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QUALITY OF LIFE AND FAMILY RELATIONS IN PATIENTS WITH ANOREXIA NERVOSA

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SUMMARY

Background

This article is about the family relations of patients with anorexia nervosa. Patients' evaluation of the functioning of the family as a whole and their separate relations with each parent were analysed. Taking Murray Bowen's family systems theory as his point of departure, the present author assumed that patients would evaluate the functioning of their family negatively, but at the same time would positively assess their relations with each parent separately.

Material/ Methods:

This article presents the results of the author's own study of 10 participants, conducted in 2007. The participants were divided into two groups: a clinical group, consisting of 5 women diagnosed with anorexia nervosa, and a control group of 5 healthy, female secondary school pupils. The clinical group was heterogeneous. The patients' age ranged from 18 to 28 ($M=21$; $SD=2.3$) and they also varied with respect to level of education. All the patients lived in Warsaw. The research instruments used included the Family Relations Questionnaire with its three component questionnaires (Family Questionnaire, Couple Relations Questionnaire, and Self-esteem Questionnaire). Each scale has items concerning the behavioural aspect of family functioning, intra-psycho functioning and moral functioning.

Results/ Conclusions:

Patients with anorexia did in fact evaluate their family as a whole negatively while evaluating their separate relations with each parent positively. Their ratings of relations with father were less positive than relations with mother. The author tries to link the results with QOL issues, because family relations are a factor often used to rate quality of life.

Key words: family relations, systems theory, eating disorders

INTRODUCTION

Many scientific disciplines, including sociology, medicine and psychology, invoke the concept of quality of life (QOL). However, due to their different perspectives, representatives of these disciplines approach the concept differently.

When psychologists talk about QOL, they refer to the contingencies which help people to gratify their needs and realize their goals, to be happy, and to feel satisfied with life (Trzebińska & Łuszczynska 2002). How the concept is defined depends on the theoretical school which the researcher represents. Tomaszewski (cf. Brzezińska et al. 2001) adopts external criteria, the same for all, such as richness of experience, level of awareness, level of activity, creativity or social participation. When all these criteria are met as far as possible, QOL is good. Campbell (cf. Brzezińska et al. 2001) indicates the following criteria of QOL: marriage, health, household activities, work, place of residence, level of education, standard of living, and – most important from the present perspective – family life.

Other researchers have adopted a different approach. Internal (subjective), not external, criteria of QOL should be used and these criteria cannot be imposed arbitrarily. Cantor (cf. Czerwińska 2002) argues that QOL depends on whether and how people realize their developmental tasks (the emotional experience which accompanies realization of these tasks and self-other comparison). Ratajczak highlights the relation between level of need satisfaction on the one hand and environmental demands and resources on the other hand (cf. Brzezińska et al. 2001). In all these approaches only individuals themselves can rate their QOL. What is more, individuals not only rate their own QOL but also select the criteria themselves.

In the medical sciences, evaluation of QOL was pioneered by David E. Karnofsky, who pointed out that both subjective improvements and objective improvement of activity or mobility should be the end product of treatment (cf. Michalak et al. 2009). QOL in this sense assumes that both the patient's health status (illness, disability) and treatment have a negative effect on his/her QOL (Schipper et al. 1996). Researchers have also discovered that, paradoxically, illness may improve QOL (for example, when the patient who feels that he/she is getting more attention because he/she is ill interprets this as sign of improved marital relations). The definition of QOL is ambiguous, and therefore the direction and scope of research will depend on the particular researcher's interests. A cardinal issue in QOL research is whether the research is to yield maximally objective results (i.e. the criteria are given and the same for all) or is to yield more in-depth information concerning a small group of people who will rate their own QOL using different points of reference, according to their own priorities.

As we can see, in both the medical sciences and clinical psychology, QOL is usually assumed to be the consequence of illness, injury etc. But what if we were to reverse this cause-effect sequence? Can poor QOL cause certain illnesses? This seems to be the case with anorexia nervosa, the subject of this article.

According to the International Classification of Diseases (ICD-10), anorexia nervosa “is a disorder characterized by deliberate weight loss, induced and/or sustained by the patient. The disorder occurs most commonly in adolescent girls and young women, but adolescent boys and young men may be affected more rarely, as may children approaching puberty and older women up to menopause.” The disorder involves specific psychopathological symptoms, such as dread of being fat and body image distortion. The dread is persistent, and the patient imposes a low weight threshold for himself or herself. Patients are usually under-nourished to varying degrees and have secondary hormonal and metabolic disorders, as well as functional somatic disorders. Other symptoms of anorexia nervosa include self-imposed dietary restrictions, excessive exercise, self-induced vomiting, self-induced purging, and the use of appetite suppressants and/or diuretics. The American Psychiatric Association’s classification system (DSM-IV 2000) distinguishes two types of anorexia, the restricting type, characterized by reducing food intake to small quantities and irregular use of purgatives, and the binge eating - purging type, characterized by alternate food intake reduction and binge eating or self-induced vomiting and excessive use of purgatives and diuretics (not to be confused with bulimia nervosa, a separate disorder).

Anorexia nervosa is a disorder with a multi-factor aetiology (Bomba & Józefik 2003, Józefik 2006), i.e. it is impossible to indicate one factor conducive to this disorder. A review of the literature reveals that the significance attributed to possible determinants depends on the theoretical school to which the researcher adheres. At present, the most frequently researched factor is the socio-cultural factor, and the socio-cultural factor which is attracting most interest is the family, also the topic of the present study.

The approach attributing the source of anorexia nervosa to the family has a very rich tradition (Bomba & Józefik, 2003, de Barbaro 1999, Namysłowska 2000, Włodawiec 2001). The present author draws upon Bowen’s theory. According to this theory, the family is a very dynamic system. After each reaction and ensuing modification, the system seeks to restore balance (homeostasis) and every change, even in one element, leads to change, for better or for worse, in every other element (Bowen 1974). One frequent solution in the latter case is for one member of the family to sacrifice him/herself by resigning from his/her dreams, ambitions or career. Something which was supposed to help to overcome current difficulties is later used to “blackmail” other family members, or may lead to the expectation of “payment” for previous sacrifices. At other times, one member of the family “falls ill” so as to maintain the status quo and cope with the difficulty (Bowen 1974, de Barbaro 1999).

The dynamic system goes through various developmental stages, and each stage means new conflicts. These conflicts can be resolved constructively or non-constructively – in ways which are seemingly effective in the short run, but detrimental to the system in the long run (de Barbaro 1999).

Dysfunctional family systems contain more traps, one of which may lead to anorexia. A triad may be produced, in which two family members form a

coalition against a third member (the “outsider”), or a conflict between the parents into which the daughter is drawn. For example, a cross-generational coalition may form between daughter and father against mother. Mother then competes with daughter for her position in the family and “beside father.” One form which this competition can take is the daughter’s slimming. However, father may withdraw from this constellation to join mother. Daughter then feels deceived and, so as not to lose completely, she intensifies her slimming to fight with mother and all of a sudden, slimming becomes the “family problem.” Father once again draws daughter into the triangle and she is now very much part of the game. Nobody wants to end the game (Bowen, 1974). Of course such a situation cannot be viewed as the rule in all families with an anorectic member. Every system has different variables and every family writes its own scenario. This is just one illustration of the mechanism described by Bowen and his followers (Namysłowska 2000).

Father’s isolation is another situation (Bowen calls it emotional cutting-off). When this happens, daughter’s disorder stimulates the family to reunite and combat the problem (first the refusal to eat, then the disease) together. Additionally, daughter may become a “communication channel” between parents or between generations in the family (Bomba & Józefik 2003; Namysłowska 2000). To summarise, when the family system is destabilized, symptoms which appear in a child either help one family member to “win” or help to restore balance in the system. The patient makes a sacrifice of him/herself and his/her health to the family.

OBJECTIVE

This study examined the family relations in patients with anorexia nervosa. Analysis of existing findings (Bowen 1974, Józefik 2006, de Barbaro 1999) suggested that patients with anorexia would rate the functioning of their families as a whole negatively, but, due to family system dynamics, especially the dynamics of cross-generational coalitions, they would rate their mother and their relations with her, and their father and their relations with him, positively. The following hypotheses were tested:

- The patients rate the functioning of their family as a whole negatively.
 - The patients rate their mothers and their relations with them positively.
 - The patients rate their fathers and their relations with them positively.
- Other hypotheses were also tested but will not be discussed in this article.

MATERIAL AND METHOD

Participants

The study was conducted on 12 women in 2007. There were initially 6 women in the clinical group, but one was rejected due to unconfirmed diagnosis. All members of the clinical group were diagnosed with anorexia ner-

vosa (without comorbidity) and were in therapy. Since the study was anonymous (and therefore the author did not have access to the patients' medical records), it was impossible to determine the patients' method or stage of treatment (Grochmal-Bach, Pachalska et al, 2009). The patients were a very heterogeneous group. The youngest patient was 18, and the oldest was 28. The mean age of the clinical group was 21 years (SD=2.3). The patients had different levels of education, but all lived in Warsaw. Four patients were in out-patient treatment (in three private consulting rooms in Warsaw) and two were in in-patient treatment at the Department of Neuroses, Institute of Psychiatry and Neurology, Warsaw. There were initially six women in the control group, but one was excluded because her family was incomplete. All these women were 18 years old and were third-year students at the Antoni Dobieszewski Senior High School No. 44 in Warsaw. None of them had a mental disorder or any other chronic disorder.

In order to respect the participants' anonymity, they were simply labelled P1, P2, P3, P4 and P5 (clinical group) and P6, P7, P8, P9 and P10 (control group).

Instruments

Participants were given the Family Relations Questionnaire (FRQ), an instrument constructed by M. Cierpka and G. Fervert in 1994. The Polish adaptation does not differ significantly from the German original. The FRQ has three component questionnaires: the Family Questionnaire (FR-1), the Couple Relations Questionnaire (FRC-2e and FRC-2f) and the Self-esteem Questionnaire (SQ). FR-1 has 40 items pertaining to the respondent's family. Respondents are requested to say how well each statement describes their family. Respondents rate each item on a 4-point scale: I agree completely, I agree to a certain extent, I disagree to a certain extent, and I completely disagree. FRC-2 and SQ have 28 items each. As before, respondents are requested to say how well each statement describes their family. They rate each item on a 4-point scale from 0 (desirable state) to 3 (undesirable state). In FRC the examiner has considerable freedom. Depending on the objective, he/she can test the daughter, son, wife, husband, father, sister and/or brother.

Each questionnaire has seven four-point scales:

- task performance (TP)
- role execution (RE)
- communication (COM)
- emotionality (E)
- affective relation initiation (ARI)
- control (C)
- values and norms (VN)

The first three scales refer to the external, behavioural aspect of family functioning. The next three scales refer to the intra-psychic level. The last scale refers to the moral sphere. The FRQ also has two control scales to identify the respondent's tendency to idealize the family:

- social expectations (SE)
- defensiveness (D)

The following cut-off points were adopted for interpretive purposes in the present study:

- 0 – 2 → very good (vg)
- 3 – 5 → good (g)
- 6 → acceptable (acc)
- 7 – 9 → bad (b)
- 10 – 12 → very bad (vb)

RESULTS

The results are presented in Table 1. As we can see, the majority of patients with anorexia rated their family's functioning as bad (only P2 gave positive ratings on most scales). The following scales were given the lowest scores: Task Performance, Role Execution and Communication. Other scales (Emotionality, Affective Relation Initiation and Control) attracted more scattered ratings. The last category, Values and Norms, received the most positive ratings.

The patients' separate ratings of their relations with their fathers and mothers (Table 2, Table 3) are as predicted. The respondents from the clinical group rated these relations as good or very good. This pattern is particularly clear when we compare the data with the data in Table 1, i.e., ratings of the family as a whole.

The respondents in the control group all rated their fathers and mothers separately, and their families as a whole, as good or very good. Only the results of P7 depart disturbingly from this general pattern. This respondent rated the functioning of her family negatively, and was particularly negative about her father.

Table 1. Ratings of the functioning of the family as a whole.

	Clinical group					Control group				
	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Task Performance (TP)	bad	bad	bad	bad	acceptable	good	bad	acceptable	good	very good
Role Execution (RE)	acceptable	bad	bad	acceptable	acceptable	very good	bad	good	very bad	good
Communication (COM)	bad	good	bad	acceptable	bad	good	bad	acceptable	bad	bad
Emotionality (E)	bad	good	bad	bad	good	good	bad	bad	good	very good
Affective relation initiation (ARI)	acceptable	good	bad	good	bad	good	bad	acceptable	very good	very good
Control (C)	Bad	good	bad	good	acceptable	good	bad	good	acceptable	very good
Values and norms (VN)	good	very good	bad	good	bad	good	bad	acceptable	good	very good

Table 2. Ratings of relations with mother

	Clinical group					Control group				
	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Task Performance (TP)	bad	good	bad	very good	bad	very good	good	bad	good	very good
Role Execution (RE)	good	very good	good	very good	good	good	good	good	good	very good
Communication (COM)	acceptable	very good	very bad	very good	bad	very good	good	acceptable	good	very good
Emotionality (E)	bad	good	bad	very good	acceptable	very good	good	bad	good	very good
Affective Relation Initiation (ARI)	good	good	good	very good	good	very good	good	good	good	very good
Control (C)	good	good	good	very good	good	very good	good	acceptable	good	very good
Values and Norms (VN)	acceptable	very good	bad	very good	acceptable	good	acceptable	bad	acceptable	good

Table 3. Ratings of relations with father

	Clinical group					Control group				
	P1	P2	P3	P4	P5	P6	P7	P8	P9	P10
Task Performance (TP)	acceptable	acceptable	very bad	very good	bad	good	very bad	bad	good	good
Role Execution (RE)	very good	very good	bad	good	good	good	very bad	acceptable	good	good
Communication (COM)	good	good	bad	good	good	very good	very bad	acceptable	very good	good
Emotionality (E)	very good	good	bad	bad	bad	good	bad	bad	very good	good
Affective Relation Initiation (ARI)	very good	good	good	very bad	good	good	bad	bad	very good	good
Control (C)	very good	good	acceptable	good	good	very good	bad	bad	very good	very good
Values and Norms (VN)	acceptable	good	bad	bad	acceptable	good	bad	very bad	good	good

Due to the nature of the present study (case study format), the data cannot be submitted to statistical analysis – the groups are too small. Nevertheless, I shall attempt a qualitative analysis to chart the direction for further research.

INTERPRETATION

The generally negative rating of family functioning in the anorectic group is an important finding suggesting that the patients themselves are aware of the problematic relations in their families. This finding justifies the interest in anorexia shown by systems psychologists. It also gives credit to the claim that when the family system is not functioning properly, family members try to repair the damage, and "falling ill" by one of the children may be one way of doing so. Our finding does not tell us, however, what the source of conflict or destabilization in the family is. On the other hand, closer inspection of the data helps us to see some interesting connections.

First, the data concerning the categories dealing with family functioning at the behavioural level are particularly interesting. None of the patients rated Role Execution or Task Performance as good. According to FRQ assumptions, this may suggest that family members assume inadequate roles, both in the context of socially acceptable norms and the context of rules previously generated by the family itself. The authors of the FRQ also associate high scores on these scales with deficient gratification of the family's basic needs and inadequate responding in crisis situations (and a child's serious illness is surely a crisis situation). Hence our analysis of the behavioural aspect of family functioning suggests that the families of the patients we studied have difficulty assuming the role of father, mother, husband, wife etc. Members of the system adopt inadequate attitudes and this may affect the family climate. The patients also feel that their families are failing to fulfil their primary tasks. Perhaps this is because they draw the child into coalitions, indicating lack of cross-generational boundaries. This in turn throws the family into still deeper crisis, which only an event such as illness of a family member can mitigate. Finally, dysfunctional families cannot cope with the situation, so that instead of trying to deal with it swiftly and constructively, they let the illness progress.

The second element which attracts our attention is the dissonance between the ill child's perception of the family as a whole and its rating of each parent separately. This pattern also confirms theories which say that parents create coalitions into which they draw their child and which focus on the very bad atmosphere in the family. The present findings may explain why parents who are in explicit or implicit conflict with one another have a negative effect on the functioning of the whole family. The system is in a state of tension, and this tension is felt by every member of the family, not only the conflicted parties. If one parent gains control or there is a balance of power, the parents will need to find an "ally." One or both parents now try to win the child over and enter a coalition with it against the other parent. However, because of the need to maintain balance within the system and its dynamics, these coalitions are short-lived and the child is tugged from one side to the other. To summarise, the child feels the consequences of the conflict between the parents and rates the family functioning negatively. Because each parent tries to draw

the child into a coalition, it may feel that this is a sign of good relations with each separate parent.

Let me continue my speculations. Perhaps illness is a response to the persistent negative atmosphere in the family, which does not change despite the changes of coalition. The child may also feel hurt or betrayed if it is "pushed out" of a coalition, in which case it may (unconsciously) act in its own interest, not the interest of one of the parents. However, the existing research fails to explain why the child responds with anorexia rather than some other disorder.

It also needs to be said that in the control group the family as a whole and each parent separately were rated more similarly than in the clinical group (this is not a statistical inference, of course). If this pattern were to be confirmed on a larger sample, it would give us an important hint as to why the child becomes anorectic. It is not hard to imagine how difficult it is to live with such mixed messages. On the one hand, mother and father are rated positively but at the same time the whole family is rated negatively, according to the same criteria. The situation in families in the throes of divorce may be quite similar.

Both groups, clinical and control, are quite similar in that they both rate their mothers slightly higher than their fathers. This seems rather obvious in Polish cultural reality, where the mother is more likely to be ascribed the role of tender of the hearth and home, and the father is ascribed the role of breadwinner who is not so involved in family life.

Finally, let me mention the Values and Norms category. This category applies to the moral sphere and was rated most highly by the clinical group. This is consistent with the systemic approach to anorexia, which assumes that illness will appear in those families in which rules of behaviour are clearly defined and strictly if not rigidly observed, at least declaratively. At the conscious level this may be seen as something positive, particularly in the context of a generally unstable system. Paradoxically, it can also be still another element against which the child may want to revolt. Healthy family systems allow their adolescent or young adult offspring to revolt within certain limits. Anorexic families usually do not, and the child must find a space in which it can contradict its family and introduce its own rules. Controlling one's food intake seems to be one such space where the child decides for itself what and how much to eat. Hence the child sets its own rules and follows them.

To summarise, the presented fragment of research demonstrates that family functioning and family relations may be an etiological factor in anorexia nervosa. This is not a sufficient factor, however, and the deeper aetiology of anorexia must still be considered unknown. Family relations, according to Campbell (cf. Brzezinska et al. 2001), are one of the most important aspects of QOL. So to what extent, we may ask, do patients with anorexia rate their QOL as unsatisfactory? And can poor QOL really lead to a disorder such as anorexia? We can only hope that this article will stimulate further research on anorexia and encourage researchers to include QOL in their studies of this disorder.

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