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Case Study

Not My Mum, Not My Dad: Enhancing Eating Disorder Intervention

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Abstract

Enhancing eating disorder interventions was the basis of the "*not my mum, not my dad*" Hypothesis 2014 [10], in the formation and maintenance of eating disorders. This work has continued for ten years and will be presented in two papers. In this paper, the basic principles will be presented with case material from across this time period. The approach is considered to mirror parts of the Maudsley model and to provide a way to achieve such methods in non-hospital environments. It can also be applied to a broader range of eating disorders. However, this enhancement has not been taken up by many, other than my supervisees who are treating clients with eating disorders.

Keywords: Eating disorders; Cases; Oppositionality; Enhanced intervention

Introduction

Case study was the empirical method of nineteenth century medicine. Case study remains an important source of ideas about how to diagnose and to treat disorders that have proven difficult to ameliorate. Psychoanalysis was built upon five case studies of Sigmund Freud and these studies are still used to teach psychoanalytic method today.

Eating disorders can be life threatening and can last a life time, even with the best methods available to mental health professionals. However, the field has been dominated by one method that started as case studies and grew to prominence as a method capable of effecting change in ninety per cent of cases that completed treatment: this known as the Maudsley method [1] and has been adopted in hospitals across the western world. Australia has many Maudsley model programs.

The widespread acceptance of the Maudsley model as "*gold standard*" has had two distorting effects upon the development of ideas in the field. Firstly, all new approaches are expected to be based on randomized control trials (RCTs). This is clearly a problem for new ideas or development of useful conjecture into evidence based practice. Secondly, credibility of practitioners has come to be based on periods of employment and training within a Maudsley model facility. Curiously, should a mental health professional leave the hospital environment for private practice, the Maudsley model has to be modified. But the altered practice is not evidence based; it is modified. It may be sound new practice, but it is not practice based on a RCT. But if you have the imprimatur, the problem is overlooked.

There is another problem: refutability. Karl Popper [2] was skeptical about the claims of Marxism and of psychoanalysis. It seemed to him that any deviation from the predictions of either social science always involved the generation of a new precept that fitted within the given field. Popper argued that one only need to demonstrate that one case of non-effect existed for a proposition to be refuted: this is the null hypothesis. RCTs use the null hypothesis to test for treatment effects. It is important to count positive outcomes, but it is also important to report outcomes of no effect or negative effect. With respect to Maudsley model research, studies were frequently reported that did not include consideration of the numbers who did not enter the program as they were deemed unlikely to benefit or otherwise unsuitable. Those who did not complete were also not reported. This is a distortion of the outcome data. The Maudsley model data was flawed, but gained such importance for the cases in

which it was successful, that this problem of research method was not identified for many years.

It was a case study report [3] that started me on the questioning of Maudsley method and the development of a treatment enhancing consideration that I first reported at a conference in 2014. Barnes was a senior paediatric surgeon at a very significant children's hospital who happened to have two anorexic daughters who were treated at the same hospital. Barnes reported on the demeaning and damaging practices of the mental health professionals in trying to re-feed his daughters and in their parent blaming interventions. This was presented at the national conference of the Faculty of Child and Adolescent Psychiatry (FCAP) within the Australian and New Zealand College of Psychiatry (ANZCP). This was a very brave encounter with the profession. Toward the end of his description of various questionable practices, he reported that he had been able to find alternate treatment for his daughters and that this had moved them away from the dangerous anorexia that had taken over their lives. Here, case study provided an instance of negative effect.

The important lesson I took from Barnes' presentation was the parents standing up for their children against the professionals, even while the professionals had tried to re-make parental authority. I had been working on a number of cases of eating disorders and parental authority was an issue in all of them, whether the disorder involved thinness or obesity or over exercising. I was also supervising young clinical psychologists seeking full registration who were former students and who worked in eating disorder programs at major hospitals. My aim was to usher the supervisees into the profession by reviewing their case work and helping them to develop their clinical thinking, especially with respect to family work. Family therapy approaches are not widely taught in Australian training programs for clinical psychologists. They were teaching me while I was supervising them.

My primary role at the time was Professor and Head of Clinical Services at Australia's oldest private psychotherapy institute: the Cairnmillar Institute. I was the most experienced in working with families and with eating disorders so the private referrals received usually found their way to my consultation room. There I met parents who had suffered the indignity of the Maudsley method.

The cases to be presented shortly, are predominantly from this period of time that led me to the "*not my mum, not my dad*" hypothesis in formation and maintenance of eating disorders. Subsequently, other cases were added to my experience and some of these are reported, here, as well. But what I have to present does not have the backing of RCTs: attempts to get the ideas reported have been blocked because my ideas do not have the backing of RCTs. The work has been shown to be applicable among my clients and among other supervisees, but I cannot get on a conference stage or into a journal to make the ideas available to the wider audience. Some of my conjectures are likely to be wrong. This is not of concern. I am close to retirement, and want someone in the international audience to take up the challenge of testing the ideas in their practice and, if indicated, in other forms of research.

The pre-history of the hypothesis lies in the beginning of a career in post-graduate study and the initial experience of a clinical psychologist in the mid-1980s. Among the many conversations between colleagues and in supervision, group supervision, seminars, and attendance at conferences, were discussions of various clinical presentations, including chat about eating disorders. There were clinical observations made about parenting styles. The stereotype of the mother of a child with eating disorder was an ambitious, career-oriented woman, who was not very available to her child. The stereotype of the father of an eating disordered child involved domestic violence and/or sexual abuse. These were not causal statements, rather they were correlational, but were statements of family-based troubles. Over time the prevalence of such stereotypes was found to be less common than first observed: mothers not so fierce, fathers not so dangerous. Yet, the ideas of parental insensitivity, neglect, and abuse have been shown to be very relevant.

I hope the audience of this journal can step forward to analyze my conjectures. There are two papers that have been written; the second documents development of the ideas subsequent to 2014. These case studies, below, are intended to demonstrate the basic argument for the "not my mum, not my dad" hypothesis. The second paper will not be presented for publication until the first is published.

Case Studies

Six cases are presented that articulate the reasons for a child not wanting to be like mother or father. Unfortunately, this leaves the child with few options to consider for what version of adult the child would like to be, unless there is a special teacher, sports club member, friend's parent, or a therapist. Without a way of envisioning adulthood, the child can refuse to grow up, or may choose alternate paths to adulthood that involves acceptance of some feature of the parent or parents, while negating most other aspects: it could be running with dad, or enjoying mum's cakes. The former leads to over-exercising and the latter to over-eating.

In the ten years or more since the hypothesis was formulated, I have continued to refine the interventions associated with the formulation for clients of my own and for those of supervisees, some of whom worked in Maudsley model [1] programs. Barnes [3] presentation was pivotal to my thinking.

But it was the cases that drove the emergence of the hypothesis. Sometimes, I worked with a parent, sometimes, I worked with a

child, sometimes with both parents, and sometimes with whole families. I was able to observe the rejection of parental models from several angles. In some cases, the presenting problem was a failed eating disorder treatment, but often there were other reasons for referral and the eating disorder emerged as important through the work on other issues. The people came to me and often did not understand the connection with diet and bodily concerns. I was not naïve to the literature, but the cases drove me to examine the literature, and something seemed missing.

Aspy Dad, Angry Mum

A mother with deep hostilities to her Asperger's husband would comment from time to time upon her children. She had attended the clinic because she had an anger problem. The adolescent boy was an active sportsman of high level skill in a team sport, once played by his sporty, outdoorsy mother. The daughter, two years older was studious but anorexic and almost impossible to engage in conversation, despite her articulateness with friends and other family (including the wife of her Asperger's uncle, the twin of her father).

A bitter separation of the parents was occurring and the mother worried about her daughter as collateral damage of the failed marriage. Fortunately, the daughter had a very supportive boyfriend and his family and had a solid connection with her school counsellor. Mother feared her daughter losing these connections as then there would be nobody for her, as father was impossible and mother felt truly inadequate.

We talked about the lack of a pathway to adulthood and discussed the mother's own life in terms of certain mentors at school and the change in her father after divorce. His example of escape from a bitter marriage had inspired her to seek divorce and a better future. She was guilty about her mother's loneliness and lack of friends. There were things about each parent that were important to this mother; mother was asked if her daughter's parents offered their daughter any view of the future.

Self-starvation was proposed as a means to avoid adulthood. The daughter was now an inpatient at an eating disorders hospital and the Maudsley model was shoved down the necks of all family members. Mother was asked to read Treasure's book for parents which she found very helpful. The daughter got a lot out of Costin and Schubert Grabb's; *Eight keys to recovery* [7], but did not think the Treasure stuff applied. There was progress, but father did not follow the regime when the daughter stayed with him. Mother was not a 'solid policeman' of her daughter's vomiting episodes, either. The girl made friends with several other inpatients and one of these relationships endured with the other girl continuing in the grips of her battle with food.

My client chose to re-think her relationship with her daughter and to try to find a way to be some sort of model of a satisfied adult. Divorcing, settling the assets, and buying a modest but comfortable home, changed my client a lot: she experienced the future as potentially satisfying. The daughter chose to live with her mother, but the big change came when her uncle, the younger brother of the twin Asperger's men, offered her employment in the office of his stationery business. The uncle was a version of adulthood that was reasonable, responsive, and caring.

A Teenage Boy Who Would Not Grow Up

The boy, Owen, constantly troubled his teachers, his parents, his peers, and his tennis coach with episodes of extended sobbing and crocodile tears. His therapists would see him for months and then would not be able to continue, or the parents would weary of the lack of progress. But was he going to make it to Year 9? I was asked to see him for play-based child psychotherapy.

The teenager was accomplished at tennis and regularly beat players 3 or 4 years older than him and twice his size. He always got the ball back. He did not mind losing a point or a match. With no other clue, this is where I started: but with table tennis on a small table in my consulting room. The father was a very interesting, compassionate man, who seemed not to be employed, and was keen to do anything to help his son; he provided the background details to his son's life and troubles. I asked the father to arrange a family session, after several sessions with his son.

Reluctantly, father agreed to invite his wife, a librarian studying a PhD, and an IT crazy older son (year 11). Both were sick of Owen and his tears and were indignant about having to come. As we talked about the need for change, I asked about grandparents. Out came a heroic story of coping with (maternal) Grandma; a woman who lived with them for ten years as her health declined and was now in full-time care with Alzheimer's. Only mother visited her, now. She had never had a good relationship with her mother, but when Grandma's breathing (smoking affected) declined she was welcomed by her son-in-law into the family home. A difficult woman, she would occupy the living room and mother and brother would retreat to their computers. Father would busy himself with household chores. Owen would spend hours with her trying to talk and fearing each choked breath would be the last.

The teenager squirmed and his brother looked absent; they did not visit. Both had refused. Was Grandma the face of the future? "I don't like thinking about death", said the younger boy. He was pleased that Alzheimer's had relieved him of his Grandma duty. I developed the thought that he did not want to grow up, so suggested he read Peter Pan [4].

Weekly games of table tennis had revealed that losing (games) was not a problem; a strange sort of grieving, indeed! He took ownership of the table tennis set and did not allow other children to use it. He tried to steal it. He hated me saying he liked being in control. He refused to believe he was a manipulator. He would not

speak about death. He refused to read Peter Pan.

He was assessed at school to have learnt nothing for a whole year: his performance had not moved, at all across twelve months! Puberty seemed on hold. We met at school and discussed this as a remarkable achievement: but we were not going to accept no progress any more. The threat of not advancing in school suddenly kicked into action unseen maturity.

A family session brought things to the fore. The brother talked of his educational plans and sneered at the younger. Mother spoke of her PhD progress. The teenager talked of his fear of being kept down and how he was on a two week trial in Year 9 with the other children as they completed school for the year. Suddenly, he could do the work! He found that he did want to grow up. Father remained silent, yet, about his future.

This reluctant family was avoiding the truth about Grandma: fear of growth/death produced stasis in the boy. Emotion laced presentation had not needed emotional treatment. Emotions were being used with political purpose: avoiding something that he could not talk about. Apart from adulthood as death, his other versions of the future were an aimless but caring paternity, or a hostile, pursuit of academia. Tennis had provided one pathway, but school could provide another.

Immigrant Alcoholic Mother Wanted A Girl

Maks was a virtual agoraphobe when first consulted. She had her computer and her room in her parents' house, but did not emerge often. Her alcoholic parents would provide meals and had not noticed her breast development. She could get to the bathroom without them noticing her. The elder brother had moved out; the younger brother was still at home and was the only one supportive of her transition.

There had been much trauma in this boy's childhood. Born in central Europe, the family arrived as migrants when he was six years old. A skinny kid, he learnt English relatively easily and often was the translator for his mother, even though the older brothers were also competent speakers of English. He was the victim of his older brothers' rage from time to time as the three boys struggled to grow up in a family short on funds and with parents who worked alternate shifts and were often not at home. Relaxation for the parents was drinking.

Vague memories of sexual experiences with the brothers were reported but were never clear. Clearer was a European memory with an uncle at about age five years involving forced oral sex. There had always been a somewhat strange enunciation used by her in sessions and this seemed to fit with this early experience.

Secondary schooling was a disaster with endless instances of bullying and quiet survival at the back of the class. School left him at age fifteen years and he worked in fast food stores, but age excluded him at about the same time he found a support group for LGBTIQ youth. Thus began his double life. All along, food was a problem: putting on weight was not an option.

After two years of therapy, involving many missed sessions as she struggled to get her way to the clinic. She was extremely sleep disturbed and would have days without shut-eye and then extended periods of very deep sleep. By this time, gender transition was public within in the home: and hostilely rejected by the older brother and father. The mother felt guilty and tried to talk with her third son. Upon my suggestion, she asked her mother if it had been hoped that the third child would be a girl. The mother agreed.

With this knowledge she arranged her departure from the cruel home into shared accommodation. She changed her name, her phone number, and her birth details, and never looked back. She moved as far to the east of the city as she had previously lived in the south-west. She enrolled in year 11 at a TAFE. All was rejected; although she admitted to some sadness at the loss of contact with her nephew.

Things remained difficult. Recovery from early childhood trauma and parental deprivation takes time. Adjustment to living as a woman is a challenge. Trying to find employment without education is almost impossible. Workplaces are not inviting of those in transition. Studying having never been a student is stressful. Living with others and maintaining a household without prior experience can be horrendous as the not so domestic habits of others emerge. Exploring the bounds of her released sexuality provided both diversion and danger. The distorted body image was the site of perversity and polyamory.

Rejection of all from before has left this trans young woman struggling to find relevance and a place in society. She enjoyed cooking for others, but rarely ate much.

Mary, Mary Quite Contrary

Mary was not really contrary when I first met her; although she had been in the past. That was more than two years before when her anorexia was ferocious, and hospitalization was necessary. Soon after, her mother, Toni, had surgery and chemotherapy for breast cancer. She was in remission when she called to ask for an appointment for her daughter under the recommendation of a former colleague and supervisee who was her psychotherapist. Mary's former therapist was on maternity leave and Mary did not want to go to the clinic she had previously attended. Five sessions of family work then proceeded to recover a sense of purpose at a time when the whole family were dismayed by the possibility of relapse.

Things had deteriorated as the end of Year 12 at school loomed. The family had always worried about the return of the illness

under threat, and it seemed to be happening with Mary becoming increasingly grumpy with the COVID lockdown, antagonistic to her two younger sisters, and lacking much interest in study. I asked if there had been much family work with them in the past: Toni said only one unsatisfactory session had occurred.

We agreed to have an introductory and light first session, but getting five people onto a Zoom call was a challenge. I suggested two laptops be used with rotation across sessions of those who were in person. Father, Tom, was sitting with Mary the first time, with Toni with the other daughters, Elizabeth and Naomi. They had adopted shortening of their names: mother had become popular with "Tones", father had always been Tom, Elizabeth was "*Beth*", "*Bette*" or "*Betty*", and Naomi was "*Nomes*". Mary was steadfastly Mary.

The family described their interests and activities. Naomi was in Year 6 and doing very well. She liked to read and be with mum and her friends. Beth was in Year 9 and absorbed with her friendship group and a couple of interactional computer games like Sims. Mary did not much like anything. She had a friendship group dissolve in bitchiness the previous year and she had not been able to rebuild by the time school closed. She did like reading and keeping to herself. Tom was a runner, and he liked to run every night and, especially, with Mary, when she kept up. Mary had forgotten her interest in athletics and exercise. Toni was another avid reader and committed mother. She was also a surgeon, and her breast cancer had taught her to be a bit tidier in her needlework. In fact, she had always liked sewing and handicrafts. Both parents were medically trained, with father Professor of Endocrinology.

The family were connected to their grandparents, but they were in Adelaide. Both parents had moved from country districts for their studies and met at the university. They came to Melbourne for the academic appointment.

Asked about the reason for the family therapy appointment; Mary quickly owned up to being the cause. Everybody tried to downplay this ownership: it was not her anorexia, but her grumpiness that was a concern coming into the exam period, some three months away. Mary agreed she had been grumpy and had lost interest. I asked about her subjects and psychology was her favourite. This is actually why she had agreed to the appointment. She wanted to know about how family therapy might work! All other subjects were going okay, but she could not enjoy herself.

I asked the other girls what they saw as their profession at this stage and Beth spoke of business ownership/entrepreneurship, which surprised her parents a little. Naomi wanted to be "*just like what mummy does*". Mary said she did not know or really care, but she did not want to be a doctor! This led to ventilation about the people at school, students, parents, even the cleaner, all expecting her to study medicine. I said she seemed to want to be different to her parents: she hissed "*yes*"!.

Somewhat dismayed, her parents agreed that this was what they understood, but they had not known how strongly she held her position. They then both said to her that they had no expectations of Mary doing medicine; in fact, they rather doubted sometimes whether the pressures were worthwhile. I was surprised that this message had never been clearly stated or categorically understood. I said that with eating disorders rejection of the parental models was often a significant factor. They had not heard this before, but felt that it made sense. We agreed to meet again.

At the second family meeting, mother was with Mary and father was with the other girls. Mary was feeling wonderful and getting stuck into her study. She felt very relieved that she did not have to follow in her parents' footsteps and the parents reiterated that this was not necessary. All the girls were looking forward to returning to school in person. It was a very light session, and we agreed to a follow up session in two months' time, just in case the study program was again becoming onerous.

About four weeks later, Toni contacted wanting a one-to-one session for Mary and asked if I could speak with the family general practitioner, whose role had been for several years to weigh Mary every month. At the regular contact, Mary had spoken of her rage on the previous weekend when not allowed to have her boyfriend visit. The boyfriend had materialized at a function not so long before and everybody considered him to be an asset. But there had been two contacts during the week, and the trouble of meeting halfway with five kilometre travel limits was a bit unsettling for both sets of parents. The ferocity of Mary's response had shocked the parents. Mary wanted someone to talk to and explain her difficulty. Meanwhile, her school performance was continuing strongly.

There was quickly arranged a session for Mary and then a follow-up with the parents. Mary and I discussed what it was she wanted her parents to understand about her. She did want to tell her parents about her antagonism to them and their careers and to her little sisters, who seemed to be able to get away with things. She wanted them to know that she liked having a boyfriend and felt that as she was studying well, she deserved a bit more freedom. She also wanted them to know that she was not ready to leave home, yet, and whatever study she did next year she wanted to be able to do while living with her family.

Surprisingly, Mary and her parents were present for the couple session. Mary had told them that she was not necessary, but father had told her she needed to attend. He apologized readily when I insisted this was a parents' session. The planned messages from Mary were gratefully accepted by the parents and they downplayed the threat for her to live in residential college. This had been what they had to do as country kids and had enjoyed it when they were

first at university. We talked about the rejection of their careers, and they repeated this was not of concern. I asked the mother about the progress of her therapy, and it had been decided with the therapist that mother and Mary had different values; the idea of rejection of values made even more sense. I asked mother to discuss this further with her therapist. This was both painful and a relief for the mother. We agreed to have the follow-up session as planned previously.

Everybody was very happy at the next session. Mary had won dux of psychology! She was very happy and enjoying the final weeks of school. Mother and father were very relaxed and happy, although he attended from his workplace. Mother was somewhere else, as well, with the three girls sitting together and enjoying each other's company. Mother commented on how much kinder Mary had been to her sisters. This was a happy session, but included some quiet reflection upon where they had come from and what things had been like. Mary spoke of her fear that her anorexia had caused her mother's cancer. The parents quickly refuted this. I asserted Mary's right to feel that she had been damaging and wanted to take responsibility for her part. The parents relaxed and Mary felt that she had been heard and understood. Mary had found her way to a sense of self that was of her own making, not fashioned by parental and school forces.

Fat Is A Feminist Reading: Chubby Charlene

Charlene was hopelessly depressed after the birth of her third son and had all the signs of post-natal depression (PND). But she was more worried by her "disgusting" obesity. I wanted to help with the PND and how it made her capacity for work, for parenting, and for being a wife almost impossible. Her overweight husband was not ready to change his habits and regularly ate a packet of biscuits in front of her as a late-night snack.

Charlene was also consulting with a psychiatrist to help with her medication, but he was more than a prescription only psychiatrist and focused upon the presence of the husband's mother within the family home as a burden that was beyond Charlene to bear. She had a love-hate relationship with the psychiatrist, but was open, expansive, and engaged with me. She was pleased somebody had recognized her PND symptoms, but the prominence of the symptoms was not the most important feature.

The depression was more about her body image than the arrival of the third child. The child represented a life sentence for her of being fat. She had not had PND with the first two children. Somehow, she had lost confidence and was struggling at work: I suggested she read Fat is feminist issue [5]. She came back astonished that the stories from forty years before and from New York applied to her.

Her fat story was from about twelve years of age. Her parents were pleasantly plump people, and her younger sister hated this, so she refused to eat. The parents responded with the injunction to not leave the table until all plates were cleared of food. Charlene would fix the problem every night. During the course of our conversations, Charlene reported raising this with her mother: "*yes*" the parents had known how the plates were emptied, but had never commented!

At about the same time, champion teenage hockey player Charlene started to complain of breathlessness when involved in fast games and in athletics. Eventually, mother and daughter went to the doctor, who explained this was not asthma. But the doctor recommended that Charlene stop high intensity activity. The symptoms went, except for moments of inadvertent activity, and despite Charlene searching medical books and satisfying herself that she had asthma, her mother would hear nothing of it. The doctor clearly knew better. As an adult she was treated for asthma and remains under monitoring. She lost years of exercise and fun by misdiagnosis.

Large food intake and no exercise impacted rapidly. But when she started university, an older banking professional took a liking to Charlene and was impressed by her size. He loved fat women and had separated from one when she suddenly lost weight. He fattened Charlene up to 170 kilograms and they had a son. The breast feeding and intensity of parenting caused this man, whom I will call Terrence, to take his affections elsewhere.

Charlene, somehow, had established a career in local government and human resources and she fell back onto this work and shared a house with her lone parent sister, who had a daughter of similar age to her son. Charlene met her current husband through work, and he proved a worthy support and a good father to his stepson. They agreed to have children, and two more sons followed in quick order, some twelve and fourteen years younger than the first son. The banker did not provide child assistance, and the mother was not keen to pursue him for child support funding as she did not want him to have access to the eldest boy.

When sixteen years, the eldest boy became interested in his father, and he went to the interstate capital to spend time there with his father. This caused much anxiety for Charlene, and she started to report severe nightmares where terrorists of all sorts: sometimes Muslims, sometimes Ku Klux Klan, sometimes Christian fundamentalists, and sometimes ninjas. I interpreted her rage against these Terry-ists. She did not hear, so I repeated my comment, and she burst out laughing. "You want to kill him but are worried that he will come after you". She applied for funding through the Child Support Agency and was awarded a steady income with compensation for several years. He did not fight the application.

A year later she had bariatric surgery, six months later she was

normal weight, but with heavy folds of skin. She was extremely happy and energized. She followed the advice of Orbach [6]. Talking over the six years of work, she felt that understanding the indulgence of the sister by her parents and the loss of exercise had placed her in an invidious position and then being preyed upon by the Terry-ist, had locked her into obesity which she had despaired of escaping. Her third son was the wake-up call to change her life if she was to see him into adulthood.

Some will wonder about surgery as an option. From my point of view, if the psychological work has been done thoroughly, the outcome can be achieved without complication. Rushing to this option has caused trouble for some other patients.

Charlene had rejected her parents as models for adulthood, but never lost her love for them. They would use indulgence as a chief parenting strategy and food proved a worthy compensation. She became defiant in the face of the slim ideal and was encouraged in this by her first partner. She regarded her body as an object, and this became an object of disgust. In her workplace she would meet people who were successful adults, and she aspired to be like these mature others.

Charlene's therapy was almost completed, but she came back because her mother had serious breast cancer. Her fears of ever making it to adulthood, of ever escaping the Terry-ist, of being a successful parent, re-emerged as fears of her mother's death. She returned to grazing on sweet biscuits and, as the days of the COVID lockdown passed, she gained twenty kilograms. Talking about her mother and her unrealized hopes for mother's understanding stopped the minor bingeing, but the story of fear had many side bars.

Keeping The Connection: Sporty Sue

A mother approached the eating disorder private clinic as she wanted to talk about her daughter's reluctance to continue with counselling for her eating disorder. Sue had been treated as an inpatient anorexic, but more recently was diagnosed as Avoidant Restrictive Food Intake Disorder (ARFID) and was also prone to excessive exercise. Sue felt she had recovered, she no longer obsessed about her body, and enjoyed food as fuel for her active body. Sue was clear: she did not need further professional help.

There had been a time when the disorder was much worse, but the changes that were achieved through the parents' couple counselling, rather than the counselling in which Sue had participated. Mother admitted her husband was difficult and that he had been very antagonistic to Sue; he often reverted to bullying as a parenting and interpersonal style. He worked in trade supplies and was very much a "*man's man*". He did not enjoy having to watch his daughter's sport, although he did like to have her go running with him.

Mother was a teacher and easily reverted to a very conscious style of problem solving and didactic explanation. She loved her daughter and had her daughter's respect, but felt that this was not enough to help her daughter become healthier and was disappointed that Sue had closed the door on counselling. Sue was a very competent student and a very accomplished netballer with a keen competitive streak. Mother still played netball and was pleased her daughter could enjoy her mother's sport.

Mother described her husband's childhood: he was the natural child to parents who fostered many children. This had left him bitter and with little tolerance of children and their needs. She had a lot of affection for her husband, but had been very surprised by his attitude to children when the babies arrived.

We explored the relationship between the girl and her parents. Sue had openly stated she did not want to be like her father, but had surprised the mother when she had said the last thing she wanted to be was a teacher, even though certain teachers had been very important for Sue when she was starving herself and when upset. Sue did say she loved her mum but was always very guarded in her showing of affection, especially when father was around. Mother was confident that Sue loved her, but was hurt by the absence of an open exhibition of these feelings.

When asked what she felt she had given her daughter, the mother commented she had kept her fed and supported her studies and sport. Mother was happy to call this nurturance, but felt that this had required a lot of persistence.

We talked about what was needed next, I suggested that nurturance and persistence was working, so this should be continued. She said she still needed the couple counselling, but wondered if the counselling service had abandoned them. I suggested that the counselling service had not abandoned them, and to trust her daughter's judgement. I encouraged her to return if the troubles re-emerged. This has not happened. Only one consultation occurred.

There is no evidence that this consultation was of any specific value as no further contact occurred, but the mother went away with a view that her daughter loved her, but did not want to be like either parent. She could appreciate her role in her daughter's recovery. She wanted more couple work but felt that her husband had had enough and would not take up a new opportunity. She knew to hang in there and to nurture.

The Maudsley Model In Template And In Failure

The Maudsley model is a tri-phasic outpatient intervention program, claiming to achieve ninety percent recovery in those who complete the program, with sessions occurring every three weeks or so over twelve months [9], originally developed by Dare and colleagues in the 1980s [1]. Re-feeding is the primary focus: dangerous levels of weight loss are confronted directly by parents

implementing strategies to get the adolescent to re-engage with eating. The second phase begins with the mood of the family lightened, acceptance of the parents' demand that the teenager eat, and steady weight gain. The third phase focuses on establishing healthy adolescent identity. This is what happens when the model works.

The story presented to a child psychiatry conference by a father [3] of his family's unsatisfactory engagement with Maudsley model treatment provides a stark view of when the Model fails. As presented, the professionals were quite authoritative about the model. The invitation to the parents to take control of their two daughters' behaviour with respect to food, had the parents confused, when the daughters did not succumb to their parents' firm directives. Unable to control their daughters, they were then subject to the extreme scrutiny of the professionals. The parents were disempowered on both fronts. The daughters continued to starve, and the parents took their daughters elsewhere and achieved recovery (father did not describe how this was achieved).

A similar account of disempowerment and felt blame was documented by Conti, Calderi, Cibralic, Rhodes, Meade, and Hewson [8], with the father refusing to participate after a period of intense commitment, and then leaving the family. The claim of the model to not blame the parents seems unsustainable in the few published accounts of when the treatment model has failed. [10] Reported parental disempowerment as one of the reasons carers complain about the application of the Maudsley model.

The Maudsley model was developed [1, 11] for anorexic teenage girls and has been very successful for some of the patients. The lack of rigorous documentation of referrals not accepted and early program discharges make reports of efficacy difficult to assess. Ninety percent of completions may recover, but it is estimated, anecdotally, that only about thirty per cent of applicant families complete. There are many other forms of eating disorder, but the eating disorder workforce is often drawn from hospital trained Maudsley model staff. There are frequent reports of teenage patients who re-present as adults with eating and feeding problems. It is conjectured that the Maudsley model is a special example of treatment that belongs to a wider range of presentations. As was demonstrated, it is at this edge that I have worked with eating disordered persons the most.

The Maudsley model obscures the role of parents as flawed versions of adulthood for the child. The model also obscures how the power of the institution overwhelms the will of the anorexic girl and compels parents to change their parenting and their lifestyles. This is warranted to save lives, but obscures the more subtle means of creating recovery.

The Model can be re-described as: dismantle deadly dynamics, re-harmonize family life, and allow adolescent differentiation. Sometimes the heavy hammer of hospital is needed, but in many other cases, dismantling, harmonizing, and differentiation, can happen in gentler, but more direct and less expensive ways.

Putting The "Not My Mum, Not My Dad" Hypothesis To Work

The application of the "not my mum, not my dad" hypothesis to clinical practice should be straightforward if the triangles are used as means for enquiry. Remember that the hypothesis is not a proven theory, but rather provides a guide to action. The aim is not to replace existing theories and models of practice: it is to augment current practice. The aim is to facilitate the natural movement toward adulthood. The aim is not to ignite battles, either!

Simply enough, enquire about who the child wants to be when grown up: who is a model of adult. Ask why the parents are not preferred examples of adulthood. This line of questioning can be put to a child, a couple, a parent, or a family. Further work on eating disorders based on eight triangular domains of family tensions are presented in a companion paper (Grimwade) [12], including an enhanced guide to diagnosis and intervention.

Conclusion

Case study method can generate new hypotheses to enhance practice. The dominance of the Maudsley model within the eating disorder field has distorted the capacity for new ideas to emerge, except if they come with Maudsley pedigree. This series of cases is designed to open up a new line of enquiry and practice.

The international audience of those involved in the treatment of eating disorders is invited to apply the "not my mum, not my dad" hypothesis in their case work and see if it applies. I encourage interested practitioners and researchers to develop the ideas further and to undertake rigorous research. I am happy to let control of any projects go to others, but would be happy to support any such research upon invitation.

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