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Causes of Adolescent Onset Anorexia Nervosa: Patient Perspectives

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This qualitative study describes the perspectives of former anorexia nervosa (AN) patients with respect to why they believed they developed AN. Previous patients with initial treatment in child and adolescent psychiatric clinics in northern Sweden were interviewed 8 and 16 years after initial assessment. The question, "What do you think today about the reasons why you got AN?" was asked at both interviews. Content analyze was used to categorize the answers. Causes were attributed to self, family, and socio-cultural stressors outside of the family. Most common were high own demands and perfectionism. At the second follow-up there were more answers in the family categories. The results agreed with results from risk-factor research.

INTRODUCTION

Previous research of patients' descriptions of causes illustrates the complexity of the illness and points to different possible contributors to the development

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of anorexia nervosa. Studies of the patients' views provide research and care providers with clues for prevention and treatment strategies. The available studies of patient perspectives contain a number of problems. It is difficult to compare definitions of categories between studies. There are also different ages and diagnostic groups that are studied (compare for example Button & Warren, 2001; D'Abundo & Chally, 2004; Tozzi, Sullivan, Fear, McKenzie, & Bulik, 2002). The studies are also made in different phases of the illness, from the beginning (Nevonen & Broberg, 2000) to the point of recovery (Weaver, Wuest & Ciliska, 2005). Some studies explore the process over a longer time while others mainly concentrate on the starting-point. There are not many studies of homogenous clinical samples on adolescent onset anorexia nervosa.

Therefore, we wanted to interview a representative clinical sample of previous patients about their ideas of the causes of their anorexia nervosa. We wanted to compare their view at 8 and 16 years after the onset of the disorder. We also wanted to compare perceived causes between those who were recovered compared to those who were still suffering from an eating disorder.

METHOD

Participants

We interviewed previous anorexia nervosa patients 8 and 16 years after initial admission to child and adolescent clinics in northern Sweden. At first admission when median age was 15.0 years all fulfilled *DSM-III-R* criteria (American Psychiatric Association, 1987) for anorexia nervosa. At the follow-ups median age was 23 and 30 years. At 8-year follow-up recovery were 46 (68%) and at 16-year follow-up recovery were 58 (85%). Recovery was defined as the absence of a diagnosis of any eating disorder—anorexia nervosa (AN), bulimia nervosa (BN), and eating disorder not otherwise specified (EDNOS)—at the time of the interview. This clinical assessment was completed with an interview modified from Steinhausen and Seidel (1993) and parts from the Swedish anorexia and bulimia interview (Nevonen, Broberg, Clinton, & Norring, 2003). The Research Ethics Committee at Umeå University approved the study. The subjects participated voluntarily after informed consent was obtained. More extensive information of the study design has been published by Nilsson and Häggglöf (2005; 2006).

Interview and Coding

In this study we asked the question "What do you think today about the reasons why you got anorexia nervosa?" The question was open-ended and

one part of a semi-structured follow-up interview. The same question was asked in the first and the second follow-up. The question gave an opportunity for the women to state their own opinions without being limited to predetermined concepts. The persons' own subjective perspectives were important since we wanted categories that were grounded in the answers, not in previous theories.

The interviewers were experienced staff members who had not treated the subjects they interviewed. The answers that could be of varying length were tape-recorded and transcribed. We used content analysis according to definitions developed by Kvale (1996). First the authors reviewed the transcripts several times and then made explicit coding instructions with three categories and eleven subcategories (Table 1). The answers were scored for each subcategory as absent or present. One answer could contain more than one subcategory. The coding was done manually by the first (KN) and last author (BH) (interrater reliability according to Cohen's Kappa was mean 0.96, ranging from 0.89 to 1.0). We also counted the numbers in each category and subcategory.

Statistical Analysis

Data were analyzed using SPSS for windows. Cohen's kappa (Cohen, 1960) was used to determine interrater reliability. Spearman rank correlations were used to determine correlations between first and second follow-up. Wilcoxon signed ranks test for two related samples was used to determine differences between first and second follow-up. Fishers' exact test was used to determine differences between recovered and un-recovered.

RESULTS

Of the eleven subcategories, four dealt with self, three with the family, and four with socio-cultural aspects outside of the family (Table 1). The first four categories had to do with the person (self): demands/perfectionism; developmental crisis or physical or mental symptoms; dieting/body dissatisfaction; and low-self esteem. The family-categories were: difficulties in family interaction/communication; stressful life-events; and high demands from family-members. The four socio-cultural sub-categories were: problems with peer/bullying, bad situation at school; ideals; moving/separation; and sports. There could be more than one sub-category for each person.

To give a clearer picture of the coding and the information in the answers, we give some examples. The translated quotations are made anonymous to prevent identification of any individual and the names are changed. The answers are marked and divided in the units that were

TABLE 1 Definitions and Examples of Causes

Definition of categories and subcategories	Examples
SELF	
Own demands/ high achievement, perfectionism/compulsory traits	“ambitious and high own demands”; “the goals were too high and difficult to achieve”; “a need to control and be perfect”;
Developmental crisis or physical or mental symptoms	“changes in body and appearance were difficult”; “I stopped to eat because I wanted to die”; “I have always felt different, developed early”; “genetics”; “something in the brain”; “gastroenteritis”;
Dieting, high degree of body dissatisfaction, overweight	“started to count calories in home-economics”; “I did not like my body”; “I was too heavy and decided to loose weight”;
Low self esteem, negative self value	“poor self-confidence”; “low self esteem -uncertain about myself”;
FAMILY	
Difficulties in family interaction and communication too little care or overprotection	“the parents did not talk openly with me or each other, no one showed any feelings, that was difficult when I was a teenager”; “my parents had no time with me and did not see that I was feeling bad”; “I wanted more attention and support from the parents”; “I was the first child of very young parents that overprotected me”;
Stressful event in family; e g death of family member, illness or handicap, sexual abuse	“disappointed at mother’s alcohol problems”; “handicapped brother was born”; “a very difficult and traumatic childhood, with abusive relations”; “quarrels and rivalry between siblings”; “the parents were talking about divorce”; “sexual abuse from six years age”;
High demands from family members for achievement or appearances	“heavy demands and expectations from my father”; “from 8 years of age, I had a lot of responsibility for my siblings”; “my mother was often on a diet”; “my grandmother said ‘what a fat girl’ when I had got muscles from sports activities”;
SOCIO-CULTURAL STRESSORS OUTSIDE OF THE FAMILY	
Problems with peer/bullying, bad situation at school, incident	“a classmate that told me I was fat”; “it was awful in school, I had no friends”; “rape at 13 years of age”;
Ideals	“the ideals of society”; “I wanted to be like everybody else”;
Moving to new place/separation	“moving to a new pslace at 10 years of age, was too old to move”; “my boyfriend broke up”;
Sports	“I was in gymnastics and was told by coaches to loose weight before competitions”

categorized and thereafter in brackets we put the subcategories that were marked according to Table 1.

Anna, Recovered

[I easily lose myself so that others can do well. I put myself low on the list of my priorities. If others didn't feel well, I would blame myself] (Low self-esteem/negative self value)

[I've had this role in the family without anyone actually demanding it. I've never screamed or been rebellious] (Difficulties in family interaction and communication)

[I want to be perfect; did not feel good, I've also placed very high expectations on myself about achievement. I've placed these demands on myself] (Own demands/perfectionism)

Birgit, Recovered

[Mother was a perfectionist and very good when she was sober. I was disappointed at her alcohol problems; there were conflicts in the family, another structure was needed for the whole family]. (Stressful family-life)

[From 8 years of age, I had a lot of responsibility for my siblings and mother; I had to make dinner and so on]. (High demands from family members)

[The year before the illness came out at 10 years of age, I did not feel good and had difficulty sleeping]. (Mental symptoms)

Cecilia, Recovered

[I competed a lot; I ate a lot when exercising and then went up in weight when I stopped]. (Sports)

[I started having back problems and had to stop exercising]. (Physical symptoms)

[I thought I was fat, I didn't think muscles were nice. I thought I would lose a bit of weight, and then thought I would lose a few more kilos. Once I lost that weight, I just kept losing more]. (Dieting, high degree of body dissatisfaction, overweight)

[I was teased when I was 7–8 years old; I was heavy then]. (Problems with peer/bullying, bad situation at school, incident)

Diana, Recovered

[I thought I was chubby, started to diet, got caught in an evil cycle that I couldn't stop where I was pulled in deeper and deeper and lost control].
(Dieting, high degree of body dissatisfaction, overweight)

[Bad feelings in the family; mama and papa were thinking about separating]. (Stressful event in family)

[My boyfriend broke up]. (Separation)

Evelyn, not recovered

[I have low self-confidence and self-esteem, so I wanted to hurt myself. Enjoyed torturing myself; let myself get hungry so it hurt. It felt good].
(Low self esteem, negative self-value)

[I had a bad sense of my body and convinced myself that everyone thought I was fat]. (High degree of body dissatisfaction)

[I wasn't popular with the boys. I wanted to be a child; so much was happening I couldn't keep up]. (Developmental crisis)

[Wanted attention, over protected, was the first child of young parents].
(Difficulties in family interaction/communication)

[The ideal was to be like everyone else when I was 14–15 years old].
(Ideals)

At the first follow-up, nine persons (13%) did not have any answer of causes, whereas at the second there was only one (1.5%) with no answer. At both follow-ups high own demands/perfectionism had the highest value. There were statistically significant more answers concerning stress/event in the family ($p=0.002$) and family interaction/communication ($p=0.023$) at the second compared to the 1st follow-up. Other subcategories were the same. Correlations between first and second follow-up were significant for development crisis, problems with peers/ bullying, ideals, moving/separation and sports. Self was the most common category with 164 answers, compared to 90 for family and 73 for socio-cultural. The most common subcategory was own demands/perfectionism, 62 (19%) of the totally 327, the other subcategories varied between 11–35 (3%–11%). No categories differed statistically significant between recovered and un-recovered. There was a tendency that unrecovered more often than recovered answered low self-esteem and problems with peers/bullying. We also noticed that only recovered mentioned moving/separation and sports in their answers of causes.

DISCUSSION

The most common answers about causes of anorexia nervosa were things that had to do with self. High own demands/perfectionism was the most common sub-category. In our definition this category included high ambitions, perfectionism, and compulsory traits. This was the most common subcategory in both first and second follow-up and for both recovered and un-recovered. Fairburn, Cooper, Doll, and Welch (1999) showed that premorbid perfectionism was more common in adolescents with anorexia nervosa as compared to healthy comparison subjects and other subjects with psychiatric disturbances. Perfectionism has been shown to promote dieting behavior (Steiner et al., 2003). In a review article on perfectionism and eating disorders, Franco-Paredes et al. (2005) identified three dimensions of perfectionist behavior: self-oriented, other-oriented, and socially oriented perfectionism, and two types of perfectionism: normal or neurotic. In our study, perfectionism in the self-area was most pronounced but there were also demands expressed in the family category. We did not distinguish between normal or neurotic perfectionism, a distinction that could be useful in future studies.

In the second follow-up the answers were more reflective and complex and there were more answers about family causes. The combinations of subcategories can be due to reflections about pressure from different sources. During anorexia nervosa there can be cognitive problems that make it difficult to reflect on causes. In our study, it seems that a reflective perspective about family factors developed during the follow-ups. Some of the previous patients had become parents and could maybe see family perspectives in another way at the second follow-up. Sometimes anorexia nervosa was seen as a result of difficulties expressing feelings, sometimes as result of pressure from family members to achieve high grades in school. Sometimes anorexia nervosa was seen as the result of a chronic illness in the family that imposed too much responsibility for the child. There were descriptions of a high degree of sensibility for other family members' needs that could result in doing too much without having been asked about it. Previous studies have shown that anorexia nervosa patients experienced higher expectations from parents in comparison with a control group (Fairburn et al., 1999). Other studies (Beresin, Gordon, & Herzog, 1989; Tozzi et al., 2002) that asked patients about the causes of anorexia nervosa found family dysfunction to be the most common answer.

Interestingly the descriptions of developmental crisis, problems with peers/ bullying, ideals, moving/separation and sport were very stable across first and second follow-up. Apparently these concrete things were possible to identify both early and late in the process.

There were no differences on a group level on the causes attributed from recovered and not recovered at the second follow-up.

There were some limitations regarding our study. Some of the findings were difficult to interpret. The previous patients could have been influenced from treatment and other information sources concerning eating disorders since a long time had elapsed. It is well known that these patients read a lot and they might reproduce the stereotypes from popular literature. In the answers it was not possible to distinguish between factors—symptoms, maintaining factors or consequences of the disorders—that preceded the onset as was done in risk factor research (Jacobi, Hayward, deZwaan, Kraemer & Agras, 2004). We could not control for how the answers were influenced by the present health status although there were not many differences between recovered and un-recovered.

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