Family functioning in adolescent anorexia nervosa: A comparison of family members’ perceptions

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ABSTRACT. Abnormal patterns of family functioning have often been reported in anorexia nervosa. Moreover, members of families with an adult with eating disorders have different family functioning perspectives. This study investigated whether differences in family members’ perspectives, similar to the ones found in families of adults with eating disorders, can be found in families of adolescents with anorexia nervosa. Perceived family functioning, measured with the Family Assessment Device, was compared between 49 control and 34 clinical families, and across family members. Differences were found between the two groups on a number of aspects of family functioning, with the clinical families showing most disturbances. There was a general agreement across family members in their perceptions of family functioning, with one notable exception. Clinical daughters disagreed with both their parents about the family level of communication, whereas control daughters disagreed only with their fathers. Disagreements between clinical adolescents and their mothers about the family communication style appear to be important in anorexia nervosa in this age group, although it is not possible to reach conclusions about the direction of causality. These findings support the use of family-oriented therapies that aim to identify and work with difficulties in communication within the family.

INTRODUCTION

Researchers (1, 2) and clinicians (3-6) have observed that abnormal patterns of perceived family functioning are associated with eating disorders. While a number of instruments have been used to investigate family functioning in individuals with eating disorders (7, 8), the Family Assessment Device (FAD) (9) has been suggested to be a good measure of pathology in the families of individuals with eating disorders (10). The FAD measures a number of specific aspects of family functioning, as well as providing a general index of dysfunction (see Method for details). By using the FAD, it has been found (2) that women with anorexia nervosa reported their family functioning as less healthy than controls. In addition, it was reported (11) that adults with an eating disorder had more unhealthy perceived family functioning on problem solving and communication than controls. A further study (12), using the FAD in a younger population, reported no specific differences between families of controls and adolescents with anorexia nervosa.

A number of studies have compared different family members’ perceptions of family functioning. While Friedmann et al. (11) reported no difference when either the individual with the eating disorder or a member of the family completed the FAD, other investigations found some disagreement among family members. Investigation of family’s adaptability, cohesion, and communication (13) in families of individuals with anorexia and bulimia nervosa found that fathers’ perceptions were dissimilar from mothers’ and daughters’ perceptions of family functioning. Moreover, daughters’ views were the more predictive of their eating pathology. Similarly, using the FAD, Waller et al. (10) found that anorexic daughters’ perceptions of their family functioning appeared to be more clinically relevant than those of their parents. The daughters reported unhealthy family functioning on affective involvement, affective responsiveness, problem solving and behaviour control when compared with non-clinical participants. In contrast, their mothers...
reported unhealthy functioning just on affective responsiveness, affective involvement, and roles. Finally, fathers’ perceptions had the least discriminatory power, and did not differentiate them from non-clinical families. Another study (14) reported that parents of adolescents with both bulimia and anorexia nervosa had similar perceptions of their family dynamics, but these differed from their daughters’, who reported the worst perceptions within the family.

The discrepancy between these studies might be explained by the fact that Friedmann et al. (11) recruited individuals with eating disorders whose position in the index family was either of mother or daughter, whereas participants in the other studies (10, 13, 14) were always the daughters in the index family. This conclusion is consistent with findings in non-clinical groups which suggest that being at different stages of the family life cycle might influence family functioning perceptions (15). In conclusion, it might be suggested that, from the studies where disagreement was found among family members, a pattern seems to emerge according to which mothers either agree with fathers or daughters, and fathers and daughters do not agree and daughters’ perceptions are usually the worst within the family.

Thus, the FAD shows differences in different family members’ perceptions when the adult daughter has an eating disorder. However, it is not known whether this difference is present among adolescents with anorexia nervosa and their families, where the FAD may have less discriminatory power (12). Such disagreement between family members would be important in informing the aims of family-based therapies in this group, since those treatments have been argued to be of great value (16, 17). Therefore, the present study examined the differences in perceived family functioning between adolescents with anorexia nervosa and their parents, comparing families of children with and without the illness.

**METHOD**

*Participants*

Family functioning perceptions were collected from mothers, fathers and adolescent daughters of 49 control and 34 clinical families (where the daughter had a diagnosis of anorexia nervosa), who gave informed consent and whose anonymity was ensured. One clinical family had twins with anorexia nervosa, and was counted as two cases. The clinical families were recruited in Centres for the treatment of eating disorders in Verona, Rome and Vicenza, Italy. All patients attending the clinics for assessment and treatment (in the appropriate age range, over the period January 2000-May 2001) and their families were asked to participate. None refused to take part. The control families were recruited by physicians in Milan, Monza, Verona and Vicenza, Italy. These were recruited from personal contacts of the clinicians over the same period. No family approached refused to take part. The daughters in each family were above 11 and below 18 years old (control girls’ mean age = 14.5 years, SD=1.47, range=12-17; clinical girls’ mean age=15.7 years, SD=1.71, range=12-17.8). Those mean ages were significantly different [t (66) = 4.71, p<0.05]. All of the clinical group daughters were diagnosed with anorexia nervosa, using the Great Ormond Street Diagnostic Checklist for the diagnosis of eating disorders in children (18). This checklist has been shown to have higher reliability than DSM-IV criteria in this age group (19). No daughters of the control group had such a diagnosis.

*Measures and procedure*

The study received ethical approval from the institutions’ ethics committees. At assessment, information was collected by clinicians about family structure and family members’ occupation, age and place of residence. The same information was collected from control families when approached. Each member of the clinical and control families (mother, father, daughter) completed the Italian-language form of the FAD (20), 3rd version (9). The FAD is a 60-item self-report questionnaire, measuring individuals’ perceptions of their family functioning. Each item is scored on a four-point Likert scale, where the participant rates his/her agreement with the statement (1 = strongly agree; 4 = strongly disagree). Higher scores indicate less healthy perceived family functioning (21).

This instrument has well established psychometric properties (9, 22), differentiating psychiatric, medical and control families (23, 24). It also distinguishes different eating pathologies (2). It consists of the following scales: general functioning (the overall health/pathology of the family); problem solving (the way the family resolves problems); communication (the clarity and directness of the family’s exchange of verbal information); roles (the clarity and appropriateness of distribution of family roles); affective responsiveness (the appropriateness of quantity and quality of feeling with which