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Family relations as perceived by females suffering from anorexia nervosa – part II

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We present results of the research on the evaluation of family and dyadic relations, together with their own functioning within the family unit. The subjects are patients suffering from anorexia nervosa and their healthy siblings as well as healthy females from the control group.

We begin with the presentation of our research results concerning the evaluation of family relations from the perspective of the parents of females suffering from anorexia nervosa. In the second part of this study we present and discuss results upon the evaluation of family relations conducted on females suffering from anorexia and their siblings together with an evaluation by their peers from a control group.

Key words: anorexia nervosa, family relations

Sample

The clinical group was comprised of females who were diagnosed with anorexia nervosa, in accordance with the ICD-10 criteria. Patients were being treated in the Department of Child and Adolescent Psychiatry of Collegium Medicum of the Jagiellonian University in Cracow and in the Department of Child and Adolescent Psychiatry of the Institute of Psychiatry and Neurology in Warsaw. The control group encompassed females from families with no history of eating disorders. The selection of the control group was presented in the first part of the article. The clinical group comprised 37 females suffering from anorexia nervosa (average age 17.3) and their 16 healthy sisters (average age 18.1) while the control group numbered 41 healthy females (average age 17.3).

Results

The same method was applied as in the case of research into family relations by parents, i.e. the Questionnaire for Family Evaluation (QFE) [1]. Both sets of data were subjected to a quantitative and qualitative analysis. A t-test was applied to determine the significant differences between groups.

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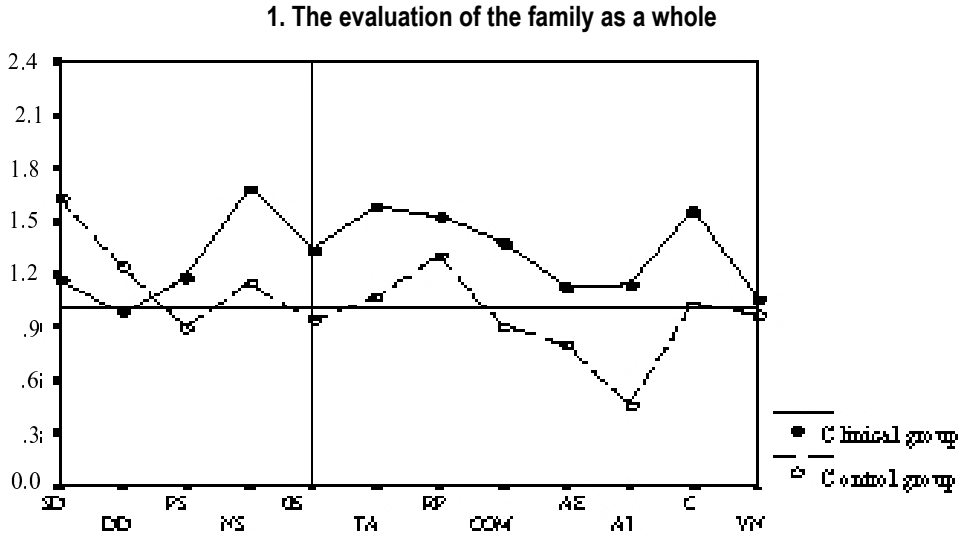


Graph 1. **The evaluation of the family conducted by the patient**

The questionnaire scales:

SD - Social Desirability
DD - Denial-Defensiveness
PS - Positive Statements
NS - Negative Statements
GS - General Scale
TA - Task Accomplishment
RP - Role Performance
COM - Communication
AE - Affective Expression
AI - Affective Involvement
C - Control
VN - Values and Norms
K -Kindness
CA - Care
G -Grudges

Table 1

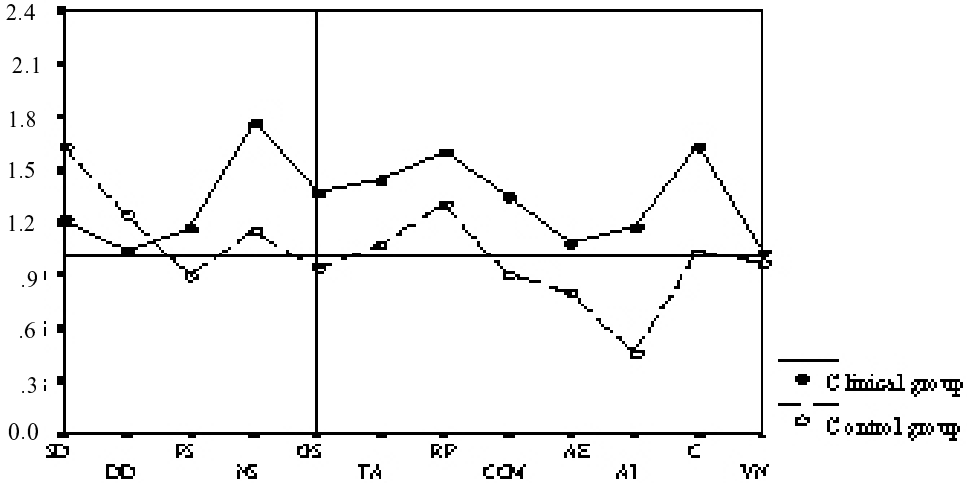
The evaluation of the family conducted by the patient

Scales	Clinical group M	Control group M	p
Social Desirability	1.167	1.634	**
Denial-Defensiveness	0.984	1.248↑	*
Positive Statements	1.181	0.893	*
Negative Statements	1.682↑	1.154	**
General Scale	1.387↑	0.933↓	**
Task Accomplishment	1.583↑	1.073	**
Communication	1.375↑	0.896	**
Affective Expression	1.128	0.793↓	*
Affective Involvement	1.146	0.457↓	**
Control	1.558↑	1.030	**

* p_i = <0.05; ** p_i = <0.01; p_i for the directional test
↑ the average deviates **upwards from** the criterial value equal to 1 statistically significant at the level of 0.05;

All scales differentiate the groups in a statistically significant manner. The scales measuring role performance as well as values and norms constitute an exception. Within the clinical group the averages, which deviate to a significant degree from the criteria, are always higher than the criteria. This suggests that in these areas, the patients evaluate the functioning of their families more poorly than others do. This relates to 5 scales. In all remaining scales the results are close to the criteria value. In the control group the picture is more diverse – the average results in the scales of affective expression and affective involvement diverge significantly in the desired direction from the criteria. This suggests that the healthy females evaluate the functioning of their families in these aspects favourably. However, a worse result concerns the role performance – the results here, in a way are similar to the scale of negative statements. This shows a divergence in an undesired direction.

The greatest differences of a statistical significance in the evaluation of the func-



Graph 2. **The evaluation of the family conducted by the patient's sister**

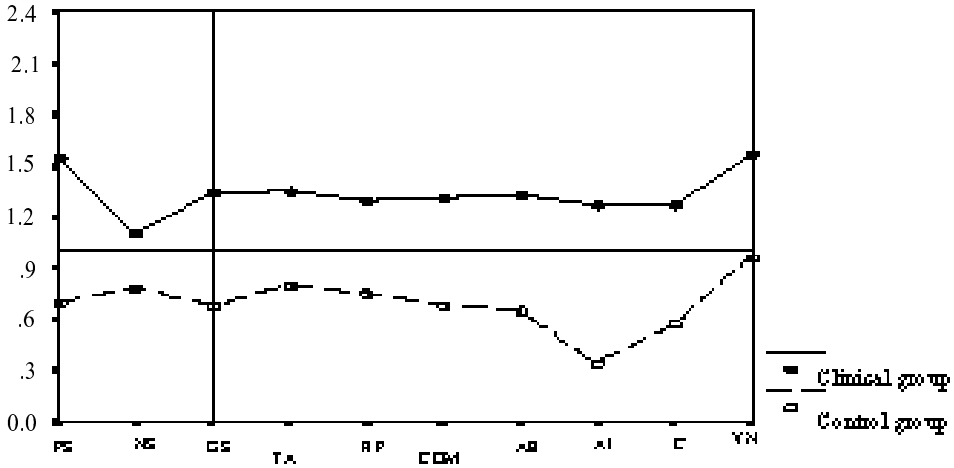
Table 2

The evaluation of the family conducted by the patient's sister

Scales	Clinical group M	Control group M	p
Social Desirability	1.213	1.034	-
Positive Statements	1.107	0.893	-
Negative Statements	1.750T	1.154T	**
General	1.370T	0.933	**
Task Accomplishment	1.444T	1.073	-
Communication	1.347	0.920	-
Affective Involvement	1.170	0.457↓	**
Control	1.025T	1.080	**

tioning of family conducted by sisters of patients are to be found in the scale of negative statements, affective involvement and control. Higher results within the clinical group indicate a poorer functioning of clinical families within the areas mentioned. Significant statistical differences appeared also in the scale of positive statements, task accomplishment and communication. Within the scale of social desirability a result higher in a statistically significant way, indicating poorer functioning, relates to the control group.

2. The evaluation of relations with parents conducted by the children



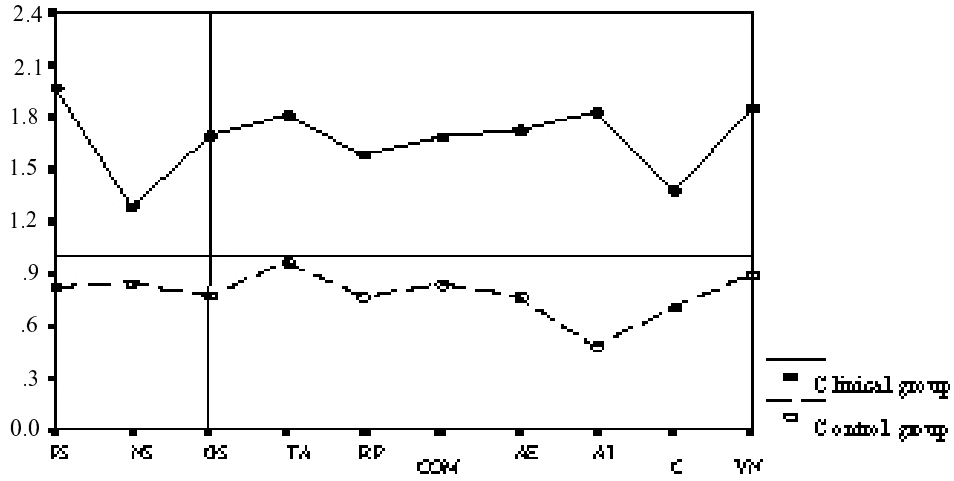
Graph 3. **The evaluation of relations with her mother conducted by the patient**

Table 3

The evaluation of relations with her mother conducted by the patient

Scales	Clinical group M	Control group M	p
Positive Statements	1.554↑	0.700↓	**
Negative Statements	1.111	0.785↓	*
General Scale	1.348↑	0.679↓	**
Task Accomplishment	1.358↑	0.799↓	**
Role Performance	1.304↑	0.750↓	**
Communication	1.316↑	0.683↓	**
Affective Expression	1.331↑	0.646↓	**
Affective Involvement	1.277↑	0.341↓	**
Control	1.277↑	0.567↓	**
Values and Norms	1.574↑	0.963	**

A comparison of results in the evaluation of mothers conducted by patients and those from the control group indicates that these groups differ from each other in a statistically significant way on each of the scales. The direction of divergence within the control group points to a positive evaluation of mothers by the patients. In the clinical group only the average for the scale of negative statements, while in the control group the scale of values and norms, equal the criteria.



Graph 4. **The patient's evaluation of relations involving the father**

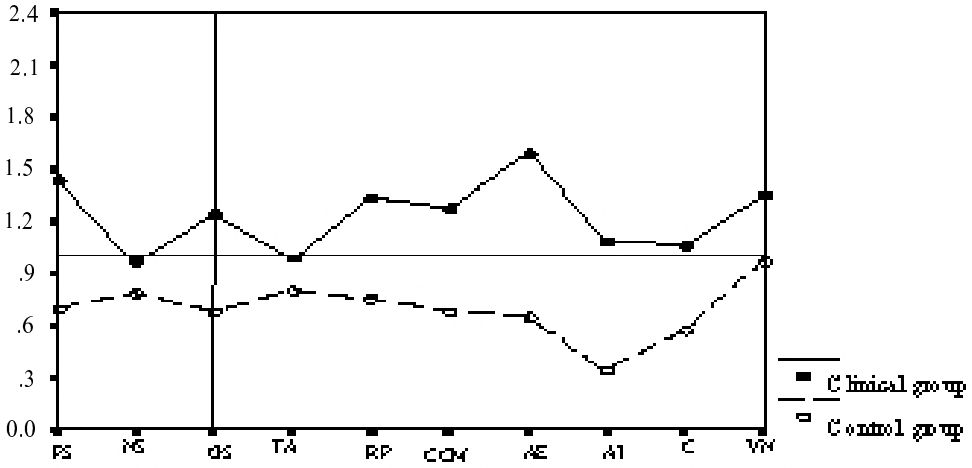
Table 4

The patient's evaluation of relations involving the father

Scales	Clinical group M	Control group M	p
Positive Statements	1.972↑	0.819	**
Negative Statements	1.297↑	0.644	**
General Scale	1.696↑	0.773↓	**
Task Accomplishment	1.810↑	0.963	**
Role Performance	1.586↑	0.768↓	**
Communication	1.690↑	0.841	**
Affective Expression	1.724↑	0.768↓	**
Affective Involvement	1.828↑	0.482↓	**
Control	1.379↑	0.701↓	**
Values and Norms	1.853↑	0.890	**

A comparison of the average results for each group shows that the trend in the differences is always to the disadvantage of the clinical group which constitutes a poorer evaluation of the father by the patient (significant difference at a level of 0.01). All divergences from the criteria within the clinical group are statistically significant in

an undesirable direction and fairly important. What is interesting however, is that this occurs more often than in the case where the patient evaluates her mother.



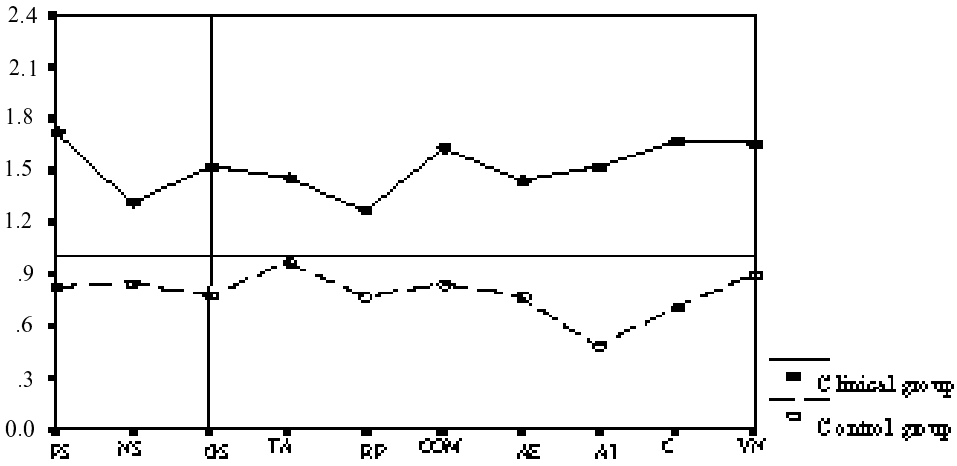
Graph 5. **The evaluation of relations with the mother conducted by the patient's sister**

Table 5

The evaluation of relations with the mother conducted by the patient's sister

Scales	Clinical group M	Control group M	p
Positive Statements	1.442↑	0.700↓	**
General Scale	1.246	0.670↓	**
Role Performance	1.344	0.750↓	**
Communication	1.281↑	0.652↓	**
Affective Expression	1.504↑	0.640↓	**
Affective Involvement	1.004	0.341↓	*
Control	1.062	0.567↓	*
Values and Norms	1.350	0.903	*

The differences between the clinical and control group are more highly differentiated in the case of the individual scales than in the case of patient – mother. The greatest difference is noted in the scale of affective expression. Evaluation in the clinical group diverges from the criteria in a negative direction only in the scales measuring affective expression and positive statements. Generally they are similar or somewhat better that the analogical evaluations of formulation made by the patient. In comparing the evaluation of the mothers by the patients' sisters and by the patients, it appears that sisters of patients not only evaluate mothers better but also do so in a way more varied than is the case with patients.



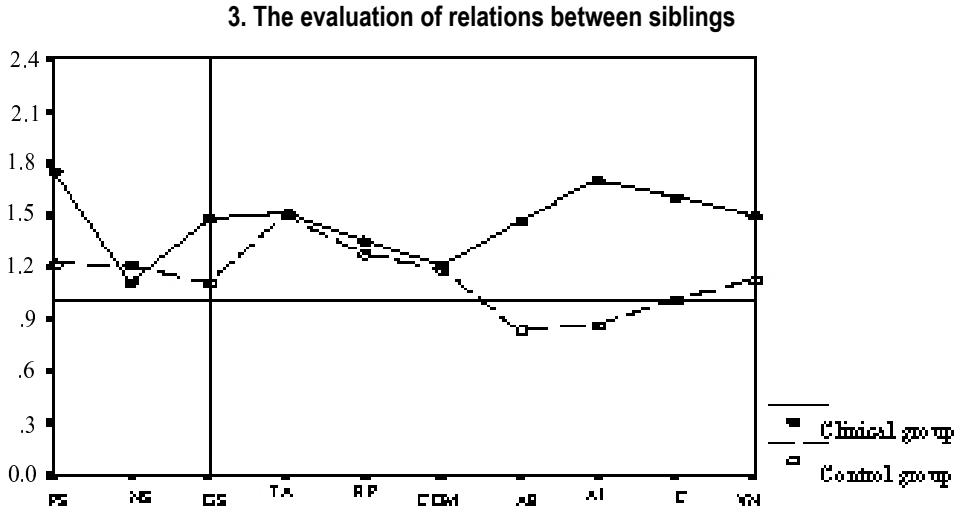
Graph 6. **The evaluation of relations with the father conducted by the patient's sister**

Table 6

The evaluation of relations with the father conducted by the patient's sister

Scales	Clinical group M	Control group M	p
Positive Statements	1.730↑	0.819	**
Negative Statements	1.316	0.844	*
General Scale	1.522↑	0.778↓	**
Task Accomplishment	1.461	0.963	*
Role Performance	1.269	0.768↓	*
Communication	1.653↑	0.841	**
Affective Expression	1.442	0.768↓	**
Affective Involvement	1.519	0.482↓	**
Control	1.673↑	0.701↓	**
Values and Norms	1.654↑	0.890	**

Statistically significant differences between the groups appear in all of the scales. Better evaluations appear also on all of the scales in the control group. In a way similar to that which patients evaluated their fathers, all of the differences between the groups are statistically significant. It can be noted that sisters, like the patients themselves, evaluate fathers poorer than they do their mothers, while patients evaluate their fathers even poorer than do their sisters.



Graph 7. **The evaluation of relations with the patient conducted by the sister**

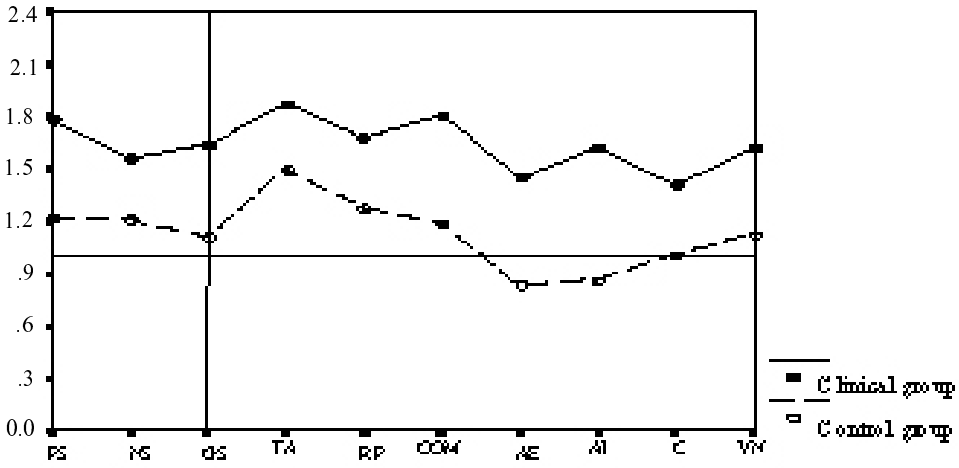
Table 7

The evaluation of relations with the patient conducted by the sister

Scales	Clinical group M	Control group M	p
Positive Statements	1.757↑	1.228↑	**
General Scale	1.481↑	1.116	**
Affective Expression	1.476↑	0.836	**
Affective Involvement	1.702↑	0.864	**
Control	1.607↑	1.014	**
Values and Norms	1.500↑	1.129	*

Statistically significant differences between the groups appear only on certain scales, i.e.: affective expression, affective involvement, control and positive statements. The direction of deviation within the clinical group is always negative, while in the control – positive. In the control group only the scales for communication and negative statements are the results close to that of the criteria. In the control group in four cases the results deviate in a negative direction – in the scales of positive statements, negative statements, task accomplishment and role performance.

In the case when the patient evaluates siblings, the differences between the groups



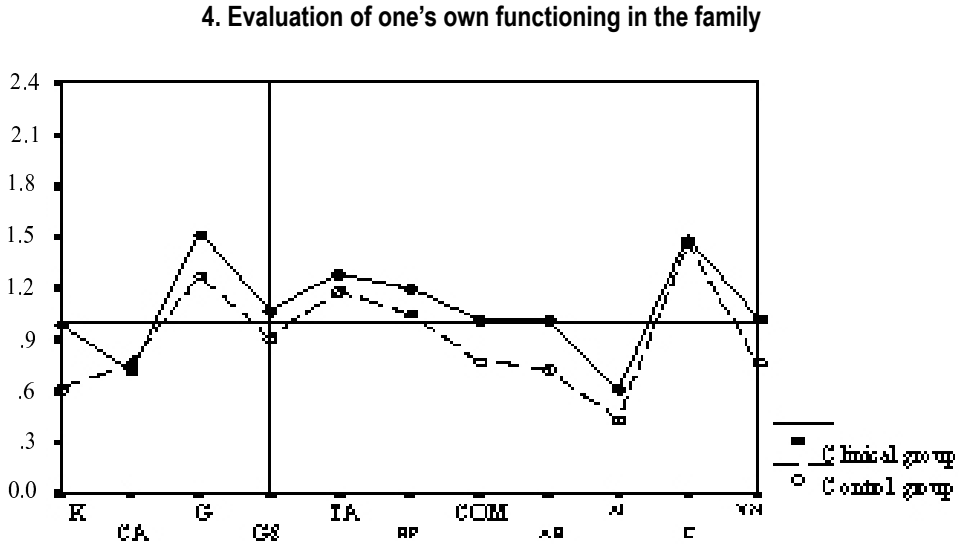
Graph 8. **The evaluation of relations with siblings conducted by the patient**

Table 8

The evaluation of relations with siblings conducted by the patient

Scales	Clinical group M	Control group M	p
Positive Statements	1.781↑	1.223↑	**
Negative Statements	1.561↑	1.214↑	*
General Scale	1.639↑	1.116	**
Task Accomplishment	1.865↑	1.500↑	*
Role Performance	1.683↑	1.279	*
Communication	1.808↑	1.196	**
Affective Expression	1.452↑	0.836↓	**
Affective Involvement	1.625↑	0.864	**
Control	1.413↑	1.014	*
Values and Norms	1.625↑	1.129	**

in all of the scales are unfavourable for the clinical group. All the results in the clinical group deviate from the criteria to a statistically significant degree in a negative direction, somewhat more clearly than in the case of patient evaluation by the sister.



Graph 9. **The evaluation of one's own functioning in the family conducted by the patient**

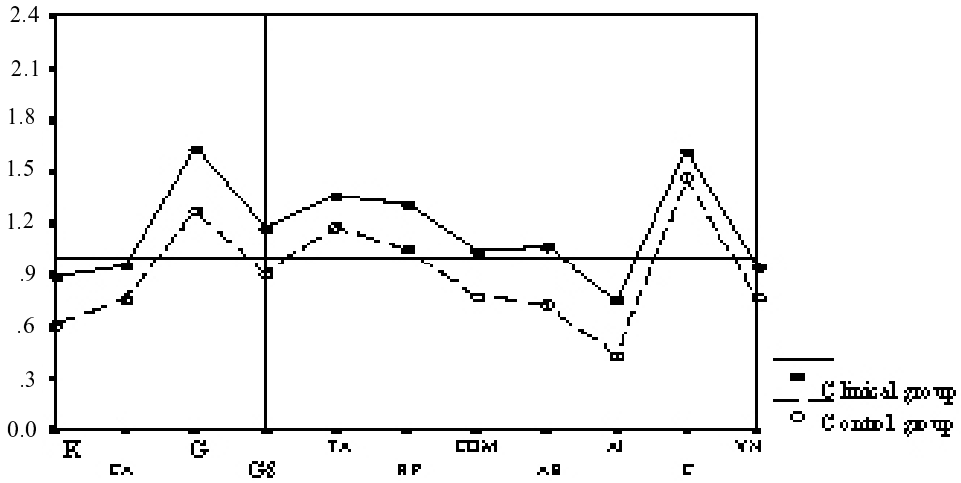
Table 9

The evaluation of one's own functioning in the family conducted by the patient

Scales	Clinical group M	Control group M	p
Kindness	0.991	0.610	**
Communication	1.012	0.774	*
Values and Norms	1.024	0.768	*

In the evaluation of one's own functioning in the family that was conducted on females, small statistical differences appear between the group of females with anorexia and the control group. These involve the scales of kindness, communication as well as values and norms. These are always greater in the clinical group which signifies worse self-evaluation. One may note a differentiated picture of our results in relation to the criteria, particularly in the clinical group where the scales of care and affective involvement deviate in the desired direction, with control, task accomplishment and grudges in the undesired. Within the control group the scales of affective involvement, values and norms, affective expression, communication as well as care and kindness deviate in the desired direction, with task completion and grudges in the undesired, this being particularly the case with the scale of control.

The scales which in a statistically significant way differentiate the groups involve



Graph 10. **The evaluation of one's own functioning in the family conducted by the patient's sister**

Table 10

The evaluation of one's own functioning in the family conducted by the patient's sister

Scales	Clinical group M	Control group M	p
Kindness	0.889	0.610↓	*
Grudges	1.632↑	1.277	**
General Scale	1.174	0.915	*
Role performance	1.316↑	1.055	*
Communication	1.042	0.774↓	*
Affective Expression	1.069	0.726↓	*
Affective Involvement	0.750	0.433↓	*

those that measure affective involvement, affective expression, communication, role performance, general scale, grudges, as well as kindness. These differences are, however, not too large, the most clearly expressed is the scale of grudges. More than likely they have the character of non-specific differences beyond this one scale.

The results for the scales of control, role performance, task accomplishment as well as grudges deviate from the criteria in an undesired direction. In the control group the situation is similar in these self same scales (with the exception of role performance), though the majority of the scales deviate from the criteria in a desired direction. In the scale of role performance, as equally in the general scale, the averages of the results almost tally with the criteria.

Discussion

The results of both parts of the study show unequivocally that all members of families in which one of the children suffers from anorexia nervosa evaluate family relations worse than do the members of families from the control group.

In the aspect of the functioning of the family as a whole, patients evaluate their families worse in all the dimensions than is the case with the control group with the exception of the dimension of role performance and values and norms. This means that both groups of families function worse in relation to the criteria adopted, from which one can deduce that non-adjustment of roles could be more highly connected with adolescence than with the disorder itself. The lack of differences within the aspect of values and norms from the children's perspective suggests cohesion in the family system of values in both groups of families. The differences between the results achieved for females from the clinical group and from the control group show that in anorexic families, empathy is extremely weak, in a manner similar to the level of the appeasement of emotional needs. Patients perceive the control imposed in their families over the behaviour of others as extremely restrictive and/or chaotic, especially not adapted to the life changes. Besides which there occurs in these families a large inability to communicate one's own judgements or emotions, which can lead to a lack of mutual understanding. The actions undertaken by members of anorexic families appear not to be adapted to the changing conditions or stress situations, and beside this they do not lead to the working out of joint solutions. A generally more negative or critical attitude towards their family can also be observed amongst patients, something in contrast to the healthy females.

Sisters of patients differ from the control group in their evaluation of family in fewer of the scales. In a way similar to patients their attitude towards their family is rather critical. They describe members of their family as rather not empathic and as not satisfying the emotional needs of others. They see their difficulties in the adequate control of the behaviour of others which makes it difficult for them to fulfil the demands of everyday life. One may suspect that sisters of females suffering from anorexia experience equally rigorous and/ or chaotic control on the part of parents whereby they find some means of dealing with it, possibly through the discovery of some area which they can control and which will not lead, as is the case of ill females, to the manifestation of disorders. One may equally suspect that parental control is concentrated in such a way upon ill females that their sisters are able to avoid it easily.

The results of the second part of the study show that the patients and their siblings (in a way similar to the parents*), in contrast to the control group, evaluate dyadic relations the poorest. This is maybe caused by the fact that such relations are connected with the strongest emotions experienced.

Patients evaluate their mother worse than females from the control group. One may also note that these evaluations are characterised by little differentiation. The increase of all the results might suggest that this is caused by some joint single factor. This

* C.f. the first part of the article, see Archives of Psychiatry and Psychotherapy 2, 2004.

could be, for example, a generally critical attitude towards the parents. Therefore this evaluation would be one arising to a significant degree under the influence of negative emotions experienced, without confrontation with the real functioning of mothers in various areas.

The opinions of patients concerning their fathers are more varied and at the same time more negative. This could suggest less empathy connected to relations with fathers and less affective involvement in contact with him. The joint feature in patient evaluation of both mothers and fathers would be the extremely critical attitude towards them.

The opinion of sisters of patients about their mother is more varied, which could indicate a less emotional evaluation, one based more on real behaviour. Within the aspect of emotionality one may suspect in sister's opinion that the mother is suppressing and/or exaggerating the emotions experienced. Possibly the reason for such an evaluation are the negative feelings felt towards her, generated, for example, from jealousy of the concentration lavished on the ill daughter. Generally, however, one can claim that the evaluation of the patients' sisters is close, although more positive, when compared to the evaluation of mothers conducted on the patients. In the aspect of task completion by mothers, sisters of patients evaluated them in a similar way to females from the control group i.e. they fulfil their function in the same way, which is a little difficult to reconcile with the result from the scale of affective expression. One of the explanations for this could possibly be again the suppression of negative feelings towards the mother. The opinion of the patient's sister as to the father is, in a similar way to the patients themselves, worse than towards the mother, though at the same time somewhat better than the image of the father as seen by patients. This obviously does not explain whether the functioning of the father in the family is in fact inadequate or rather he remains blamed for the difficulties experienced by the family.

Sisters of patients describe the ill as individuals for whom both the revealing of their own feelings as well as the possibility of an adequate assessment of the emotional states of other members of family is extremely limited. The reason for this could be suppression on their part of their feelings, or equally the abandonment of ill sisters to a strong symbiotic relation with one individual, in this case more often with the mother. One can more than likely connect this with the ill females' difficulties in adequately coping with the demands of everyday life. We may equally suspect that the method of control by them of other members of the family does not result in the family's efficient functioning; it is rather a form of expressing a desire to subordinate it to oneself. In addition it could be perceived that the aims which patients desire to achieve are not cohesive, because of this their behaviour introduces chaos into the functioning of family.

Patients evaluate their sisters poorer than in the case of the evaluation of siblings from healthy families – this concerns all of the dimensions examined. It can be generally stated that the attitude of patients to their sisters is highly critical. Various explanations are offered here. One of which is the possible rivalry for parental favours, as a result of which patients devalue their sisters in order to raise their attractiveness in this way. However, it should also be concluded that siblings from the control group also evaluate

themselves fairly critically, something born out by the fact that the majority of results achieved by them significantly deviate from the accepted criteria in the direction of a worse evaluation. Therefore, the very fact of rivalry would not be a characteristic feature here, but rather its intensification.

Results in the evaluation of patients by their sisters could indicate that it is based upon external behaviour, while the most significant spheres – particularly emotionality – are evaluated slightly positively or even positively. Hence one may suspect that the sibling, whose sister is suffering from anorexia, is either not emotionally connected (she cuts herself off from the sufferer's problems), or she feels an enmity which could result from jealousy over the care and attention given by parents to the sufferer. In turn patients evaluate their sisters worse than they are evaluated by them, which might equally be explained by the envy experienced by them and/or strong rivalry over parents, attractiveness or something else.

The evaluation of one's own functioning within family conducted by patients is positive in almost all of the aspects examined. In contrast to healthy females they perceive themselves as less kind to the remaining members of family, displaying difficulties in communicating with parents and siblings as well as not possessing a clear and cohesive system of values. Against the background of a significantly more critical evaluation of the functioning of the family as a whole and its individual members, worthy of note is their idealised image of themselves. This idealisation of themselves could be paradoxically a reaction to the hidden low evaluation of themselves. One may for that suspect that with the aim of raising evaluations of their functioning within the family they devalue their siblings while simultaneously idealising themselves.

The evaluation of one's own functioning within the family conducted by sisters of patients appears to be extremely critical, as they perceive the weak sides of their functioning in several areas. The greatest difference, in comparison with females from the control group, concerns grudges. This would confirm earlier assumptions concerning the fact that for sisters of patients, parental concentration upon the sufferer could be a difficult situation, causing the experiencing of a range of unpleasant feelings, hindering the display of feelings to other members of family, and also burdening them with additional duties.

The results discussed indicate that in the families of patients suffering from anorexia the worst evaluation on the part of all the members of family is the functioning within dyadic relations. The dyadic relation between father and daughter is especially negatively assessed - both equally on the part of the father as on part of the patients, as well as the patients' sisters. This is a negative evaluation on the part of the father, particularly in the area of task accomplishment as well as in values and norms. In his opinion there is little positive statement. Daughters evaluate the relations with their father poorly in those very same dimensions as well as in the affective involvement. This result is extremely interesting, for within the literature on the subject there has been much less attention paid to the weakness of the dyadic relationship between a father and a child in the families of individuals suffering from anorexia than has been paid to the difficulties in the mother-child relationship [2, 3]. It must, however, be admitted that the defining of the cause and result links between the poor functioning

of this relation in the evaluation of members of the family system and those falling ill with anorexia nervosa is not clear and requires further research as well as particular attention during the process of family therapy.

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