Assessing Guilt in Adolescents with Anorexia Nervosa

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Objective: This study explores the role of guilt in adolescents with anorexia nervosa. Numerous clinical observations have suggested guilt in adolescents or parents contributes to the development of anorexia nervosa, though systematic assessment of this phenomenon has not been undertaken.

Methods: The Interpersonal Guilt Questionnaire was used to assess types and levels of guilt in adolescents with anorexia nervosa and their parents.

Results: We found significantly elevated levels of self-hate guilt in adolescents with anorexia nervosa compared to adolescent norms. However, parents had lower levels of guilt compared to adult norms.

Conclusion: Self-hate guilt is elevated in adolescents with anorexia nervosa. Treatment strategies should take this phenomenon into consideration when developing clinical approaches.

INTRODUCTION

Anorexia nervosa affects approximately 0.48% of females between the ages of 15 and 19 (1). It also has the highest mortality rate of any other mental illness (2). There are a myriad of approaches and theories that purport to account for the illness, but most of them remain untested. One of the more compelling theories suggests that guilt is a central theme in patients and families with anorexia nervosa.

In 1978 Minuchin, Rosman, and Baker described the "anorectic system" as a system in which loyalty and protection take precedence over autonomy and self-realization (3). Children in anorectic systems are particularly loyal to, and protective of, their parents at the expense of their autonomy and self-development. Guilt is seen as the motivator behind this self-sacrifice. Friedman theorized that the relief of guilt is instrumental in treating patients with anorexia nervosa in order for them to return to normal developmental tasks of adolescence and young adulthood (4). Similarly, Dare and Eisler suggested that decreasing parental guilt is

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essential to successful family treatment (5). In addition, according to others, mothers feel guilty and experience intense feelings of failure when their child develops anorexia nervosa (6, 7). Maine (6) argued that this is in part because they bear the responsibility for the family's emotional life (6). She also believed that for many women this is rooted in their search for approval and praise for being the perfect "super-mom." Fathers, she explained, feel guilty when they sense that they are unable to make an impact, which can often be the case with anorexia nervosa.

Systematic study of guilt and psychopathology has been limited. However, Joseph Weiss and the San Francisco Psychotherapy Research Group developed and tested a measure to assess guilt in the context of control-mastery theory. Control-mastery theory emphasizes the role of interpersonal guilt in a wide range of psychopathology. According to the theory, certain kinds of interpersonal guilt impede normal, healthy development. Control-mastery theory, though founded on the principles of classical analytic theory, is unique in that it contends that the repetition of pathogenic behavior is an adaptive attempt to master one's problems rather than an unconscious drive. Similarly, the theory supports the idea that certain forms of guilt have adaptive underpinnings.

In 1997, O'Connor, Berry, and Weiss (8) reported on the development of a new measure (Interpersonal Guilt Questionnaire [IGQ]) designed to operationalize and assess several kinds of interpersonal guilt related to the fear of harming others (8). In 1999, O'Connor, Berry, and Weiss reported on their most recent studies utilizing the IGQ-67 (9). These studies included a subject pool of 223 college students from a large university and a pool of 61 college students from another large State University. The results support the hypothesis that interpersonal guilt, as measured by the four subscales of the IGQ-67, is correlated with a wide range of psychological problems and symptoms.

If guilt does play a critical role in the etiology of anorexia nervosa, as Friedman suggested, then the IGQ may be able to elucidate specific forms of interpersonal guilt that are present in both the adolescent with anorexia nervosa and his or her family. Knowledge of the specific forms of interpersonal guilt that are most prominent in adolescents with anorexia nervosa may contribute a great deal to the growing body of research on treatment and recovery.

The purpose of this study is to explore the relationship between guilt in families with adolescent anorexia nervosa with other important clinical factors, such as expressiveness and overall conflict, using the IGQ. We wished to examine the following three hypotheses:

Hypothesis I: Guilt as measured by the Interpersonal Guilt Questionnaire-Adolescent version (IGQ-69), (9, 10), will be significantly higher in the adolescent eating disorder sample than in the historical group of adolescents.

Hypothesis II: Guilt as measured by the Interpersonal Guilt Questionnaire (8, 9), (IGQ-67), will be significantly higher in the parents of adolescents with anorexia nervosa than in the historical sample of adults.

Hypothesis III: In the quality of interpersonal relationship domain of the Family Environment Scale (FES), (11), levels of expressiveness and conflict will be correlated with the following subscales:

(a) negative correlation between expressiveness and overall guilt, as measured by the IGQ;

(b) positive correlation between conflict and self- hate, as measured by the IGQ.

METHODOLOGY

Subjects

Participants in the study were between the ages of 12-18 years. They met DSM-IV diagnostic criteria for anorexia nervosa within one year of assessment and were without other significant comorbid psychiatric illness (psychosis, organic brain syndrome, i.e., conditions that would prohibit the use of psychotherapy). Subjects for this study were recruited from an eating disorder clinic that draws primarily from northern California. Comparison adolescent subjects were a historical sample of 330 adolescents from two local high schools ages 12-18 (10). Comparison adult subjects were a historical sample of 224 adults from community organizations from four major metropolitan areas (12). Each adolescent and their parents were asked to complete the following measures:

Measures

1. Interpersonal Guilt Questionnaire (9, 10), (IGQ-67 adult version and IGQ-69 adolescent version). These self-report questionnaires are used to evaluate specific types of interpersonal guilt. Scales include survivor/outdoing guilt, separation guilt, omnipotent responsibility guilt, and self-hate.
2. Family Environment Scale (FES), (11). The FES is a 90-item self-report questionnaire that takes approximately 15 minutes to complete. It assesses categories such as cohesion, independence, conflict, expressiveness, achievement orientation, and control.
3. Eating Disorder Evaluation (EDE), (13). The EDE is a psycholog-

ical measure used to evaluate the severity of eating disorders. It is a-one-to-one interview, which lasts approximately 90 minutes and assesses the individual's thoughts and preoccupations surrounding food, body, weight, and shape issues. It is widely used by researchers and clinicians working with eating-disordered individuals (14).

Procedure

Before completing the above questionnaires, all adolescent subjects and their parents had given written consent according to our institutions' approved protocol for this study. Each subject met study criteria and agreed to the specific requirements outlined in the consent forms.

Data Analysis

The hypotheses outlined were tested using correlations and t-test analyses. IGQ means of this study's clinical adolescent sample were also compared to a historical sample of noneating-disordered adolescents. IGQ means of this study's parent sample were also compared to a historical sample of adults.

RESULTS

Demographic Characteristics: Of the 35 families assessed, approximately 29 (82.86%) were White, 3 (8.57%) were Hispanic and 2 (5.71%) Asian, and 1 (2.26%) was mixed race or other. 33 subjects (94%) of the adolescents in this study were female. Hollingshead analysis (see Table I) determined that 28 (80%) of families met criteria for category II, III, or IV. These demographics are consistent with regional demographics. The median age of subjects was 14 years. Twenty-six (74%) of subjects were from intact families. Nine were either single-parent families or reconstituted. Most of the patients were from a three county area near the study site.

Patients in the study were assessed for their eating disorder symptomatology using the Eating Disorder Examination (EDE). When compared to EDE anorexia norms, results on the four subscales (see Table II) suggest patients scored in the anorexic range in all dimensions (14).

Hypothesis Testing: Hypotheses I and II of this study utilized two historical data sets for correlational purposes. Hypothesis I proposed that adolescents with anorexia nervosa would have significantly more guilt when compared to a nonclinical sample of adolescents from a historical data set. Among the subscales, self-hate was statistically significant, $t(34)=2.33$, $p=.0260$. Survivor guilt, separation guilt, and omnipotent responsibility guilt were not significant. Magnitude of the affect was

Table I. DEMOGRAPHIC VARIABLE FREQUENCIES (N = 35)

Variable	Count	Percentage
Ethnicity		
Hispanic	3	8.57
Euro Amer	29	82.86
Asian	2	5.71
Other	1	2.86
Social Classification		
I	6	17.14
II	7	20.00
III	16	45.71
IV	5	14.29
V	1	2.86
Family Structure		
Nuclear	26	74.29
Single	5	14.29
Reconstituted	4	11.43
Age at Start of Treatment		
12	3	8.57
13	2	5.71
14	15	42.86
15	9	25.71
16	3	8.57
17	3	8.57

calculated using eta squared and indicated that 14% of the variance in self-hate scores is related to group membership (being in the nonclinical group versus being in the adolescent AN group). (Table III).

Hypothesis II proposed that parents of adolescents with anorexia nervosa would have greater guilt when compared to adults without

Table II. EATING DISORDER EVALUATION DESCRIPTIVES AND NORMS

	Current Sample (N = 34)		EDE Norms	
	M	SD	M	SD
Eating Concerns	1.24	1.22	1.25	.23
Weight Concerns	2.36	1.59	2.12	.19
Shape Concerns	2.79	1.66	2.55	.20
Restraint	2.97	2.02	3.15	.33

Table III. ADOLESCENT GUILT: CURRENT SAMPLE V. MULHERIN SAMPLE

	Current Sample		Mulherin Sample		
	M	SD	M	SD	t
Survivor Guilt	69.67	12.51	66.4	9.8	1.55
Separation Guilt	41.72	7.61	39.2	8.2	1.96
Omnipotent Responsibility Guilt	44.48	8.42	44.8	8.0	−.22
Self-Hate	38.87	13.39	33.6	10.7	2.33*

*p < .05 **p < .01

children with anorexia nervosa from a historical sample. Results did not support this hypothesis. Parents in this study demonstrated no differences on separation guilt, omnipotent responsibility guilt and self-hate when compared to the historical group. However, parents had significantly lower levels of survivor guilt, $t(63) = -2.62$, $p = .0109$. Magnitude of the affect was calculated using eta squared and indicated that 10% of the variance in self-hate scores is related to group membership (being in the historical group versus being in the AN group). (Table IV).

Hypothesis III suggested (a) a negative correlation between expressiveness and conflict and (b) a positive correlation between conflict and self-hate. A positive correlation was found between conflict in the family and self-hate in the adolescent, $r(31) = .35$, $p = .0440$. There were no significant findings, however, to support a relationship between expressiveness and conflict. Magnitude of the affect was determined using r

Table IV. PARENTAL GUILT: CURRENT SAMPLE V. ASANO EUROPEAN-AMERICAN SAMPLE

	Current Sample		Asano Sample		
	M	SD	M	SD	t
Survivor Guilt	61.54	8.56	64.35	10.22	−2.62*
Separation Guilt	37.34	7.05	37.11	8.85	.27
Omnipotent Responsibility Guilt	44.55	5.76	45.64	8.14	−1.51
Self-Hate	27.74	7.49	28.34	8.89	−.64

*p < .05 **p < .01

Table V. FAMILY AND ADOLESCENT VARIABLE CORRELATIONS

	Count	Correlation
Fam. Expressiveness—Fam. Conflict	33	.13
Fam. Conflict—Adol. Self-Hate	33	.35*

*$p < .05$ **$p < .01$

squared and indicated that 12% of the variance adolescent self-hate is associated with variation in family conflict (Table V).

DISCUSSION

This study was conducted in order to determine whether relationships exist between important variables, such as guilt and conflict, in families with an adolescent with anorexia nervosa. Research suggests that guilt plays an important role in maintaining psychopathology in individuals as well as children (9, 15). It is also suggested that guilt plays a critical role specifically in the maintenance of anorexia nervosa (4).

Results for this study yielded three significant findings. It was predicted that adolescents with anorexia nervosa would score higher on the IGQ than a nonclinical sample of adolescents. This hypothesis proved to be true for one of the four subscales i.e., self-hate. The second significant finding indicated that parents in this study have significantly lower guilt than adults in the comparison group. The opposite finding in this case was expected. Thirdly, as predicted, conflict in families was correlated with self-hate in adolescents with anorexia nervosa. These findings are potentially important in our efforts to understand and help families and adolescents with anorexia nervosa.

Hypothesis I correctly predicted that adolescents with anorexia nervosa would experience higher levels of guilt than the nonclinical comparison sample of adolescents. The eating disorder literature supports the idea that females suffering from anorexia nervosa experience a significant amount of guilt (e.g., 4, 16-18). Furthermore, Zerbe (1993) discussed the role of guilt in thwarting healthy development and the achievement of positive goals in a person's life (18). She also addressed the negative impact of unconscious guilt about doing as well or better than one's parents. These theories support the general notion that excessive guilt can play an important role in the development of psychopathology in adolescents and in relation to anorexia nervosa in particular.

Interpersonal guilt has been defined as a painful emotion stemming from the belief that one has caused harm to another person (15). Accord-

ing to Weiss's (1986) theory there are three types of interpersonal guilt: separation guilt, survivor guilt, and omnipotent-responsibility guilt (15). These forms of guilt, which serve to maintain many interpersonal ties, lead to maladaptive behavior and consequently psychopathology. It is these forms of interpersonal guilt, in addition to self-hate, in which control-mastery is most interested.

Separation guilt stems from a powerful belief that to become more independent from a parent will result in harm to that parent. Control-mastery theory upholds the idea that this type of guilt relies on both internal and external factors. For example, it may depend on the strength of the child's desire to become independent from his or her parents, the tendency of the child to exaggerate his or her effect on their parents, the projections the child may put onto parents of dependency, and the real reactions the child's parents may have toward any attempt to become separate or independent from them (15). Survivor guilt, first used to describe the guilt suffered by persons whose parents or siblings had died, has been broadened by Modell. Like separation guilt, survivor guilt is based on a belief. This belief is rooted in the idea that receiving good things in life will cause others, namely one's parents and siblings, to suffer. In other words, achieving success or happiness is done at the expense of someone else. According to Modell (19), this form of guilt rests on the idea that in life there is a limited supply of good things. The third type of guilt, omnipotent responsibility guilt, involves an exaggerated sense of responsibility and concern for the well-being of others (8). Self-hate originally was considered a fourth type of guilt but is currently understood as related to, but not a form of, interpersonal guilt. Self-hate is closely related to shame and is an extreme and maladaptive self-evaluation that may occur in compliance with harsh, punishing, or neglectful parents (9). Each of these forms of guilt, in addition to self-hate, is measured in both the adult and adolescent forms of the Interpersonal Guilt Questionnaire (IGQ).

Self-hate is perhaps the most important IGQ subscale when considering the nature of anorexia nervosa. The self-hate subscale is reported to be more indirectly related to interpersonal guilt and is indicative of the type of self-criticism associated with highly guilty people (9). It is also most strongly and independently associated with psychopathology. Therefore, it is considered by O'Connor as the most robust indicator of psychopathology and distress (9). The IGQ self-hate subscale is also reported to be the subscale that is closely related to shame (9). Many authors speak about anorexic patients experiencing intense, pervasive, negative thoughts of ineffectiveness directed toward the self (20). Such all-encompassing neg-

ativity directed inward suggests experiences of shame. According to Tangney (21), shame causes an individual to feel like a "bad" person for it triggers a universal negative evaluation of the self; it attacks a person's core identity causing feelings of worthlessness. In addition, patients with anorexia nervosa do not typically attend to their own needs nor do they feel they should. They disavow their own needs while being highly attentive to the needs of others (20, 22). They have a tendency to blame themselves for their illness and all the subsequent difficulties that the family must endure as a result of their health problems (6, 22). As a result of not being able to differentiate their own needs from those of their parents, they become overly compliant, perfect children (22). In being "perfect," such children are more apt to blame and think negatively about themselves when something goes wrong. These ideas lend support to the notion that adolescents with anorexia nervosa are likely to experience specifically more self-hate than a nonclinical sample of adolescents. These ideas also suggest that shame may be more profoundly impacting adolescents with anorexia nervosa than the particular forms of guilt delineated in the IGQ.

Hypothesis II expected guilt to be higher in parents of adolescents with anorexia nervosa than in the historical comparison group of adults. This hypothesis was not borne out. Contrary to what was expected and the clinical literature predicts, parents with an anorexic child were not higher in any form of guilt than the comparison group. In fact, parents of anorexic children exhibited significantly lower levels of guilt than the comparison group of adults. It is interesting to try to understand these findings. It is possible, of course, that the IGQ failed to accurately assess guilt in this group or that the comparison norms were problematic. A possible reason for this is that the comparison group used did not differentiate guilt by gender. There is evidence that women and men differ in terms of guilt feelings (23). Thus, it is possible that with a comparison group stratified by gender, significant differences might have been found. Thus, this it is an important limitation of the study resulting from the available comparison norms on the IGQ.

Alternatively, it is possible that parents of children with anorexia nervosa are in reality less guilty than expected. Some authors have suggested that families of patients with anorexia nervosa are characterized more by minimizing and avoiding conflict through control and social isolation than by guilt per se (3, 7). Thus, these families are emotionally threatened and appear more anxious than depressed or guilty. In this formulation, parents would tend to experience difficulties with anxiety and fear of taking action rather than with guilt. It should be noted, in addition,

that parents of children with anorexia nervosa are often "surprised" by the illness because heretofore their child has been "perfect" and an example of their competence as parents. Thus, they are ill prepared initially to see themselves as to blame for the illness. In this study, children and parents were assessed at the point of initial treatment so that these types of feelings may have been predominant. It would be interesting to see if more guilt and shame developed in parents over time as they became more aware of both the illness and its implications for them as parents.

Hypothesis III predicted that there would be (a) a negative correlation between expressiveness in the family and overall guilt in the adolescent and (b) a positive correlation between conflict in the family and self-hate in the adolescent. Again, self-hate was the significant subscale. No relationship was found between expressiveness and guilt in families. This finding again supports the need to address feelings of self-hate in the adolescent with anorexia nervosa. If the underlying issues concern adolescents' sense of self-worth and other experiences related to shame versus conflicts related to a suppressed need for autonomy and independence, then the clinical focus in helping adolescents recover should perhaps be on precisely these issues. Etiological hypotheses regarding anorexia nervosa in the literature suggest a relationship between adolescent independence and guilt. It is argued that adolescents regress to anorexic behaviors out of anxiety about leaving the family and thereby to preserve it and the well-being of the parents in particular (20, 24). Similarly, anorexia nervosa is conceptualized by many as an illness rooted in autonomy issues (20). The results noted above suggest that guilt is not operative in this way. Instead, these results suggest that anorexia nervosa has more to do with internal shame and avoidance of failure as a result of perceived deficits than with preserving the family or parents.

If this study's findings are correct, and shame in the form of self-hate is a fundamental experience of adolescents with anorexia nervosa, how might the clinician respond to this effectively? There is a long-standing dispute about how to treat anorexia nervosa. Some propose that individual work supporting the adolescent's autonomy is key. Others propose that the illness is best treated in the context of family work. Unfortunately, the scientific evidence to support any specific treatment for anorexia nervosa is not particularly strong (25). Nonetheless, of the treatment interventions studied, a family-based approach developed at the Maudsley Hospital is the most promising (5). This approach initially employs the family in refeeding the adolescent, rather than focusing on the adolescent taking on this responsibility alone. It may be that engaging the family and enlisting

the parents to "take charge" of eating allows the adolescent to give up responsibility for eating, thereby reducing self-hate and shame. It is also possible that this approach helps to both contain and manage parental anxiety by providing them with a focus for action as well as therapeutic containment by a nurturing therapist. A detailed description of this approach is now published and preliminary results are promising (25, 26).

Limitations of the present study include the scope of the population recruited, the loss of some parent data due to noncompliance, the inherent limitations of self-report measures, and limitations of the Interpersonal Guilt Questionnaire, which has not been widely tested with adolescent populations. In addition, evidence suggests that men and women differ in their experiences of guilt, and it is, therefore, possible that results would vary with a gender specific comparison group (23). Demographics for this study illustrate that the majority of subjects are upper middle class by income and education. Again, given the predominant locations from which participating families were recruited, these demographic findings are not surprising. These characteristics, though, may limit the generalizability of the findings.

Several areas for future research are suggested by our results. It would be important to follow patients and families before and after treatment to assess changes in IGQ scores. In this way it would be possible to explore the impact of treatment on self-hate and family conflict. Other areas of potential research include comparing adolescents with anorexia nervosa to adults with anorexia nervosa to determine whether levels of self-hate differ as a result of age. It would also be interesting to compare adults diagnosed with anorexia nervosa to adults who have recovered from anorexia nervosa to determine whether recovery affects levels of self-hate or other forms of guilt. Lastly, in an effort to broaden and allow for a more thorough understanding of the influences of psychopathology of the measurement of guilt, it would be useful to administer the IGQ on adolescents and adults diagnosed with a broad range of diagnoses.

CONCLUSION

This report explores the impact of guilt on adolescents with anorexia nervosa and their parents. The Interpersonal Guilt Questionnaire was used to measure different forms of guilt in both the adolescent (IGQ-69, adolescent version) and each parent (IGQ-67, adult version). Two historical samples were used as comparison groups for subjects in this study. In considering the significant results of the present study, several points were explored. Adolescents with anorexia nervosa have significantly higher

levels of self-hate than adolescents without anorexia nervosa. If the underlying issues for such adolescents involve extreme and maladaptive self-evaluation, then it is critical for therapy to address this. While exploring independence and autonomy issues may also benefit the adolescent and family, these issues are perhaps secondary. It may, in fact, be essential to first address the self-hate and negativity that pervade the adolescent's identity in order for the adolescent to break free from the binds of anorexia nervosa. This might best be accomplished using a family treatment that absolves the adolescent from responsibility for eating thereby reducing her self-hate and shame.

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