat properly, you will take many breads per meal. Besides, I don't wish to accompany you back to your office everyday. It is exhausting and burdensome.” (Patient Y in family treatment session 3)

## Don't Treat Me As Young Though I Dislike Growing up

- “I often dreamed of my happy childhood during hospitalization. There was no need for me to think about my future, my career and my family. As a child, I liked singing and dancing very much and I dreamed to be a singer or a dancer. My eyesight deteriorated gradually when I was in primary six. I could hardly see the blackboard and follow the teachers' instructions. My academic performance at school dropped but I dared not tell my parents.” narrated a young person suffering from AN.

## Don't Treat Me As Young Though I Dislike Growing up

- Her father asked her daughter sharply in the enactment: “I bought a shop for you and you can run a small business. That would tackle your career problem. Why did you turn me down?” The daughter replied with irritation: “I don't like to work now. I have my own dream.”

## I Dislike Living Up to My Parents' Expectations

- “I am in great distress. I am forced to live a life that makes my parents happy only. They would like me to be an ordinary girl, study a popular subject in the university, graduate with a good degree and settle down in a good and comfortable job. When I think of my future, I become miserable. That’s not how I wish to paint my life in future.” (Patient T in treatment session 6).

## I Dislike Living Up to My Parents' Expectations

- The 26-year old daughter burst into a rage and fought back by talking fast to her parents: “You strongly advised me to stay in the marriage even though my husband had beaten me seriously. You don’t allow me to come back home when I cried for help.”

## I Dislike Living Up to My Parents' Expectations

- The therapist explored and asked: “Why is it so?” The parents replied apologetically: “We old guys believe that a married daughter is like water being poured out in the front door. The fate of a divorced woman would be sorrowful. Besides, her ex-husband is a good guy. He beat her because of her bingeing and purging.” (Patient Y and her parents in treatment session 3)

## Cultural meaning of a married woman in traditional Chinese society

- Being a property of her husband's family
- Mr. & Mrs. Y's disapproval of their daughter's divorce
  - An expression of such internalized cultural beliefs
  - Unaware of the hurt and harm on the daughter

# Contributions of this Study

- First study conducted in Shenzhen with an attempt to identify parent-child conflicts and
- to contextualize the meanings of these conflicts in Shenzhen

# Limitations of the Study

- Low generalizability due to small sample
  - Over-represented by the afflicted young people from middle class families or above
- Lack of control group for comparison
  - Uncertain whether the parent-child conflicts identified differed from typical parent-adolescent interactions in Shenzhen

# Discussion

- Principal source of conflicts coming from the symptoms of the disorders
  - Self-starvation
  - Purging
  - Bingeing
- Maturity fear of growing up and pursuit of life goals
- Common concern underlying these types of parent-child conflicts is the fight for individuation and autonomy from the parents, who are successful with high expectations on their child

# Discussion

- Dynamics of parent-child interactions discerned in lunch session similar to that unfolded in the West (Minuchin, Rosman & Baker, 1978; Fishman, 2006)

# Discussion

- Maintain a well-defined professional distance in the lunch session
- Parents' ignorance of the nature of the disorders and their lack of experience in managing it
- Upbringing of the Shenzhen parents results to the generational gap with the inflicted young person

# Discussion

- Differentiation from the parents difficult for these Shenshen young people
  - Influence of filial piety
  - Letting go the adult child more difficult for parents' living in family-oriented societies such as Spain, Italy, and Latin American countries (Minuchin, Nichols & Lee, 2007)

# Implications for Family Therapy

- Parent-child conflicts as the here-and-now contexts to escalate family stresses and induce a sense of crisis
- Shift of conflicts from eating versus non-eating to developmental issues such as autonomy and independence
- Enhance parents' understanding on the different types of stresses and tensions faced by their emaciated daughters in a rapidly transforming society

# Implications for Family Therapy

- Avoid parent blaming
  - Parents' coping can be a cause and a consequence of eating disorders (Eisler,2005)
  - Further increase parents' guilt, shame and bring more pains and suffering

# Therapeutic Focuses

- To perceive the linkage of the unfavorable family context to symptoms of eating disorders
- To facilitate parents to perceive their active role in helping and collaborating as a team to refeed the emaciated young person
- To increase the young person's sense of personal effectiveness and their sense of mastery in different aspects of life other than dieting and weight loss

# Therapeutic Focuses

- To help the young person to appreciate the diversity in the standard of beauty rather than to adopt uncritically the Western standard of beauty, that is, being thin and slim

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**End of Presentation**

Thank you very  
much

