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Happy Families?

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Summary: Sixteen consecutive patients with anorexia nervosa were studied and compared with a control group of other patients coming to an adolescent service, matched for sex and admission status. The anorexic group were not significantly different from the controls in social class and I.Q., and had a male-to-female ratio of one to four. However, they were significantly more likely to have perfectionistic personality traits and to profess to be happy with their families; these families had few external stresses, were very close, and had a high degree of exclusivity.

In an adolescent unit for patients aged 11 to 18, we appeared to be seeing an increasing number of patients with anorexia nervosa. Our clinical impression was that the cases we dealt with covered a much larger range of intellectual ability and socio-economic status than the classic upper social class, private boarding school, highly intelligent girl. It seemed that the biggest difference between the anorexic and other patients lay in the area of family dynamics. We therefore did a retrospective study of the cases of anorexia nervosa seen over a four-year period, and compared them with other adolescent patients of the same unit.

Method

The case records of 16 consecutive adolescent anorexic patients referred to the Nottinghamshire Child Psychiatric Services between October 1973 and November 1977 were examined. In this context, 'adolescent' refers to secondary school age 11–18 years. All index cases were known personally to one or both authors. Case records of controls were also examined, as were those of the closest three adolescent referrals of the same sex admitted or seen as an out-patient, according to the status of the index patient. Because of the clustering of the anorexic admissions, only two controls were available for eight of the in-patients, giving 40 controls in all.

Our definition of anorexia nervosa was a combination of food avoidance, fear of fatness, amenorrhoea (if applicable), and at least 10% loss of body weight.

The particular factors focussed on were as follows: (a) age of referral and onset; (b) pubertal status; (c) social class; (d) intelligence; (e) previous personality; and (f) family factors. These last were classified as follows (classification in brackets): (i) whether the natural parents were living together and the siblings present (intact); (ii) whether the family spent most of their spare time together (close); (iii) the degree of mixing with other people outside the family circle (exclusivity); (iv) whether the patients perceived themselves as satisfied with the relationships in the family (happy); (v) the presence or absence of overt pressure on the family e.g. socio-economic, gross interpersonal disharmony or illness (external stress).

These family factors were obtained from the notes made while the child and family were in treatment. While we acknowledge the 'softness' of these data, the information was easily available retrospectively on both the index patients and controls from the standard history taking and treatment records available.

Results

The age of onset was less defined in the control group, as there were a number of children with diffuse behaviour and family problems, accumulating stress over some years. The anorexics, on the other hand, were mostly described as good children, with no problems prior to the food refusal and weight loss, so that the onset could be dated more specifically. The mean age at referral for the anorexic group was 14.3 years, and 13.5 years for controls (difference not significant). The sex ratio was of interest, as there were four boys out of the sixteen cases, giving a male-to-female ratio much higher than usually quoted. Ten of the anorexics and 26 controls were pubertal when first seen (difference not significant). The anorexia nervosa cases came from families of all social classes. Only two were from social class I and went to private schools. There was no significant difference between the two groups in social class (mean for anorexics 3, control 3.6). The intelligence of the anorexic patients covered a wide range and was not significantly different from that of the controls. Three of the index patients were in the ESN(M) range, two of these were at ESN(M) schools: five of the controls were ESN(M), and one was at an ESN(M) school. The difference between the index group and the controls on individual factors was in the personality characteristics described for the two groups. Twelve of the 16 anorexic patients were described as having obsessional traits, i.e. being very neat and tidy, and perfectionistic, with high standards, prior to the onset of their anorexia. This is significantly different to the controls, only two of whom had this type of personality characteristic; one girl had an obsessional neurosis and another girl had school phobia.

There was no significant difference in the number of families which were intact. (Table). Three of the index

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TABLE
Family variables

Variable	Anorexics (n = 16)	Controls (n = 40)	Significance (χ^2)
Intact	12	27	NS
Close	15	10	P <0.001
Exclusive	13	5	P <0.001
Happy with	14	9	P <0.001
External stress	4	32	P <0.001

families were not intact; one had suffered the death of the father ten years previously; in one the parents were separated, and in the third there was a step-father. This is roughly in keeping with other authors' findings. There was a significant difference in the degree of closeness of the families (P <0.001). The one family with an anorexic patient that did not see themselves as close were a very disrupted family with the parents separated, the father was an alcoholic, and two of the siblings away at boarding school. There was a significant difference (P <0.001) in the exclusivity of the families. Two out of the three index families with an 'open' family were quite easily treated as out-patients, the third family produced a boy patient who, although he had a previously cheerful outgoing personality, became more overtly delinquent with time. Of the five exclusive families in the control group, two contained patients with school phobia, one a symbiotic psychosis, and the fourth was an Asian family cut off from both Asian and English communities. The fifth family had an only child with acute hypomania. Only two of the index patients expressed any dissatisfaction with their families. One was a girl whose parents were separated and whose father was alcoholic; the other was a girl with an extremely economically deprived family who lived with mother, step-father and four siblings near to a rat-infested rubbish dump. The extent of the anorexics' dissatisfaction was significantly different from that of the control group, 31 of whom expressed dissatisfaction (P <0.001). The amount of external stress experienced was also significantly different between the groups (P <0.001). Two of the three families in the index group were families who were not intact, and had a variety of economic burdens as well as overt psychiatric illness (in one of the parents) or much interpersonal stress. The third concerned a girl in an intact family where the father was pathologically jealous, and there were severe marital and drink problems.

Discussion

As we saw sixteen patients with anorexia nervosa in a four-year period, we suggest that this condition is likely to be more common than previously reported by other workers (Warren, 1968; Kendall *et al*, 1973) in this younger age-group. Direct comparison of figures is difficult, however, as we do not see patients over school leaving age. Moreover, the demographic details show the anorexics to be spread over the whole range of social class, intellectual level, and type of schooling, and with a ratio of male-to-female much higher than normally reported (Crisp *et al*, 1976; Crisp & Toms, 1972; Dally, 1969; Halmi, 1974) thus implying a more heterogeneous group of patients than usually described. Significantly more of the index group had perfectionistic personality traits than the controls, in keeping with Duddle's finding that 21 of 23 anorexic students had definite obsessional traits (Duddle, 1973). However, there was nothing significant in the number of index families who were not intact, i.e. 3 out of 16, in keeping with the findings of Halmi (1974), Theander (1970), and Kay & Leigh (1954), who found broken families in anorexics in 18%, 13%, and 24% of cases, respectively. The anorexics were significantly more likely to come from an exclusive family with few external stresses, with whom they professed to be happy. Perhaps ways of individuating in this kind of family are very limited for someone with a personality of this type. Bruch (1978) vividly describes the 'good' girls who develop anorexia nervosa, who previously have had a profound desire to do what would please their families, to the point of being quite unable to identify their own needs, even to themselves.

Our findings suggest that a child with perfectionistic personality traits, from a family with little overt conflict and little contact with the outside world, has few ways of developing autonomy and a sense of identity during maturation. Although there are a variety of patterns, our findings confirm a clinical impression that the above constellation is an extremely common one in families presenting through an adolescent with anorexia nervosa.

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