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Assessment of Social Support Dimensions in Patients with Eating Disorders
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The aim of this study is to assess social support dimensions (providers, satisfaction and different support actions) in patients with eating disorders (ED), looking at diagnosis, socio-demographic and clinical characteristics, and self-concept. Method: A total of 98 female ED patients were recruited. The ages of participants ranged from 12 to 34 (Mean=20.8 years old, SD=5.61). Patients have a primary DSM-IV-R diagnosis of anorexia nervosa (61.2%), bulimia nervosa (27.6%) or an unspecified eating disorder (11.2%). Social support was assessed using the Escala de Apoyo Social Percibido (EASP). This scale measures social support providers, satisfaction and specific social support actions, which can be grouped into informational, emotional and practical support. Self-concept was assessed using the Cuestionario de Autoconcepto (AF-5). Results: The two most frequent providers for these patients were mothers (86.7%) and partners (73.1%). Patients’ satisfaction with social support was high and they reported that they received informational support more frequently than emotional and practical support. Family self-concept showed positive relationships with social support dimensions. Conclusion: These results show the importance of the family network in connection with these disorders and its relation to self-concept. Keywords: social support, self-concept, satisfaction, eating disorders

El objetivo del presente trabajo fue evaluar las dimensiones del apoyo social (proveedores, satisfacción y tipos de apoyo) en pacientes con un trastorno del comportamiento alimentario (TCA), atendiendo a su diagnóstico, variables sociodemográficas y clínicas, así como a su autoconcepto. Método: Participaron 98 mujeres diagnosticadas de un TCA. La media de edad fue 20.8 años (dt=5.61). Un 61.2% estaban diagnosticadas de anorexia nerviosa, un 27.6% de bulimia y un 11.2% de un TCA no especificado. Para la evaluación del apoyo social se utilizó la Escala de Apoyo Social Percibido (EASP) que evalúa proveedores de apoyo, satisfacción y acciones específicas de apoyo que se agrupan en los diferentes tipos de apoyo; informativo, emocional e instrumental. Para la evaluación del autoconcepto se usó el Cuestionario de Autoconcepto (AF-5). Resultados: Los análisis mostraron que los proveedores de apoyo más frecuentes para las pacientes con un TCA eran su madre (86.7%) y su pareja (73.1%). Presentaron una satisfacción elevada con el apoyo e informaron que recibían más apoyo informativo que instrumental y emocional. El autoconcepto familiar mostró relaciones positivas con las distintas dimensiones del apoyo. Conclusiones: Estos resultados manifiestan la importancia de la red familiar en estos trastornos, así como para el desarrollo de su autoconcepto. Palabras clave: apoyo social, autoconcepto, satisfacción, trastornos alimentarios

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Eating disorders have become a growing problem, especially among women (Herrero & Viña, 2004). The prevalence rates for these clinical symptoms oscillate between 0.2% and 0.8% within the general population, but among young people it reaches 1% to 5% for anorexia nervosa and from 2% to 3% for bulimia. In Spain, the prevalence rate is between 0.3% and 3% of the population, although this figure varies according to age, tests carried out, the place of assessment and the criteria used for diagnostic classification (Linde, 2005; Menéndez & Pedrera, 1999). Eighty percent of these disorders occur in adolescents and despite being associated in general with young people from a middle-high social class, it is argued that these disorders occur equally across the different social classes (Bueno, Velilla, Sarría, Guillén, & Jiménez, 1999; Morandé, 1998).

Due to the fact that these disorders are frequently of a chronic nature, it is not surprising to observe that other psychological and clinical problems often coexist with them. Generally, they are accompanied by affective, anxiety, substance abuse and personality disorders (del Río, Torres, & Borda, 2002; Echeburúa & Marañón, 2001; Ruiz-Lázaro et al., 1996). Feelings of dysphoria and depression and the presence of anxiety frequently accompany anorexic and bulimic behaviour, both of which are considered fundamental variables in sustaining eating disorders. Self-assessment of these patients and their low self esteem, linked to non acceptance of their own body condition the nature of their relationships, their aspirations and attitudes. In general, this leads to difficulties in expressing emotions and a lack of coping strategies in stressful circumstances, especially in social situations, which leads to a deterioration of relationships and social isolation, both typical aspects of eating disorders (ED), (Beato & Rodriguez, 2000; Quiles, Terol, & Quiles, 2003). The assessment and approach towards the type of social resources and support which are available to patients with an ED is a subject of interest in this field. For example, the study for revising social support among ED, carried out by Quiles (2003) reveals that both anorexics and bulimics can rely on fewer providers and receive less family support than the healthy population. With regard to the adaptation of support, lower levels of satisfaction are reported. ED patients also perceive less emotional, practical and informational support than the control groups they are compared to. Furthermore, a greater number of support providers are related to a better adjustment, and satisfaction with support is related to better levels of self-esteem (Grissett & Norvell, 1992; Tiller et al., 1997).

In this sense, social support has become a central theme in mental health studies and the bibliography about this subject has generated an intense debate in relation to the diverse positive effects of social networks on psychological well-being (Sánchez, 2004; Sánchez & Barrón, 2003). However, there are still very few studies which have evaluated this construct and dealt with its conceptual complexity in these patients. From a functional and psychological perspective of social support, it is argued, therefore, that the support process is conditioned by the subjects’ perception and their evaluations respond to a subjective feeling of being supported and to the experience of real support actions in specific situations (Burleson, Albrecht, Goldsmith, & Saranson, 1994). Social functional support, therefore, alludes to how social relations have certain effects on the health and well-being of subjects. A series of variables to be considered in order to determine the evaluation of social support at this level of analysis are proposed: sources or providers, quantity or quality of support and types of support (House & Khan, 1985; Lin, Dean, & Ensel, 1986; Moss-Morris & Michel, 1982).

The number of people who subjects have contact with represents a broad spectrum of support sources or providers available (relations, neighbours, partners, work colleagues, health workers, association members, and the like). Thus, each of the different members who make up the subjects’ social network is a potential support provider, but it is possible that not all of them will form a part of the support network. With regard to the variable quantity/quality of support, quantity is understood as the quantification of support behaviours and actions in relation to the provider or providers who render them. On occasions, the number of real support providers is referred to by identifying it with the size of the network, and consequently, its operativization becomes somewhat confusing. On the other hand, quality of support reflects the adaptation of social support. It refers to the balance between the recipient’s needs and to what extent they are covered. The majority of authors coincide when they indicate that this variable should be assessed in terms of the subjects’ satisfaction with the support received (Barrón, 1996; Durá & Garcés, 1991; Saranson, Levine, Bashman, & Saranson, 1983; Tardy, 1985). With respect to types of support, the majority coincides in at least three categories: emotional, practical and informational (Díaz Veiga, 1987; Lin et al., 1986; Tardy, 1985). Emotional support is operativized in terms of expressions of affection, care, empathy, and so forth. Practical support means carrying out actions or supplying materials or services which are useful for solving practical problems. Informational support includes all those interventions that involve advising, informing or guiding. The final effectiveness of each type of support will depend on the nature of whoever provides the resource, on its usefulness and attributed efficacy, on the type of relation which is established between the recipient and the provider, as well as the nature of the stressful situation.

An interesting aspect in the study of social support is its relation to self-esteem. Interaction in support contexts permits growth and personal development, as well as the configuration of positive perceptions about oneself. This development of self-esteem shapes in turn the attitude towards the search for and the acceptance of help, in this way creating a completely interdependent binomial: support/self-esteem (Herrero, 1996). Self-esteem, conceptualized as the valuation...
of oneself, is a product of interaction with others and the different contexts of this interaction will be associated to the different evaluations of oneself. That is to say, to different self-concepts. For this reason, the objective of this paper is to evaluate the different dimensions of social support (providers, satisfaction, and types of support) in patients with ED in the context of its diagnosis, socio-demographic and clinical variables and self-concept.

In this study we hope to find that: (a) the main support providers of these patients are to be found within the family network, (b) there are differences between anorexics and bulimics in their satisfaction with support, and (c) there exist positive relations between self-concept and the different support dimensions.

Method

Participants

Ninety-eight women diagnosed with ED, who were being treated as outpatients in the Unidad de Trastornos de la Alimentación (Eating Disorder Unit, EDU), at the Hospital Universitario de San Juan de Alicante, Spain, participated in this study. The age range was from 12 to 34 years old (M = 20.8, SD = 5.61). Out of these women, 61.2% (n = 60) were diagnosed with anorexia nervosa, while 27.6% (n = 27) were diagnosed with bulimia, and 11.2% (n = 11) had an unspecified ED (American Psychological Association, Diagnostic and Statistical Manual of Mental Disorders, 2000). Among those with anorexia, 43.9% had restrictive anorexia nervosa, and 17.3% purgative anorexia. Among those with bulimia, 24.5% were purgative subtype, and 3.1% non-purgative.

On the other hand, 90.8% of the participants are single, and out of these 46.9% have a partner. In the context of educational level, 33.7% are in secondary education and 31.6% have had a university education. Finally and with respect to their employment situation, 70.4% are unemployed, while 29.6% are working. The course/duration of the disorder oscillates between 1 month and 20 years (M = 45.58 months, SD = 45.52). All patients were going to the EDU, and the time they had been receiving treatment fluctuated between 1 month and 5 years (M = 16.86 months, SD = 17.69). Fifty per cent had been hospitalized at some time and had received hospital treatment, the time spent in hospital lasted between 1 month and 6 months (M = 1.6 months, SD = 2.36). With regard to treatments, 67.3% received psychological treatment, 55.1% were treated with medication and 71.4% followed nutritional guidelines.

Regarding co-morbidity, 14.3% had some kind of affective disorder, the most frequent being depression (9.2%), and 14.3% suffered some kind of anxiety problem. Finally, 6.1% had problems with substance abuse, the most frequent being alcohol (3.1%).

Measures

Sociodemographic variables and clinical records. In conjunction with the team of professionals at the UTA (ED Unit) a questionnaire was drawn up, which includes sociodemographic variables (age, education level, employment situation, and marital status) and clinical variables. It was completed by the EDU psychiatrist. Clinical variables included were the following.

1. Diagnosis. Qualitative item where the different types of eating disorders of those within the study sample group are reflected, following the criteria of the DSM-IV-TR (2000).
2. Period. Months since the start of the disorder up to the date of the interview.
3. Time receiving treatment in the EDU. Months receiving medical attention at the EDU up to the date of the interview.
4. Admission in the EDU. Registers whether the patient has been admitted in the EDU at some time, if affirmative the time hospitalized is included.
5. Comorbidity. Includes information about the existence of other psychological disorders in the patient: affective disorders, anxiety problems, and/or substance abuse. The diagnostic criteria for these disorders are based on DSM-IV-TR (2000).

Self-concept. For the evaluation of self-concept, the Autoconcepto Forma 5 Questionnaire (AF5; García & Musitu, 1999) was used. It is made up of 30 items and is designed to evaluate 5 dimensions of self concept; social, academic/professional, emotional, family and physical. The sample used for father’s the AF-5 scale consists of 6,483 subjects of both sexes (2,859 males and 3,624 females) with an age range between 10 and 62 years old. This questionnaire has an internal consistency equal to 0.85 (García, Musitu, & Veiga, 2006).

Social support. The Escala de Apoyo Social Percibido (EASP; Rodríguez-Marin, López-Roig, & Pastor, 1989, Terol et al., 2000) was used. Perceived social support is evaluated in reference to a specific situation, in this case, to an illness. In its original version, it consists of a list of nine possible providers: husband, parents, children, brothers and sisters, work colleagues, neighbours and friends, and finally doctors and nurses. In our study, due to the age of a large section of the study sample, we considered it appropriate to include the term partner as well as husband, and to refer to work colleagues or classmates. Considering the literature about the subject (Calvo, 2002; Stern, Dixon, Lake, Namzer, & Sansone, 1989) it was decided not to include both parents in the same category, but to consider the father’s support and the mother’s support separately, with a final scale of 10 possible support providers, who are evaluated by considering each as a category.

For each provider, subjects evaluate three questions. First, whether or not they perceive support from this
provider; second, how satisfied they are with the support they perceive, using a Likert 5 point scale, from 1 (nothing) to 5 (a lot); and third, specific support actions that are perceived from each provider, and that can be grouped into different types of support: informative, emotional, and practical (Terol et al., 2000).

1. With regard to the number of support providers, it is hoped that subjects will spontaneously name those who provide them with support. The patient is asked an open question: “Since you have had this illness, who would you say has helped you, or is in some way supporting you in this situation?” This first question about providers makes it possible to get information about: (a) total number of potential providers (TPP) or number of people available; (b) total number of real providers (TRP) or number of people they perceive they get support from; (c) total number of non providers (TNP) or number of people they do not perceive they get support from; and (d) total number of non network (TNN) or number of people who are not available on the network.

2. For satisfaction with support, the following question is asked, but only about those members of the network that the patient has referred to as support providers. In the interview with the patient, the question asked is: “To what extent have you been satisfied or are you satisfied with the help received from each provider?” In this way, the following variables are obtained: (a) satisfaction with support (SS): level of satisfaction with support from each real provider; and (b) mean satisfaction with support (MSS): total of the level of satisfaction perceived regarding real providers divided by total number of real providers.

3. For support actions, patients are asked about the ways in which they have been helped by each one of the support providers mentioned: “In what way has the provider helped or supported you?” The total number of support actions can be perceived for each provider oscillates between 0 and 12, including the fact that the patient may mention actions which are not listed. Following this, the different actions on the scale are specified: listening to you, encouraging you, entertaining you, advising you, visiting you, doing jobs, offering financial help, accompanying you, and other ways. In this way, the following variables of support actions are obtained: (a) support actions by the real provider (SARP): number of support actions perceived for each provider (if it is perceived that the couple advise or offer help), the support actions for the couple are two); and (b) all support actions by real providers (ASARP): the total number of each of the perceived support actions by the real providers. (For example, Total number for offering help = 4, indicates that four providers are perceived to offer to do things for the patient).

The factorial structure of this part of the questionnaire shows three factors which correspond to the different forms of support mentioned in literature (Terol et al., 2000): Emotional support, which includes the actions visiting, accompanying and entertaining, the aim of which is to palliate the emotional impact in some way. Informative support, which includes informing, advising, listening and encouraging. Practical support, which includes actions related to offering services and material or tangible support, offering help, doing tasks, and financial support.

**Procedure**

Patients with ED were selected by the psychiatrist and psychologist at the EDU, according to the following criteria: female, patients diagnosed with ED, in an age range of 11 to 35, and receiving treatment as outpatients at the time. During their consultation, the patients were informed about the objective of the study and they were asked to participate voluntarily in the research. After their acceptance, the patients were then interviewed, which in most cases was done on the same day, or coincided with a day they had to come to the unit for their consultation. The interview took place in a room on the same floor as the EDU. Before starting the interview, we introduced ourselves, explained the objective of the study in more detail and how the assessment was going to be carried out. Instructions were then given about how to complete the battery of questionnaires and they were also given the opportunity to ask about any doubts they had regarding the objectives of the study and about the tests to be done. They were also informed about the total confidentiality of their answers. The interview took about 35 min. Out of the 100 patients sent by the Unit psychiatrist and psychologist, 98 completed the interview, while 2 left before finishing it.

**Statistical Analyses**

The SPSS (version 12.0) statistical package was used. The following analyses were made: descriptive study of the variables used in the study, Pearson’s product-moment correlation was used for analyzing relations between variables. The t-test was used as parametric test for two independent samples for the analysis of differences, ANOVA of a factor as a parametric proof for independent K samples, and the Bonferroni procedure for multiple comparisons.

Following the recommendations by Cohen (1988), we consider effect size, understood as the level to which the effect studied is present in the sample studied, that is to say, as a measure of the true difference between two averages in order to avoid the bias of the sample sizes. Therefore, not only is the level of statistical significance of a result to be considered, but also the significance or real importance of the result. In this way, we use the $d^*$ index, which indicates to what point a statistical significance is relevant by eliminating the effect of the sample size. Cohen classifies the size of effect as low if $d^* 0.20$, average ($d^* 0.50$) and large ($d^* 0.80$).
Results

The Dimensions of Social Support and Differences according to Diagnosis

Table 1 shows the descriptive results of the variable, social support providers, the number of patients who say they perceive support from each of the potential providers (real providers), or not (non providers), and those who say they do not have one or any of them on the network (not available). Furthermore, the frequency percentages of real providers and non providers calculated from the total of those available are added (see %*).

The most frequent support providers from the family network for these patients are their mothers and their partners. Out of these patients, 87.6% receive support from their mothers, and 73.1% of those who have partners receive support from them. With regard to the social network, they receive support most frequently from friends (70.4%). In relation to the professional network, patients feel supported by both the team of doctors (80.6%) and by the nurses (66.1%). There are two groups of potential and available providers from which support is most frequently not perceived: children (80%) and neighbours (82.47%). Finally, according to the results of the descriptive analysis, the providers not available on the network that most stand out are children and partners, who present the highest levels of frequency: 89.9% and 46.9%, respectively.

In a second analysis, we calculated the total number of real providers perceived by each patient. The range oscillates from a single provider up to 10 (M = 5.2, SD = 2). The majority of patients (64.1%) feel supported by a number of providers, which ranges from 4 to 7. Only one patient claimed to have a single provider, 9 had two, and 11 claimed to perceive support from three. Although the maximum range of providers is 11, the maximum number of real providers one patient reported to have is 10. Of the total number of non providers reported by each patient, the average was 3.3 (SD = 1.98, Range 0-9) 72.3% did not feel supported by a number of providers, which ranges from 3 to 6.

If the sample is classified into bulimics and anorexics, the results of the analyses of differences for the total number of support providers show that the anorexics (M = 5.46, SD = 2.05) can rely on a greater number of real providers than the bulimics (M = 4.51, SD = 1.82), t = 2.1, p < .05, d = .44. The degree of satisfaction with support given was evaluated with respect to those who were considered as real support providers. The highest levels of satisfaction in the context of the family network correspond to the support perceived from the mother, and more than 47% are very satisfied with the support received. With respect to the nuclear network, more than 50% are very satisfied with the support from their partners. In contrast, among the scores for the lowest satisfaction (little and sufficient), 8 patients mentioned their neighbours and 19 their work colleagues or classmates. The average satisfaction with support was high (M = 3.99, SD = 0.78). No differences were found between anorexics and bulimics regarding satisfaction with support.

Listening, encouraging, and advising are perceived by patients as the most frequent support actions that providers give, the three of which correspond to the category of informative support. Instead, the least perceived actions by this group of patients are those of receiving financial support, visits, and doing jobs (see Table 2). When support actions are analysed according to diagnosis, anorexics receive more actions of informing (t = 2.86, p < .01, d = 0.60), and accompanying (t = 2.18, p < .05 d = .45) than bulimics.

If we analyse support actions according to the three categories emotional, practical and informative (Terol et al., 2000), the informative support category (t = 10.69; t = 13.77; p< .001), followed by emotional (t = 2.63, p < .01) are observed to be those received with most frequency and differentiate significantly from the practical category

With respect to the total number of actions provided by each provider, it is the mother who provides most actions

Table 1

<table>
<thead>
<tr>
<th>Support Providers</th>
<th>Real Providers</th>
<th>Non Providers</th>
<th>Not Available On Network</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>%(*)</td>
</tr>
<tr>
<td>Mother</td>
<td>85</td>
<td>86.7</td>
<td>87.6</td>
</tr>
<tr>
<td>Father</td>
<td>59</td>
<td>60.2</td>
<td>62.1</td>
</tr>
<tr>
<td>Brothers/Sisters</td>
<td>61</td>
<td>62.2</td>
<td>67</td>
</tr>
<tr>
<td>Partner</td>
<td>38</td>
<td>38.8</td>
<td>73.1</td>
</tr>
<tr>
<td>Children</td>
<td>2</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Partner</td>
<td>44</td>
<td>44.9</td>
<td>45.3</td>
</tr>
<tr>
<td>Friends</td>
<td>69</td>
<td>70.4</td>
<td>70.4</td>
</tr>
<tr>
<td>Neighbours</td>
<td>17</td>
<td>17.3</td>
<td>17.52</td>
</tr>
<tr>
<td>Doctors</td>
<td>79</td>
<td>80.6</td>
<td>80.6</td>
</tr>
<tr>
<td>Nurses</td>
<td>37</td>
<td>37.8</td>
<td>66.1</td>
</tr>
<tr>
<td>Others</td>
<td>24</td>
<td>24.5</td>
<td>50</td>
</tr>
</tbody>
</table>
(M = 7.2, SD = 4.09), followed by the father (M = 4.11, SD = 4.21), friends (M = 3.77, SD = 3.25), and brothers and sisters (M = 3.63, SD = 3.87). And the lowest number are provided by children (M = 0.04, SD = 0.31), and neighbours (M = 0.41, SD = 1.31).

**Differences in Social Support according to Sociodemographic and Clinical Variables**

The description of social support is completed with the analysis of the differences in the socio-demographic and clinical variables. It is the older patients (32-35 years old) who received more support action from their children, since logically this is the age range in which this provider can become available (F = 6.28, p < .001). Furthermore, the group of patients between 16 and 23 received more support actions from their mothers than patients between 24 and 27 (F = 2.45, p < .05). The group of patients between 28 and 31 received more support actions from their brothers and sisters than the group between 12 and 19 (F = 3.51, p < .01).

With regard to marital status, single women with a partner in contrast to those who do not have a partner had a greater number of real support providers (F = 4.14, p < .01), they also received more listening actions (F = 6.31, p < .01), financial actions (F = 4.77, p < .01), offers of help (F = 5.05, p < .01), and more support from friends (F = 4.64, p < .05). And finally, single women with a partner, although they do not live together, received more practical support (F = 7.44, p < .001), and support from their partners (F = 29.99, p < .001), than those who do not have a partner and those that have a partner and live together.

With respect to the course/duration of the illness, patients who have had the disorder for between 12 and 15 years received more support actions from their children than those who have had the problem fewer years (F = 6.24, p < .001), which is coherent with the fact that the availability of children as potential providers at an older age is more likely. Patients who have had the problem for more than 20 years received more support actions from their neighbours (F = 12.37, p < .001) and from nursing staff (F = 2.4, p < .05).

In reference to comorbidity, patients with anxiety crisis received less support actions from their parents (t = 1.98, p < .05; d = 0.56), and more from the nursing staff (t = 2.62, p < .01; d = 0.74). Patients with a substance abuse disorder received more informative and practical support (t = 3.12, p < .01; d = 1.27; t = 2.49, p < .05; d = 1.02), more support actions from their partners (t = 2.59, p < .05; d = 0.98).

**Table 2**

**Actions received**

<table>
<thead>
<tr>
<th>Support Type*</th>
<th>Average (sd) Minimum-Maximum</th>
<th>Actions</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informative</td>
<td>3.44 (1.73) 0.25-8</td>
<td>Listening</td>
<td>3.86</td>
<td>2.06</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Encouraging</td>
<td>3.80</td>
<td>2.03</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Advising</td>
<td>3.76</td>
<td>2.03</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Informing</td>
<td>2.33</td>
<td>1.74</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Entertaining</td>
<td>2.32</td>
<td>1.81</td>
</tr>
<tr>
<td>Emotional</td>
<td>2.01 (1.44) 0-8</td>
<td>Accompanying</td>
<td>2.18</td>
<td>1.65</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Visiting</td>
<td>1.52</td>
<td>1.90</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Offering help</td>
<td>2.19</td>
<td>1.74</td>
</tr>
<tr>
<td>Practical</td>
<td>1.68 (1.19) 0-4.33</td>
<td>Doing jobs</td>
<td>1.65</td>
<td>1.72</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Financially</td>
<td>1.19</td>
<td>1.04</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Others</td>
<td>1.51</td>
<td>1.48</td>
</tr>
</tbody>
</table>

* Classification support types Terol et al. (2000).

**Table 3**

**Relations: social support dimensions and self-concept**

<table>
<thead>
<tr>
<th></th>
<th>Academ/Employ Self-Concept</th>
<th>Social Self-Concept</th>
<th>Emotional Self-Concept</th>
<th>Family Self-Concept</th>
<th>Physical Self-Concept</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Providers</td>
<td>.023</td>
<td>.070</td>
<td>–.080</td>
<td>.301**</td>
<td>–.120</td>
</tr>
<tr>
<td>Average Satisfaction</td>
<td>.136</td>
<td>.081</td>
<td>.031</td>
<td>.219*</td>
<td>.072</td>
</tr>
<tr>
<td>Informative Support</td>
<td>.082</td>
<td>.132</td>
<td>–.081</td>
<td>.372**</td>
<td>–.048</td>
</tr>
<tr>
<td>Emotional Support</td>
<td>.029</td>
<td>–.005</td>
<td>–.096</td>
<td>.217*</td>
<td>–.142</td>
</tr>
<tr>
<td>Practical Support</td>
<td>.167</td>
<td>.127</td>
<td>.027</td>
<td>.408**</td>
<td>.037</td>
</tr>
</tbody>
</table>

* p < 0.05, ** p < 0.01, *** p < 0.001.
from the doctor \( t = 2.74, p < .05; d = 1.12 \), and from the nursing staff \( t = 2.74, p < .001; d = 1.45 \). Finally, with respect to self-concept, patients with greater family self-concept, could rely on a greater number of real support providers \( t = -2.33, p < .05; d = 1.85 \), and received more informative support \( t = -3.25, p < .05; d = 1.18 \).

**Relation between Social Support and Self-concept Dimensions**

Table 3 presents the relations between the different dimensions of social support and self-concept. It is apparent that it is only family self-concept which presents significant positive relations with the different support dimensions.

**Discussion**

This paper analyses social support dimensions in women diagnosed with an ED, in relation to diagnosis, sociodemographic and clinical characteristics, and their relation to self-concept. The results show that patients with ED are reported to have an average of around five real support providers, mothers, health workers, partners and friends being the most frequently mentioned. Out of these patients, 86.7% consider their mothers as a support provider, and in fact, during the course of the illness and hospital consultation, the mother is the family relation who accompanies the patient on most occasions, in spite of the difficult and tense relations between mother and daughter concerning this type of disorder (Casper & Troiani, 2001; Okon, Green, & Smith, 2003; Wade, Bulik, & Kendler, 2001). This result contrasts with that of other chronic illnesses, such as cancer, arthritis or chronic pain, where the people who suffer are usually adults, and the availability of their mothers as a provider is substituted by another important figure of support, such as their partner or children (Terol et al., 2000).

Other members of the social network, such as fathers and brothers and sisters, hold an intermediate position as support providers, while neighbours, children and work colleagues or classmates were mentioned in the last position. According to the literature about this subject, the father occupies a secondary role. ED involves problems with food, which is traditionally provided and dealt with by the mother. When the first signs of ED appear in their daughters, a majority of fathers denies its existence or minimize its importance. It is the mother who tends to be the first to accept the evidence and transmits her concern to the father, who still refuses to accept it and devalues it with all types of justifications: "These are just silly ideas youngsters have", or "Just let me sit and have dinner with her, and you'll see how she eats". In the case of fathers, this type of message persists, and therefore, these patients very often consider that their fathers do not understand what is wrong with them, which makes it difficult for them to consider them as important a figure of support as their mothers (Calvo, 2002; Treasure, Gavan, Todd, & Schmidt, 2003). In the case of the neighbours, the patients stated that they did not have a close relationship with them, so it was difficult for these providers to be recognised as a source of support for them. The providers not available on the network were usually their children, since the average age of these patients is 20; the majority do not have children and those that do, have very young children (between a few months and 3 years old), and although they are an important motivation for the patients' recuperation, they did not identify them as a source of support.

Work colleagues/classmates were also recognised as infrequent support providers. These patients tend to report that their colleagues are unaware of the existence of their disorder, either because they did not want them to know about it or because in that way they avoided the possibility of it interfering with their work, and so it is difficult for patients to perceive them as a source of support. However, there are times when work colleagues have their suspicions about the patient's problem, but no comment is made either by the colleagues/classmates or the patient, creating thereby a "conspiratorial" silence, which is to a certain extent incompatible with offering help. More than 40% of these patients did not have a partner. Perhaps the characteristic behaviours of patients with these disorders, such as: refusing to go to dinners and social acts so as not to be observed and assessed, their social isolation, their corporal dissatisfaction, their low sexual appetite and their irritability makes it difficult for them to have or find a partner. With regard to the differences between anorexics and bulimics, the former refer to a greater number of real providers. Patients with bulimia reported that their personal relationships were very limited and unsatisfactory. Furthermore, they often tend to have negative social interactions and indicate that the majority of these involve conflict, for example, the relationship they have with their parents who disapprove of their conduct and use either excessive control or the contrary, show total indifference (Collings & King, 1994; Grissett & Norvell, 1992; Okon et al., 2003, Tiller et al., 1997).

The results also showed that the patients who had been suffering ED longer (course/duration), received more support from their children, their neighbours and nursing staff. In this sense, the greater the evolution of the problem, the more likely it is that patients will be older and possibly have children. They also have a closer relationship with nursing staff due to the large number of visits to the unit, which can encourage a more favourable relationship and facilitate support perception.

With respect to satisfaction with providers support, the average was high, around 4 on a 5-point scale. Satisfaction with support is determined by the quality of support given by providers and in this case the support provided by...
partners and mothers, followed by fathers and health workers is especially represented by this score. These results are similar to those found in other studies, where the importance of the family and health workers and satisfaction with the support they give stands out again (Broomfield, Humphris, Psychol, Fisher, & Vaughan, 1997; Mathieson, Logan-Smith, Macphee, & Attia, 1996; Terol, 1999). However, literature about EDs has often insisted on emphasizing the difficult relations that are established between patients and family members (Casper & Troiani, 2001; Okon et al., 2003; Wade et al., 2001). It is the family that reminds them that they are not well, that they should eat and, and who ask for medical assistance, that is to say, the ones who oppose their objectives. In spite of this, in our results, these patients are satisfied with the support they receive from their family members and perhaps this is because they recognize that these are the providers who remain, who they can turn to when they do not feel well and who they will always receive comfort from. On the other hand, in contrast to what might be expected in the literature about the subject, no differences are found between anorexics and bulimics regarding satisfaction with social support (Tiller et al., 1997). The different evaluation of satisfaction with social support could be partly responsible for this difference. While, in Tiller’s study, satisfaction with support was obtained from the difference between the real and ideal levels of support, in our study satisfaction was evaluated with respect to those who were considered real support providers, by asking the patients to what extent they were satisfied with the support they received.

In reference to the types of support, for EDs informational support is generally perceived with significantly more frequency than emotional and practical support. One possible explanation is that the informative support category used includes actions such as listening and encouragement, which along with informing and advising could represent a group of behaviours which represent what the process of giving information means. To feel that they are being listened to and to perceive that they are being encouraged seems to be closely related to information or advice variables and patients can also perceive emotional functions in them. Moreover, anorexics received more information and accompanying actions than bulimics. This result reflects concrete support behaviours for patients with anorexia, who on the one hand are adolescents, and as mentioned, the action of the mother’s accompanying them for treatment and consultation was more frequent. But added to this, since this disorder is life threatening for these patients, information acquires a special importance and causes health workers to make an effort in transmitting the seriousness of the situation and the possibilities that the patient has of getting better. In contrast to these patients, bulimics are usually older, they come to the clinic alone and their condition is perceived as less serious and threatening. But moreover, information for these patients is of particular importance for them to understand and deal with their illness. In fact, in the case of patients with ED who have a substance abuse disorder, they received more informative support. Perhaps, the situation of these patients is more evident and serious for the members of their social network and, as the results show, encourages more instrumental actions and support from providers. It is usual that due to the perception of seriousness, all resources within their means are activated.

This low perception of emotional support could also be explained by the tendency of these patients to perceive the offers of help, affection and care from friends and family as non support. The reason for this is because on occasions they consider these support providers as their “enemies” in their crusade towards becoming thin. Furthermore, since support is perceived, it cannot reflect the reality of the support provided, because self-esteem reduces the perception of support. However, we would like to highlight the fact that these patients do not perceive it and acknowledge the lack of it. This is like a vicious circle that has no reason to coincide with real objective measures, where low self-esteem diminishes the perception of support and this lack of perceived support diminishes self-esteem. With respect to the relation between self-concept and social support dimensions, it was family self-concept that showed significant positive relations. In our study, this self-concept was evaluated precisely by being “more or less criticised at home”, “feeling more or less happy at home”, “loved by parents”, “parents would help with any type of problem” and “being able to confide in them”. Out of our providers, the family, (mother, father, brothers, sisters) were who they considered as support providers and they were satisfied with this support, be it to make them feel happy at home, to help them with any type of problem to be able to confide in the family and to make them feel loved and not criticized. From this point of view, we can observe how family members and providers in general not only favour adjustment in situations where help is necessary, but they also constitute a context for interaction with profound implications on the development of self-concept itself. Furthermore, this development of family self-concept can condition the attitude towards the search for help and the receipt of help, creating a completely interdependent binomial support/self-concept. So, family interaction characterized by the presence of support permits promoting this self-concept which in turn conditions the attitude of people towards family relationships which involve the perception and reception of help (Herrero, 1996).

All these results should be interpreted taking into consideration the limitations that our study presents. Regarding the design of this investigation, it should be pointed out that it is a transversal study, which does not permit establishing precise conclusions about the temporal sequence of events. Therefore, future research is recommended using longitudinal designs which permit determining whether the characteristics that these patients
present with regard to the variables studied preceded the illness or are consequences of the illness itself. As far as the sample is concerned, and in the context of diagnosis, a high percentage of these patients were anorexic (60%), therefore, when we talk about our study of the “group of patients with ED”, we should consider that not all the diagnoses are equally represented, although it is representative of the percentage of anorexics and bulimics who are treated at special units. Another aspect to be taken into account is the age of these patients, since approximately 70% were under 23 years old. This can influence the bias effect of the analysis with respect to the source, since in these age ranges children, partners and perhaps neighbours and friends all lose importance, in contrast particularly to the mother and to a lesser extent the father. Furthermore, in order to assess the differences between the different dimensions of social support, in future studies it would be interesting to have a control group to contrast with women with ED.

However, based on these results it is possible to propose that any therapy aimed at treating ED should include strategy training which would allow these patients to broaden their support networks and relations, encouraging the possibility of a greater number of support behaviours from sources other than the family. In this way, treatments which include training in communication skills, problem solving and coping skills which help these patients improve their day to day life, increase self-efficacy, reduce family conflicts, and improve the quality of their relations, could help them to have a more receptive attitude regarding help offered by others. Here, health workers have a very decisive role, helping them to generate both as the recipient and giver, to have realistic expectations about what is going to happen in the different phases of coping with the problem, in order not to see the usual and normal difficulties of the process as failures. Likewise, health workers can help both the person who gives support, by showing him what type of help would be most useful in each case, and the recipient by helping him to maintain more social relations so as not to one person alone (Barrón, 1996).

References


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