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Growing Up in Pain: Anorexia Nervosa and Family Therapy in a Chinese Context

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Additional information is available at the end of the chapter

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Abstract

Despite the increasing visibility and complexity of anorexia nervosa (AN) in Chinese societies such as Hong Kong, family treatment for Chinese children and youths suffering from AN has been inadequately documented in the literature. In this chapter, the author will describe conceptualization of the disorder in the light of a systemic and developmental framework; describe the process of contextualizing the symptoms of AN; identify critical issues pertinent to treatment success; and highlight the therapist's roles in the healing journey of patients with AN, using a case illustration. More importantly, the author will critically appraise, through a cultural lens, key family therapy concepts, namely emotional enmeshment versus emotional disengagement, boundary and cross-generational collusion, which have restrained the parent/s and the patient to join hands together to drive away the disorder.

Keywords: anorexia nervosa, family therapy, Chinese, growing up, pain

1. Introduction

In ancient China, a student once asked the Zen master what Zen (禪) was. The old master said, 'Eating while eating and sleeping while sleeping'. The answer was simple but unintelligible to the student. Another Zen master Joshu (Chao-Chou), when asked the same question, answered: 'your everyday life is the Tao' [1] (p. 74). The Zen master's wisdom has shed light on the fact that living an ordinary life is a blessing, but a blessing not easily achieved by most people, and particularly not by families facing anorexia nervosa (AN).

A young woman, Ann (pseudonym), a 35-year-old single mother of two young children, a 12-year-old daughter, Sarah, and a 9-year-old son, Mark, called at a university-based family centre

to request family therapy service. *The young woman* explained: 'Sarah has been suffering from AN for six months. She had steadily gained weight in the hospital and was discharged a month ago. However, after she returned home, her body weight dropped rapidly. I need professional help and advice on how to help my daughter'.

Shame is the part of traditional Chinese culture; such cultural characteristics continue to shape people's help-seeking behaviour in contemporary Chinese societies such as Hong Kong [2]. Having a family member suffering from a mental disorder such as AN is perceived as a loss of face, *mianzi* (面子), and shameful. The results of a recent study [2] have shown that Chinese parents with children that have mental health needs preferred enlisting help from their family members, relatives and friends, rather than seeking help from helping professionals. Seeking help from mental health professionals such as family therapists was usually the last resort. Ann must have struggled hard before she called for help. I appreciated her having the courage to seek help, enquired what effect the disorder might have on her daughter's and family functioning, reiterated the need for the whole family to participate in family therapy, and reassured that I would be able to meet them in the coming week. Ann replied that she would be able to meet the therapist with her two children, but her ex-spouse, a manager in a financial company in Mainland China, would not participate in the treatment because he was residing outside Hong Kong. Ann's marriage ended up in a divorce that was initiated by her ex-husband after Ann discovered his extra marital affair.

Having worked as a mental health social worker in a psychiatric unit of a public hospital in Hong Kong before joining the university, my passion for helping children and youths with mental health needs has grown day by day; paradoxically so has my sense of professional incompetence. My search for a better practice never ceased until I got training and received my qualification in the clinical supervision of family therapy from Wai Yung Lee, the first Chinese family therapist trained by Dr. Salvador Minuchin, Master of Structural Family Therapy (SFT) [3–5]. I later received training directly from Dr. Minuchin in New York. Thereby, my professional practice was transformed from an individually oriented practice to a systemically based practice. Inspired by the classic book written by Minuchin et al. [6] and being gratefully trusted by psychiatrists of the Department of Psychiatry of our university, I had carried out two clinical research projects 19 years ago; both of these studies aimed to assess the treatment efficacy of structural family therapy (SFT) in helping Chinese families with AN in Hong Kong [7] and Shenzhen [8], respectively.

Sarah suffers from AN, a mental disorder that is believed to be closely related to growing up issues in children and youths, specifically the problem of individuation and autonomy arising from having an excessively caring mother as proposed by Bruch [9]. While appreciating Bruch's [9] ingenious contribution to expanding the conceptual understanding of AN from a biomedical model to a psychological domain, family therapists have to be vigilant regarding the mother-blaming attitude that has been implied by Bruch's [9] psychoanalytical propositions, and be open to explore the roles the father and other family members may play in contributing to an overtly close mother-daughter relationship [10, 11], an area that has been overlooked by Bruch [9].

It is estimated that about 0.48% of *all* children and youths aged 12–18 in the USA are diagnosed with AN. Among those being diagnosed, 90% of them are female. AN has become increasingly visible in Chinese societies such as Hong Kong [12] and Shenzhen [13].

Children and youths with AN persistently engage themselves in dieting and excessive exercise, pre-occupied with the fear of gaining weight and dissatisfaction with their body shape despite emaciation and a deterioration in their health and psychosocial well-being [14]. The aetiology of the disorder is multiple, involving the dynamic interplay of biological (e.g. temperament and coping), psychological (e.g. sense of ineffectiveness and low self-esteem) and sociocultural factors (e.g. women's status in society, slimness as the standard of beauty in society) [15]. However, it remains unclear that the more important but scarier issue is that the child or the youth feels frightened, out of control and inadequate to face the situation other than through an obsession with dieting, bingeing and excessive exercising.

If untreated, the disorder seriously threatens the afflicted child or youth's health, increases psychological distress and affects her schooling, family relationships and peer relationships. The child or youth would become emotionally and socially isolated [14, 16]. The family suffers too. These families are tormented by constant fights and conflicts between the parents and the afflicted child/youth over eating and non-eating at meals, marital distress between the parents, a tense family atmosphere and family dysfunction [13].

Food is the best medicine for children and youths with AN. However, the challenge faced by clinicians is how to motivate them to take charge of their health and assume recovery. Psychotherapy is the adjunct treatment. The success rate of psychotherapy has ranged from 36 to 63% [17]. In Great Britain, among all the schools of psychotherapy, family therapy has demonstrated its treatment efficacy for helping children and youths aged 18 or under with a history of illness of less than 3 years [18]. The results of our Hong Kong study [16] have shown that Chinese families of the children and youths with AN benefited from family therapy in terms of reduced symptomatology, lower psychological distress, improved family functioning and greater couple satisfaction, in addition to the families' positive subjective experiences towards family therapy reported in the post-treatment interviews [19].

In adapting the Western-based family therapy model, namely structural family therapy [4, 5], to Chinese families with AN, it is critical to review and examine the similarities and differences between the Eastern and the Western perspectives on some of the taken-for-granted family therapy concepts, namely the emotional enmeshment, boundaries and inter-generational collusion that may have different meanings in Chinese culture. This should be done looking through a cultural lens. The overtly close emotional relationship between a mother and her children is appreciated as an expression of children's filial piety and loyalty to the family. According to Xiao Jing (孝經), the Classic of Filial Piety, children are expected to obey their parents in childhood, honour the family name during adulthood and take care of their parents in their old age [20]. Sacrificing one's self-interest and personal development for the sake of the family's well-being is cherished in Chinese society. Nevertheless, the process of cultural reflexivity is harder than it appears to be, especially for a Chinese family therapist like myself who was brought up in Chinese culture, where traditional cultural values and beliefs have been too familiar and thus invisible to me.

In this chapter, I shall describe the conceptualization of the disorder in the light of a systemic developmental framework; describe the process of therapy; identify critical issues pertinent to the treatment's success; and highlight the therapist's roles in the patient's and her family's journey to recovery, using a case illustration. More importantly, a focus will be placed on the following areas: (a) understanding the patient's major issues and concerns that have been distracting her through the symptoms of AN and have made her get stuck in her growth and development; (b) critically appraising the key family therapy concepts, namely emotional enmeshment versus emotional disengagement, and boundary and cross-generational collusion, seen through a cultural lens, which have restrained the parent/s and the patient from joining hands together to drive away the disorder; and (c) on the basis of the above assessment, helping the parents and the patient to generate options and possibilities to transcend the stifling family context, which in turn would enable the patient to combat the disorder and deal with the developmental issues.

2. Family therapy and anorexia nervosa

Unlike therapists using psychotherapy oriented towards the individual who aim to effect changes in the patient's emotion, behaviour or cognition, family therapists take a totally different track in helping. Theoretically grounded in a systemic framework [21], family therapists perceive individuals and families as an integral part of the eco-environment and are in continuous interactions with the larger social contexts (e.g. school, social services and community). The underlying assumption of family therapy is that a change in the environmental context will bring about a change in the individual [4, 5]. Such change is feasible because families in distress are believed to be richer and more resourceful than what they have seen in themselves; their family lives are more complex than what has been presented in treatment [4]. During assessment and treatment, family therapists focus on assessing the consequences of the disorder on the patient and the family, rather than focusing on its cause [22].

Similar to other human behaviour, the symptoms of AN are contextually dependent, that is, a patient's behaviour would affect her immediate social context including her family, school and peers, which in turn would influence the patient's behaviour as well. To what extent has the social context—albeit the family, school or peers—contributed to the maintenance or escalation of the symptoms? In what way has the patient's symptoms impacted the family relationships and family coping? These are key clinical questions that a family therapist would bear in mind during a family assessment while listening to the family story, and observing and discerning the family drama, which is usually full of pathology, fault-finding and blaming, mostly pointing to the patient. 'She is too obstinate and so she self-starves herself; she is losing her head to keep dieting'. All this blaming would have consumed most of the family's energy and limited their ability to look for options and possibilities for better coping.

The foremost task that a family therapist has to undertake is to help transform the family's conceptualization of AN from an individual pathology to a family concern. This requires the therapist to see the situation through an interpersonal lens to conceptualize the patient's

symptoms [23]. If the family holds the view that the therapist is an expert able to fix the patient's pathology and that they have no role to play in the healing, they would not participate in the treatment. Such a therapeutic task could be achieved through shifting the family's care and concern from the symptoms themselves to the symptomatic family interactions that have maintained those symptoms [24]. Minuchin, Reiter and Borda [5] referred to this as a process of externalization: '... pushing the symptoms out of the symptom bearer and helping the family members to see the family's participation in constructing and maintaining the symptoms in the symptom bearer' (p. 19), which is different from the process of externalization as understood by the Narrative School [25], that is, a process of constructing AN as the common enemy of the family members, which is related to the societal standard of beauty—slimness is beautiful.

Such a therapeutic step is illustrated by the therapist's work with Ann's family.

3. Case vignette: a neglected sibling

Sarah was weighed before treatment, which is a necessary step for the therapist to monitor her body weight, assess the patient's health risk and provide feedback on the family's treatment response.

Sarah weighted 29 kg, with a height of 138 cm (body mass index, BMI, of 15), which is lower than the average of BMI 17, the normal range of a BMI for her cohort. Her BMI indicated that her symptoms were severe [14] (p. 339). Ann was slender, looked tired and slightly depressed. Sarah was a friendly teenager who greeted the therapist with a sheepish smile. She chose to sit close to her mother on a larger sofa, and Mark, the younger son, sat a bit uneasily on another sofa opposite his mother and his sister.

After listening to the mother's description of Sarah's history of the illness, I turned to Sarah to find out more about the different aspects of her life. Engaging the patient as early as possible is paramount for assessing the family [13]. In doing so, the patient would not mistakenly think that the therapist is her parent's therapist only. Sarah responded to the therapist's questions with ease. She was studying in primary 6 in a reputable school in a neighbourhood that was far away from their present home, a new town that the family moved to after the couple divorced. She had a few friends in school. She did not like to study very much and was not particularly good at any academic subject, but did well in gymnastics. Last year she was one of the Hong Kong junior athletes who competed in an international gymnastics contest. Athletes in gymnastics and dancers are high-risk groups for AN since the sport requires them to keep their body shape and be slim [26]. The information provided gave the therapist a hint to explore the likely linkage of the disorder to her favourite sport.

The therapist:: Did your dieting relate to your wish to excel in gymnastics?

Sarah:: Not really. I am unhappy and I don't want to eat when I am in a bad mood.

Therapist:: I see. Who has made you unhappy at home?

Sarah:: My mom and my younger brother, Mark. They often fight with each other. It's very noisy at home.

Ann explained embarrassingly: My son was diagnosed as suffering from attention deficit hyperactivity disorder (ADHD) and suspected Asperger's syndrome (AS) at the age of 3. He has problems in reading and writing. Ever since he started schooling, I have had to spend tremendous amount of effort and time in homework supervision, and provide remedial training at home so that he would not lag behind in his academic performance. Mark is easily distracted during study. His misbehaviour has put me at my wit's end. Sarah is different. She is self-disciplined, fairly independent and not demanding. She has taken care of her own things so well that there is no need for me to nag her. I never knew she feels she is neglected, insufficiently cared for and not loved until the psychiatrist told me about it.

The therapist nodded and turned to ask Sarah:: Do you feel so?

Sarah replied without any hesitation:: Yes. I am unhappy because my mom would never ask if I long for anything.

Ann clarified that and said:: That's untrue. I have tried my best to meet your needs in the past.

Feeling a bit upset, Sarah replied:: Yes, only if I asked for it. You seldom spend time with me and listen to what has been happening in school.

The therapist asked:: Did your mom change after the onset of your disorder?

Sarah grinned and said:: Yes, she spends more time with me; she has meals with me and hugs me until I fall asleep.

Parents of a child with special educational needs (SEN) such as Ann tend to spend more time and effort with the child with SEN than with the typically developing sibling [27] similar to what has been experienced in this family. Caring for a child with SEN was an insurmountable task for solo mothers such as Ann to be saddled with. Besides having to rear children, she was a part-time secretary. She had undoubtedly relieved her financial insecurity, but she had to pay the price of sacrificing her sleeping time and rest.

A study conducted in Spain [30] has indicated the contribution of parental bonding to development and maintenance of eating disorders (ED). About 8.6% and 12.9% of the patients perceived their parents' parenting styles as neglectful. Patients with ED who perceived a neglectful maternal parenting during their first 16 years reported higher scores in the subscales of drive for thinness and body dissatisfaction than those who perceived the affectionless control and affectionate constraint styles. Patients who perceived a father's neglectful parenting during the first 16 years indicated higher scores in bulimia and ineffectiveness in comparison to patients who perceived other styles [30].

3.1. A day in the schedule of the family

Ann and the two children usually went to sleep quite late, at around 12:00 mid-night. They woke up at 9 o'clock in the morning. Sarah took an hour to finish her breakfast, and by half

past 10, Ann had to take the two children to school, which was about an hour and a half of traveling. The tight schedule left them little time for lunch. Besides, she would not yet be hungry after the late breakfast. In the evening, Sarah and Mark had dinner by themselves, with their domestic helper preparing their food, and before their mother returned home at 7 o'clock. Ann's evening itinerary was full: homework supervision with Mark; story time with Mark and Sarah, respectively; and hugging and sometimes struggling with Sarah's temper tantrum until she fell asleep.

Ann did not complain about how exhausted she was. Nevertheless, her body language and her facial expression had already revealed it. The therapist felt strongly for her. It was a mission impossible for a single mother like Ann; only the Buddhist goddess Kuan Yin with a thousand hands (千手觀音) could do it.

The therapist acknowledged her difficulties: What an impossible job you are doing! It must be a heavy burden for you to look after two children, especially Mark, who has a learning difficulty, and Sarah, with an eating disorder. Did your ex-husband share in the childcare with you before the break up of your marriage?

Ann:: Not. He is a career-oriented man. He played with them after work but I had to go 'solo' supervising Mark's school work. The situation was absolutely worse when we moved to live with my husband three years ago on the Mainland. I was a stranger in the city and we had uprooted ourselves from Hong Kong. After I discovered his affair, we fought day and night to an extent that I could hardly tolerate it any more.

Ann's eyes were filling with tears. Sarah moved to comfort her mom while Mark became more irritated, restless and distractive.

Sarah elaborated:: My mom cried every day. Mom and dad fought every day.

The therapist asked empathetically:: It must have affected both of you. How did you feel at that time?

Sarah said:: We were frightened. Mark and I hid in our room but kept listening to their heated argument in the next room. My mom was depressed, angry and hysterical. She acted as if she were crazy.

The therapist turned to Mark and asked:: How crazy was your mom at that time?

Mark shrugged and said:: Like a mad woman.

Sarah said:: More than mad. She was insane.

While telling their story, Sarah moved closer and closer to her mom, like an Australian koala bear; Mark became more restless and fidgeted. He kept playing with his fingers. The family drama that had emerged reminded the therapist of the voice of Bowlby [28], who described the behavioural response of children under the threat of losing their caregiver. Apparently, the two children were trapped by the parents' marital discord and felt very nervous about losing their parents. They were in pain when seeing their mother in pain. They have become their mother's guardian angels.

The therapist asked:: It seems that both of you are on the side of your mom. Is that true?

The two children said:: Yes.

The therapist asked:: For how long have you been protecting your mom?

Sarah replied quickly:: Since my dad's disloyalty toward her.

The therapist said to Sarah in empathy:: You must share your mom's sadness a lot.

Sarah nodded and cried. Apparently part of Sarah's sadness had come from her mother's misery.

3.2. Social support of the family

Ann's younger sister, Helen, has provided strong support to the family. Ann could leave the two children in Helen's home if she was late at work. The two children liked staying in their aunt's home because they could play with their cousins. They loved their aunt; she was well educated and respectful in church. Both families were Christians, and the support given by the church to the family was strong too. Ann would seek advice from Helen should she meet any problem. What puzzled her most was that Sarah had no problem eating at Helen's home, but eating has become problematic at her own home.

3.3. Family assessment

Sarah's symptoms, when contextualized in her family setting, symbolized the yearning of a 'neglected' sibling for attention and care from the depressed and exhausted mother in a post-divorce family of a child with SEN. Unfortunately, the mother has gone through a marital crisis of being betrayed and deserted by her ex-spouse. The symptoms could be regarded as the children's expression of their anxiety, insecurity and sadness, which have been arising partly from the mother's anguish and depression, and partly from their parents' marital discord, stormy separation and divorce. Probably due to the gender difference and differences in temperament, Sarah, the sensitive, submissive and loyal child, had expressed her emotional turmoil as AN while Mark acted out his pain and suffering through distractibility and hyperactivity.

Ann had already been aware of the fact that the symptoms of AN had provided a psychological gain to Sarah—she had won back her mother's love and care. However, she came to realize the two children's emotional turmoil was in response to the parents' marital discord, separation and divorce only after she heard of the children's stories during treatment.

Refeeding Sarah has posed a great challenge for the family. The tight daily schedule of the family had given Sarah a legitimate excuse for not eating well at lunch; the mother's part-time job has hindered her from supervising Sarah's dinner too. The domestic helper was apparently not a parent substitute as indicated by Sarah's low body weight. Nevertheless, in their narratives, it was a glimmer of hope—Sarah ate well at her aunt's home. It was a mystery why Sarah ate well there but not so at her own home, one that deserved further exploration in the second session.

3.4. Treatment goals

The treatment goals were three-fold: the therapist would assist Ann to (a) reschedule their daily timetable to refeed Sarah and supervise her meals; (b) respond to Sarah's longing for love and care without reinforcing her regressive child-like behaviour of refusing to eat while helping Sarah to win her mother's love and concern through age-appropriate ways; and (c) foster her psychological well-being through continuing to mobilize support from her younger sister, Helen's family, and the church as well as from her religion, and by doing so, help reduce the psychological burden of caring for the two children with different needs.

The therapist faced two dilemmas in achieving these treatment goals: (a) whether to persuade Ann to give up her part-time job, which had provided her with financial security, personal meaning and distraction from the heavy domestic duties, or to identify the better alternative that would be for Ann to balance the dual demands of work and family and (b) while appreciating the mother's effort to take more care of Sarah's emotional needs, driven by guilt, she might lack the confidence to demand that Sarah behave maturely, if needed.

4. The family's solution to refeeding and the therapist's challenge of the rigid family script

The therapist was worried about Sarah's situation, as her weight had remained unchanged at the time of the second session. Her worry was confirmed by the mother's report. Two days before the session, Ann found out that Sarah had not taken any meals for a whole day. Desperate and totally frustrated, she took Sarah to the emergency department of a nearby hospital to ask for hospitalization. The doctor agreed to admit Sarah to the hospital, but Sarah pleaded to have a last chance at self-help by living at her aunt's home rather than being hospitalized, which was acceptable to her mother as well as the doctor. The therapist perceived it to be the right time to unveil the mystery of why refeeding seemed to be more promising at the aunt's home than at the family home.

4.1. Different family schedules

The therapist asked with great curiosity: I am puzzled about this arrangement. Sarah, there must be differences between staying at home and living with your aunt's family. Can you tell us the differences?

Sarah said: It is quite different. In their family (Helen's), they sleep earlier and eat earlier. All the children have to sleep at 10:00 p.m., whether you like it or not. I can wake up earlier and have my breakfast earlier; in doing so, I feel hungry at lunch and can take in more food then.

Ann protested mildly: Why can't you do that at home?

Sarah defended jokingly: You're my mom and Helen isn't. I dare not disobey her.

It was amazing that the mother and the daughter had already identified their way to refeeding, when only the week before, the therapist had kept worrying about how to help reschedule the family routine to ensure adequate parental supervision at mealtimes.

4.2. Different parenting styles

Jauregui Lobera et al., [30] have found that the stereotyped parenting styles among families of patients with ED were characterised by low care and high control during the first 16 years and the same parenting styles could be applicable to current styles of the mothers. To what extent is this true to Sarah's family?

Further inquiry about the difference in the parenting styles among Sarah's father, mother and her aunt Helen had revealed that in the eyes of Sarah, her father had played with them in the past. Her mother had taken care of their daily life, but her aunt was firmer than her parents in relating to her. She appreciated her father's providing autonomy and space, and her mother's being remarkably capable of attending to the details of their life and her aunt's firmness in limit-setting.

Ann welcomed Sarah's short stay with her younger sister since it did provide a temporary refuge for her, relieved her from the caring burden, and enabled her to have more time to take care of Mark. She did not feel she was being undermined by such an arrangement. Since childhood, she had known fully well that Helen was more capable than her. In reflection, Ann perceived herself to be as capable as Helen in limit setting with her children when she was not lethargic and moody. She had already quitted her part-time job to have more time for the family and herself.

4.3. Challenging the rigid family script

Sarah's weight had increased 1 kg by the third session, indicating her stay with her aunt had taken effect. This had allowed room for the therapist to shift the focus of the work from fostering parental supervision during mealtimes to the rigid family script—albeit each of the family members had to sacrifice their personal needs in order to help Mark, the child with SEN. Such an issue was naturally brought up when Sarah told the therapist that she preferred staying at her aunt's home rather than returning home sometimes.

Ann, the mother, explained to the therapist: She (Sarah) felt very bored at home.

The therapist turned to ask Sarah: How come? I remember that you like playing the piano.

Sarah said: It's because I couldn't do it. I didn't want to disturb and distract Mark from doing his homework.

The therapist asked in great puzzlement: I am confused and I don't understand. What do you mean?

Sarah explained: Mark did his homework in the sitting room, where our piano is. If I practiced my music, Mark would not concentrate on his school work.

The therapist continued asking: I see. Does your mom ask you to sacrifice your hobby to help Mark?

Ann cut in and said: No. I've never made such a demand. She is too eager to please me and be a good girl. That's the problem. (Ann sighed!)

At this point the therapist perceived it to be the right moment to invite Ann, the mother, to talk directly to Sarah, her daughter on this issue.

Sarah asked her mom: Is it really true that there's no need for me to ask for permission if I want to watch television?

Ann replied reassuringly: Yes, as long as you ask Mark to do his homework in his room.

Sarah looked at her mother with an unbelievable gaze.

Ann reassured her daughter with care and concern: Yes, I don't want you to feel that you have no say at home.

The mother's repeated reassurance was extremely crucial for Sarah, who has been shaped by the family context to suppress her own needs to accommodate the special learning needs of her younger brother. Was Mark really a child with a big problem?

On the contrary, Mark was quite a smart child. He liked to make observations and conduct different experiments. For instance, during bathing, he tested the effect of heat on water. He studied each part of his toys and reassembled them to understand their operational mechanisms. He concentrated deeply on scientific experiments and observations. He became distractive and inattentive only when learning Chinese and English. After hearing the strengths of Mark from Ann and Sarah, the therapist said: 'Thanks for telling me so much about him. Otherwise I would misunderstand him as a problem child'.

The reframing of Mark from a problem child in the family to a child with his own unique strengths and talents had allowed the therapist to be more forceful in challenging the rigid family script that Sarah, the elder sister, should sacrifice her personal needs for her younger brother, Mark, a child with SEN. The therapist ended the session by asking Mark and Sarah if they could work out their own way of relating to each other in a mutually fulfilling manner, rather than turning to their mother for advice and approval. Both of them responded to the therapist's suggestion with their witty smiles.

5. Key treatment strategies

The clinical case reported above has illustrated the fundamental treatment principle and strategies of SFT, that is, to help shift the family's conceptualization of their difficulty from the symptoms and pathology, in our instance, Sarah's AN, to the stifling familial context that has maintained or escalated the symptoms [24]. That shift, if it had been achieved, would have enabled the family to actively participate in treatment to change the undesirable family context and discover the multiple meanings of the disorder at the individual and familial levels.

Our case has provided anecdotal evidence in a Chinese context to support the results of Jauregui Lobera et al.'s study [30] that the ED symptoms are associated with neglectful parenting. In Sarah's family, her symptoms can be understood as the expression of an unfulfilled need of a neglected sibling for parental care and concern in a post-divorce family of a child with SEN; The disorder has symbolized Sarah's emotional response towards her mother's anguish and depression at a deeper level as well.

The excessively close relationship between Ann and her two children, Sarah and Mark, can be attributed partly to the strong parental bonding [30], changing family shape, that is, a post-divorce family and their experience of being abandoned by the father, and partly to the gendered division of labour between man and woman in the family before the divorce. Nevertheless, the family structure discerned can also be interpreted culturally as arising from the children's filial piety towards their lonely and sorrowful mother and their loyalty to the family. Having recognized the cultural meaning, the therapist had more empathy towards them. Her awareness of the power of our cultural forces in shaping people's beliefs, emotional expressions and coping is heightened; it also points the way to assist the family to transcend cultural constraints to have more options and possibilities for living a better life.

Minuchin et al.'s [5] multi-layered self has guided the therapist to discover that Mark, an inattentive and distractive child, is a child with great curiosity and concentration regarding scientific observation and inquiry. In understanding each person's personality and strengths within the family, the therapist has successfully joined Mark, a child with SEN, and challenged the inflexible family script—that each of the family members has to sacrifice their personal needs, hobby and leisure activities to help him.

A review of the family's daily schedule has assisted the family to find their own idiosyncratic way of refeeding Sarah. Sarah gained body weight steadily from the third session onwards. At the end of the treatment (total no. of sessions offered = 9), Sarah's body weight had increased from 29 to 38 kg (BMI = 20).

With the shift in the family definition of their presented problem, the next step in treatment for families with two parents is to, on the one hand, collaborate with the parents through empowerment and the instilment of hope for refeeding the patient with AN, and on the other hand, to encourage the patient to elicit help and assistance from her parents to drive away the disorder [13]. Paternal engagement is of great clinical utility in helping Chinese families since the father is often the head of the family. The therapist would find means to actively engage the previously less involved or absent father in the treatment and childcare such as meal supervision, mediating the mother-daughter conflicts, and providing emotional support to his spouse and the patient [11].

The parents' resistance to collaborating together in helping may indicate the need to explore their marital relationship and the history of their upbringing. A few Chinese parents had experienced extreme poverty, massive famine and starvation during the Cultural Revolution in China in the 1960s and 1970s, and they tended to respond to their daughter's self-starvation with rage and hostility [11]. An empathetic understanding of their upbringing and its linkage to their here-and-now emotional response would help clear up the misunderstanding between

the parents and the patient and reduce their hostility. Couple therapy may be required for a few parents with marital problems [13].

However, in helping post-divorce families such as Ann's family, in which the father's involvement is minimal due to his living far away, the therapist would need to search for an alternative treatment strategy to replace the strategy of parental collaboration. The family's temporary measure to place Sarah in the care of her aunt's home has underscored the importance of kinship as a family resource for Chinese families. According to traditional Chinese culture, the concept of family *jia* (家) refers to the kinship and the extended family, rather than just the immediate household [29]. Hence, the therapist would need to identify the healer/s of the family not only within the household itself but also among close relatives of the family. A similar treatment principle would be applicable for families with different family shapes (e.g. blended families) in Chinese societies.

Handling unresolved conflicts (e.g. mother-daughter conflicts) and relapses by preventing the emergence of the symptomatic cycle is an integral part of the treatment process, while supporting the patient's individual development and transformation is paramount [13]. All these can be achieved through continued collaboration with the family and the patient. In view of the life-threatening nature of the disorder, family therapists without any medical training should not hesitate to seek medical back up from a doctor experienced in managing patients with AN. Collaborating with a family-oriented social worker in the community, who would actively take up the role of a case-manager to mobilize community resources for the family (e.g. multi-problem families), would definitely facilitate the patient's and the family's journey of healing.

Being a part of the therapeutic system, the therapist has to be watchful of how his or her own response has influenced the family, which in turn would also affect the therapist's responses. An artful use of self and a continued discovery of the multiple layered of self [4] would help to overcome therapeutic impasses and challenges that have arisen from treatment. The more readily the therapist could move away from his/ her comfort zone to deal with family conflicts and intense emotions in the family with courage and mindfulness, the greater the likelihood he or she would be able to achieve the goal of helping.

6. Conclusion

Family therapists assist the family and the patient to use their resources and strengths to transcend the stifling familial context and drive away the disorder. However, similar to the learning experience of a Zen student [1], the family's healing is a process of self-discovery. A Zen master cannot give enlightenment to his student and so it is with the therapist. A therapist, at the best, is only a participant observer [5] in treatment and a companion on their journey of recovery.

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