

Family relations as perceived by parents of females suffering from anorexia nervosa – Part I

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Summary

The article presents the results of research upon the assessment of family relations on the part of the parents of girls suffering from anorexia nervosa.

Key words: anorexia nervosa, family relations

Introduction

The research on the aetiology of anorexia nervosa reflects the widespread use of the multifactorial model in the development of the disorder. Family influences, besides those of a socio-cultural, individual and biological perspective, are perceived as the predisposing factors that trigger as well as perpetuate the process of the disease [1]. Two tendencies appear within the research on significance of family factors. The first, based chiefly upon clinical experience, attempts to formulate comprehensive models, describing its own patterns of the relations within a family towards a patient suffering from anorexia and her place within the family system [2, 3, 4, 5]. The second, basing itself upon psychometric research and the analysis of demographic data, concentrates rather upon the family's selected characteristics and levels of functioning [6]. Both of these tendencies are mutually complementary. The concepts that arise upon their basis are often the source for further research inspiration.

There exists within the literature a series of data indicating the importance of varied aspects of the functioning for families of anorexic patients. On the basis of research conducted by Leung and associates [7] it is determined that the risk of falling ill with anorexia nervosa is connected with, on the one hand, dysfunctional family models which have a direct influence, among other things, upon the formulation of a sense of lower self esteem amongst anorexic patients. In another sense, there is also a connec-

tion with the excessive significance placed by members of the family on appearance and body weight of the individual suffering from an eating disorder. Glendinning and Phillips [8] have drawn attention to the fact that the low sense of self esteem observed among those suffering from anorexia results in them being, to a great extent affected by the influence of their peers and families.

Other authors have pointed to the strong mechanisms of triangulation as well as the disturbance of the process of separation / individuation occurring in families with eating disorders. Connected with this is the development and maintenance of psychopathological symptoms. They also emphasise the strong mechanisms of bonding and the importance of specific family delegations as well as social expectations [2, 3, 4, 5, 9]. An important area of the research conducted is the problem of patient self control and their sense of having an influence upon the family system. The results of research to date do not enable one to unequivocally define their role within the generation and course of anorexia nervosa [10].

There is relatively little research in the literature on the subject which covers all members of the family and which takes into consideration the perspective of each individual in a family. This results equally from methodological problems as it does from organisational difficulties connected with such a research project.

The aim of the article is to present past research results* pertaining the image of family relations via the parent's eye of girls suffering from anorexia nervosa.

Sample

Data was collected from patients who had been diagnosed as having anorexia nervosa in accordance with the ICD-10 criteria, as well as their families treated in the Outpatient Family Therapy Unit of the Department of Child and Adolescent Psychiatry of Collegium Medicum of the Jagiellonian University in Cracow and at the Department of Child and Adolescent Psychiatry of the Institute of Psychiatry and Neurology in Warsaw. The control group consisted of families which did not have a single member suffering from psychiatric disorders and where no one had been treated psychiatrically. The selection was random, from an area limited to the regions of Cracow and Warsaw. Subsequently another selection was undertaken to pair individuals not treated with particular patients of the same sex and the same age, from families situated in the same phase of development and possessing the same (or approximately the same) number of children. Details are presented in the tables 1 and 2.

27 subjects from the clinical group had completed secondary education, 24 higher, with 12 primary, in the comparative group 25, 39 and 19 respectively.

* The researches were undertaken in the frame of the KBN research project KBN 4 PO5B 093 13. The head of the project: Professor I. Namysłowska, MD.

Table 1

Characteristic of family's members

	Clinical group		Control group	
	N	Average Age	N	Average Age
Mothers	31	44.2	42	44.9
Fathers	32	47.1	41	47.4
Daughters	37	17.3	41	17.3

Table 2

A number of children in families

	Clinical group	Control group
One child	3	11
Two children	17	21
Three children	9	7
Four children or more	3	3

Measure

KOR Questionnaires were used in the research. These constituted an adaptation for Polish circumstances of the FAM III Questionnaire. A more detailed presentation of the research instruments employed may be found in the publications of Beauvalle et al. [11] and Namysłowska et al. [12]. These questionnaires are instruments that allow for a varied description of the family system where family relations are formulated in three perspectives:

- in the Questionnaire of Dyadic Relations the members of the family describe their relations with other individuals in the family;
- the family as a whole;
- in the Questionnaire of Self-Evaluation the members of the family describe how they evaluate their place in the family.

The KOR Questionnaire related to 7 measures such as: Task Accomplishment (TA), Role Performance (RP), Communication (COM), Affective Expression (AE), Affective Involvement (AI), Control (C) and Values and Norms (VN). They are briefly described below.

The measure of task accomplishment (TA) is culturally and socially conditioned, and partly determined by the norms and values characteristic for a given family. Correct task accomplishment allows a family to achieve biological, psychological and social aims. The authors of the model divided these aims into basic items concerning daily functioning (eating, shelter, health), development, guaranteeing the development of the members of the family in accordance with the phases of the cycle of their life as well as so-called crisis aims enabling a family to overcome crises. The authors treat this ability on the part of the family to adapt to stresses and to avoid them as the primary indicator of the health of a family.

The Role performance (RP) is essential for the normal task achievement. The Family roles are socially ascribed, reinforcing behaviour, demanding the cooperation of members of the family in various activities. The authors of the model divide them into the traditional and the idiosyncratic. The traditional, specific to each family, such as the role of the father, mother, child are in part socially defined, but the family must also reach its own definition, one that is the most effective for it as a whole. These roles are significant for the accomplishment of family tasks, while the idiosyncratic roles are an expression of family and/or individual pathology. An example of the idiosyncratic role could be the role of the patient, which has, for example, to ensure family cohesion and to protect it from disintegration.

Communication (COM) and affective expression (AE) are measures guaranteeing a family the realisation of basic tasks and the division of roles. Communication in this model represents the means of information exchange between family members. Its aim is the achievement of mutual understanding. Such communication may concern the expression of emotions (emotional communication) and the carrying out of everyday tasks (instrumental). The more dysfunctional the family system, the more disturbed the emotional communication. The Affective involvement (AI) relates to the degree and quality of mutual interest and how one cares about him/herself.

Control (C) may be performed in a family in an inflexible, an elastic way, it may have a 'laissez faire' or chaotic character. This division concerns differences in the range of expectation of style of functioning and of constructiveness and responsibility. Optimally, the control of a family should strengthen the durability of a certain style of functioning by the methods of upbringing, as well as, the attitude towards emotional support, and equally the sense of individual responsibility.

The Family values and norms (VN) influence all aspects of functioning within a family, and constitute the sum of what a family accepts and does not accept. They can be in accordance with, or to various degrees, not in accordance with, the values and norms of the social system within which a family functions.

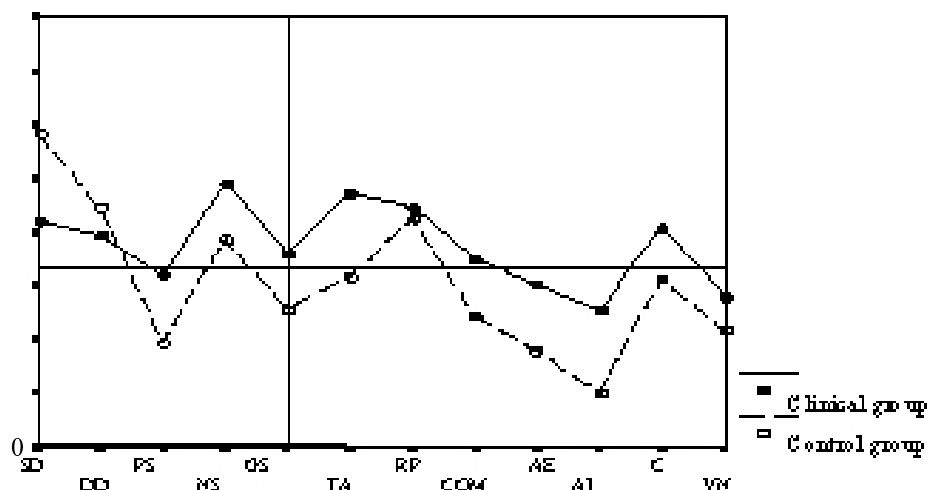
In addition to the clinical scales a Social Desirability scale (SD), and Denial-Defensiveness scale (DD) are embedded in the General Scale (GS). As a result of the procedure of normalisation and causal analysis an additional two causal scales are introduced besides the original scales: the Scale of Positive Statements (PS) and Negative Statements (NS).

There are equally introduced in the concept of criteria, upon the basis of statistical analyses measuring the state of the desired functioning of a family corresponding to results worse than the arithmetic average by 1 standard deviation within 557 normal families tested. Our results evaluated above by the criteria indicate a horizontal line on graphs, and represent in reality extremely unfavourable results of family relations (diverging from those desired) while the results below are more favourable evaluations of family relations (close to a desired state).

Results

The data was calculated upon the means of statistical methods and is presented in the following tables and graphs. It is subjected to a quantitative and qualitative analysis. The t-test was employed for independent groups in the evaluation of the significance in differences between groups.

1. The Evaluation of the family as a whole



Graph 1. The evaluation of the family conducted by the mother

The questionnaire scales:

- SD - Social Desirability
- DD - Denial-Defensiveness
- PS - Positive Statements
- NS - Negative Statements
- GS - General Scale
- TA - Task Accomplishment
- RP - Role Performance
- COM - Communication
- AE - Affective Expression
- AI - Affective Involvement
- C - Control
- VN - Values and Norms

Table 3

The evaluation of the family conducted by the mother

Scales	Clinical group M	Control group M	p
Social Desirability	1.266	1.748	**
Denial-Defensiveness	1.182	1.341	**
Negative Statements	1.471 [↑]	1.160 [↑]	**
General Scale	1.075	0.766 [↓]	**
Task Accomplishment	1.471 [↑]	0.942	**
Communication	1.042	0.727 [↓]	**
Affective Expression	0.905	0.535 [↓]	**
Affective Involvement	0.756 [↓]	0.296 [↓]	**
Control	1.220 [↑]	0.936	*
Values and Norms	0.633 [↓]	0.645 [↓]	*

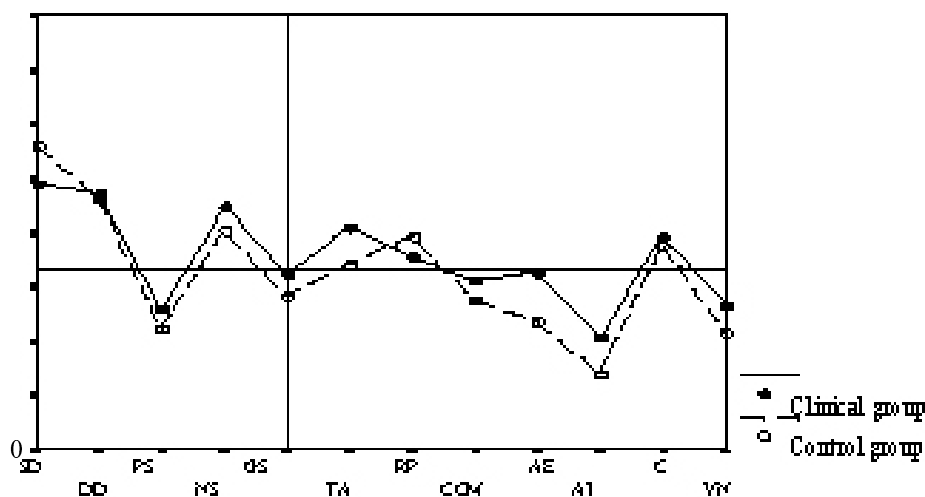
* $p_i < 0.05$; ** $p_i < 0.01$; p_i for the directional test;

[↑] the average deviates **upwards** from the criterial value equal to 1, statistically significant at the level of 0.05

[↓] the average deviates **downwards** from the criterial value equal to 1, statistically significant at

The clinical group and the control group differ in a statistically significant way on all scales with the exception of the scale in role performance and the scale of positive statements. Mothers of anorexic patients do, on the whole, evaluate their family worse than do mothers of girls from the control group. On 8 scales mothers from the control group evaluate family more positively than mothers of anorexic patients who on 3 scales evaluate their family as dissatisfactory, in five at the level of the accepted criteria, while in the remaining two above the accepted criteria.

Fathers from both groups generally evaluate family in a similar way, i.e. on the



Graph 2. The evaluation of the family conducted by the father

The evaluation of the family conducted by the father

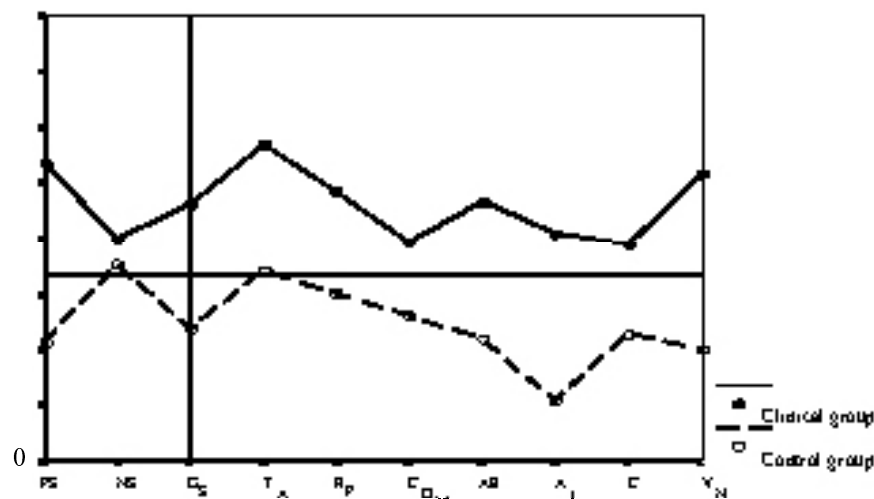
Table 4

Scales	Clinical group M	Control group M	P
Affective Expression	0.986	0.708↓	**

level of the accepted criteria. Our groups differ statistically in a noticeable way only for results obtained within the scale of Affective Expression. Fathers from the control group positively evaluate emotionality, bonds in the family, fathers of the anorexic patients evaluate this measure at the level of accepted criteria.

2. The Evaluation of marriage relationship

Parents of anorexic patients describe their spouses significantly worse than do par-



Graph 3. The evaluation of the marriage relationship conducted by the mother

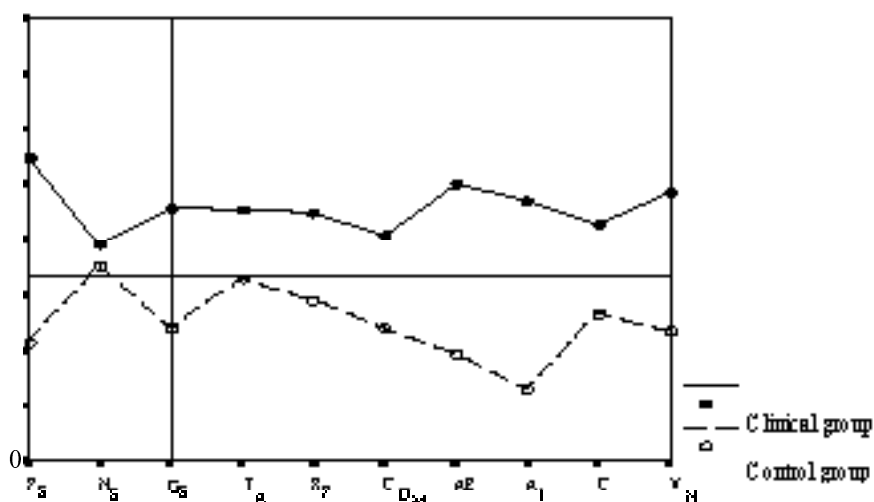
Table 5

The evaluation of the marriage relationship conducted by the mother

Scales	Clinical group M	Control group M	p
Relative Statements	1.012 [↑]	0.840 [↓]	**
General Scale	1.322 [↑]	0.710 [↓]	**
Task Accomplishment	1.710 [↑]	1.024	**
Role Performance	1.400 [↑]	0.289	**
Communication	1.125 [↑]	0.720 [↓]	*
Affective Expression	1.403 [↑]	0.855 [↓]	**
Affective Involvement	1.234 [↑]	0.327 [↓]	**
Control	1.100	0.824 [↓]	**
Values and Norms	1.550 [↑]	0.801 [↓]	**

ents from the control group. Both mothers and fathers from the clinical group evaluated themselves in 9 out of ten scales mutually negatively in comparison with parents from the control group where a reverse dependence was observed i.e. mothers of healthy girls perceived their husbands positively in 7 scales and fathers also perceived their wives positively in 7 scales. In the remaining scales results do not differ from the criteria. Statistically significant differences concern all the scales with the exception of the scale of negative statements.

As far as comparison within the sphere of the clinical group is concerned, mothers



Graph 4. The evaluation of the marriage relationship conducted by the father

Table 6

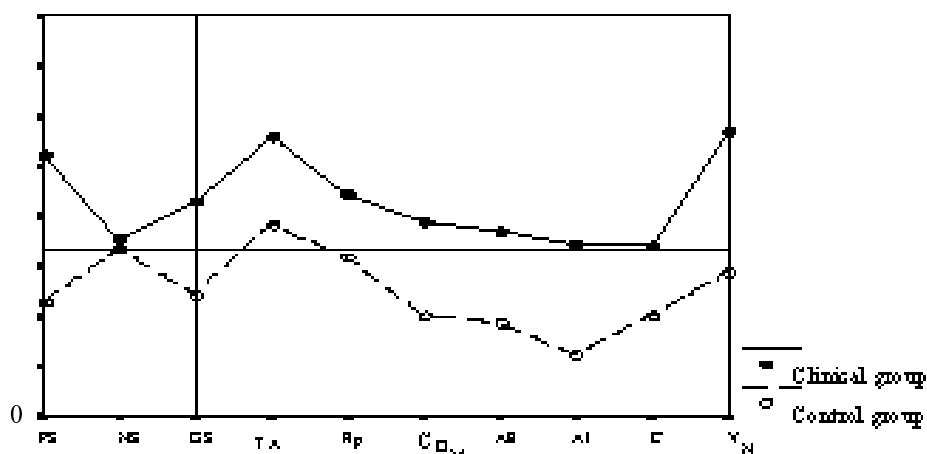
The evaluation of the marriage relationship conducted by the father

Scales	Clinical group M	Control group M	p
Positive Statements	1.090 ^T	0.644 ^J	**
General Scale	1.374 ^T	0.721 ^J	**
Task Accomplishment	1.367 ^T	0.633	**
Role Performance	1.351 ^T	0.872	**
Communication	1.227	0.710 ^J	**
Affective Expression	1.503 ^T	0.530 ^J	**
Affective Involvement	1.414 ^T	0.300 ^J	**
Control	1.230 ^T	0.700 ^J	**
Values and Norms	1.461 ^T	0.701 ^J	**

evaluate communication with their husbands as worse than their husbands with them (fathers of anorexic patients evaluate communication with their wives as being at the level of the accepted criteria). In the control scale, in a similar way, fathers evaluate their wives better than their wives value them.

3. The evaluation of the relationship between parents and children conducted by parents

Generally parents of anorexic patients describe their child in a significantly worse

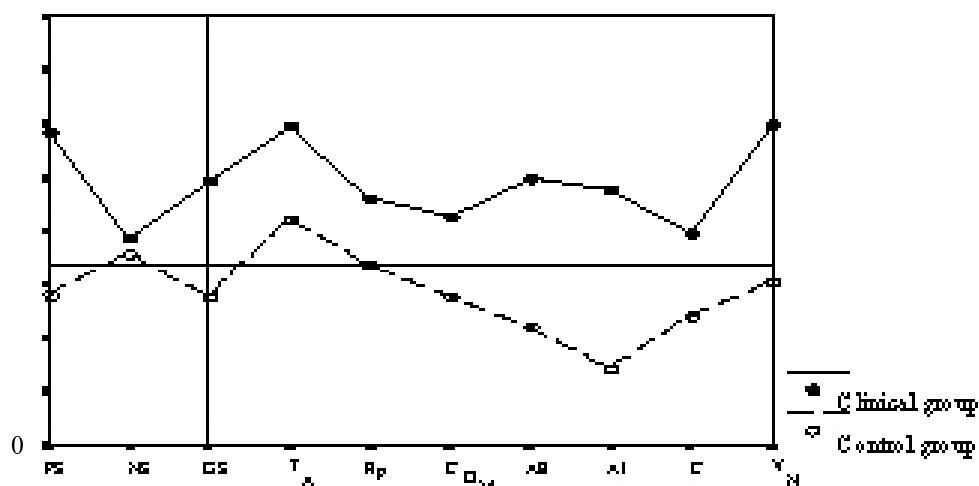


Graph 5. The evaluation of the relationship between parents and children conducted by the mother

Table 7

The evaluation of the relationship between parents and children conducted by the mother

Scales	Clinical group M	Control group M	p
Positive Statements	1.573 ^T	0.820 ^J	**
General Scale	1.204 ^T	0.727 ^J	**
Task Accomplishment	1.078 ^T	1.155 ^J	**
Role Performance	1.335 ^T	0.953	**
Communication	1.108	0.801 ^J	**
Affective Expression	1.110	0.557 ^J	**
Affective Involvement	1.034	0.305 ^J	**
Control	1.027	0.801 ^J	**
Values and Norms	1.700 ^T	0.252 ^J	**



Graph 6. The evaluation of the relationship between parents and children conducted by the father

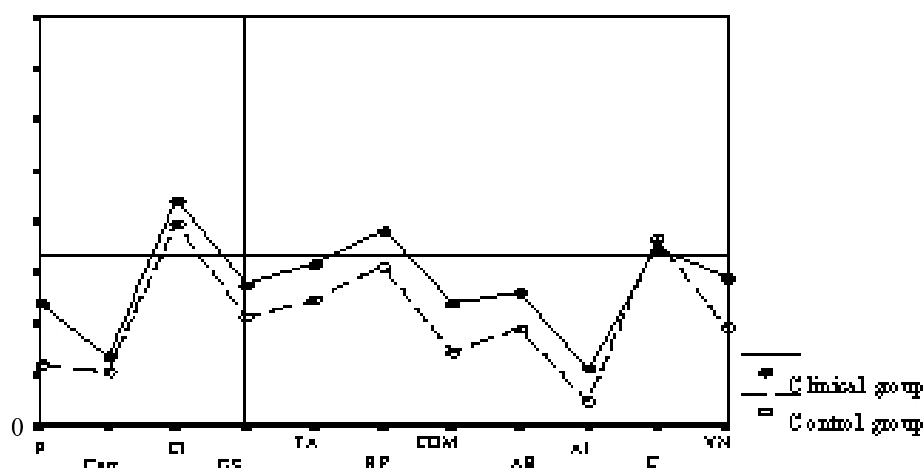
The evaluation of the relationship between parents and children conducted by the father

Table 8

Scales	Clinical group M	Control group M	P
Positive Statements	1.752↑	0.232↓	**
General Scale	1.424↑	0.231↓	**
Task Accomplishment	1.722↑	1.270↓	**
Role Performance	1.322↑	1.010	**
Communication	1.224↑	0.227↓	**
Affective Expression	1.400↑	0.157↓	**
Affective Involvement	1.430↑	0.425↓	**
Control	1.103	0.710↓	**
Values and Norms	1.705↑	0.007	**

manner than parents of a healthy child. In particular, fathers of anorexic patients formulate a significant amount of negative evaluations. Mothers of anorexic patients evaluate their child negatively in five scales, with the remaining 4 being at the level of the criteria. Fathers of anorexic patients evaluated them negatively in eight scales, and in 1 at the level of the criteria. Mothers of healthy children evaluated their child positively in 8 of the scales, with 1 at the level of the criteria, while fathers – in 7 positively and 2 at the level of the criteria. In the control group there was no variation in a negative direction noted in any of the measures.

4. The evaluation of one's own functioning in the family



Graph 7. The evaluation of one's own functioning in the family conducted by the mother

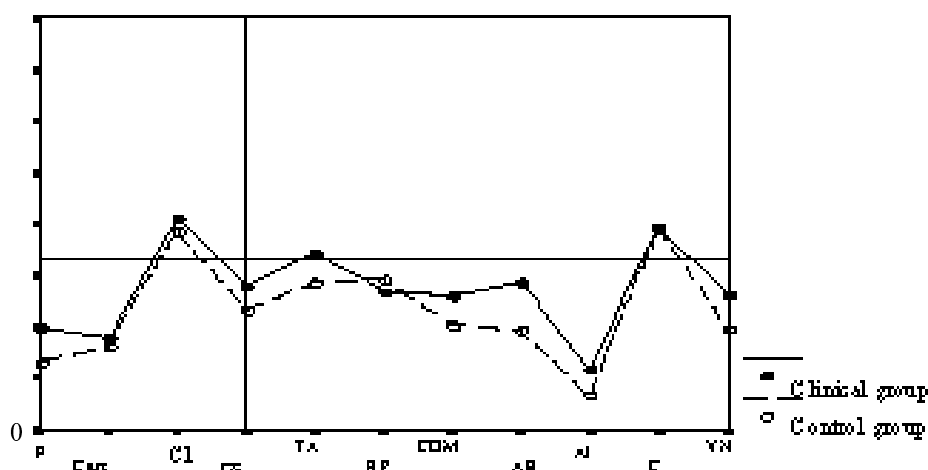
Table 9

The evaluation of one's own functioning in the family conducted by the mother

Scales	Clinical group M	Control group M	P
Friendliness	0.717↓	0.360↓	**
General	0.825↓	0.640↓	*
Task Accomplishment	0.943	0.733↓	*
Communication	0.716↓	0.430↓	**
Affective Involvement	0.335↓	0.145↓	*
Values and Norms	0.856	0.576↓	**

Mothers from both investigated groups evaluate themselves generally positively, though the evaluation of mothers from the control group is better than that from mothers of patients suffering from anorexia. The difference between the results is of statistical importance in 6 scales.

Generally the self-evaluation of fathers of patients with anorexia and fathers of the



Graph 8. The evaluation of one's own functioning in the family conducted by the father

Table 10

The evaluation of one's own functioning in the family conducted by the father

Scales	Clinical group M	Control group M	P
Friendliness	0.596↓	0.396↓	*
Affective Involvement	0.857	0.577↓	*
Values and Norms	0.799↓	0.583↓	*

girls from the control group is pleasing, with the results from the two groups being similar. Significant statistical differences concern three scales, where fathers from the control group formulate a more pleasing self-evaluation than those from the clinical group.

Discussion

Our results indicate many statistically significant differences that appear within the groups surveyed. The greatest difference was observed in the evaluation of family relations pertaining to dyadic relations. This relates equally to the mutual evaluation of parents, as well as their relations with their children. Our results point to the dissatisfaction amongst parents of anorexic patients with their marital relationship, incompatibility of roles, an incoherent value system and a critical evaluation of the way in which spouses fulfil family tasks. These results primarily illustrate, a lack of flexibility and difficulties in the processing of joint solutions. They equally point to an

insufficient manifestation of feelings, a lack of empathy, or emotional involvement, and also to a sense of the loss of autonomy. In contrast to parents of anorexic patients, parents of healthy children evaluate their mutual marital relationship as pleasing. Our results confirm the information provided by researchers who point to the weakness of the marital subsystem in anorexic families, particularly to difficulties in resolving problem and crisis situations, as well as the achievement of autonomy on the part of individual members of family [2, 3, 4].

As far as an evaluation of relations with children, parents of anorexic patients also express many critical evaluations. In contrast to these relationships, parents from the control group evaluated their relations with their child, in all areas researched, as pleasing. Worthy of particular note is an extremely critical evaluation of children in the family, including patients, expressed by the fathers. An explanation for this phenomenon would clearly require extensive research. A hypothesis may be formulated whether it is an expression of jealousy (or rejection) of the mother's links with children, the inclusion of children in marital conflicts, or whether it is the inadequateness of father's evaluation. Their excessive demands, also do not point to the specific difficulties of coping with the stage of adolescent children.

A clear difference between the groups examined is apparent in these family evaluations. This relates to the image of family as presented by the mother. The clinical and control groups of fathers are close to each other in their view of the family, with the exception of results from the emotionality scale. The negative evaluation of emotionality within the family made by fathers of anorexic patients indicates that they consider the spectrum of feelings expressed in the family to be narrow, insufficient and inadequate. Mothers of anorexic patients in perceiving that their families had difficulties with processing of solutions, display a tendency to react to the crisis even under the influence of small problems. They equally evaluate in a critical manner the division of influences within the family and the means of exerting control which expresses itself in difficulties in fulfilling tasks of everyday life. It is interesting that the mothers from both groups poorly evaluate the way in which the various members fulfil their roles in the family. One may speculate that this result conveys family difficulties connected with the phase of the cycle of family life – the period of adolescence or also that it expresses in general the problems of the contemporary Polish family manifesting itself particularly in this area.

The most positive evaluations concern self-evaluations against the backcloth of family. Mothers and fathers from both groups generally view themselves positively, although a greater number of positive evaluations are formulated by parents from the control group.

The arrangement of all our data presents a coherent image of family relations in the control group – this is generally a positive image, with a note of the areas of difficulty. We are dealing in the case of the clinical group with a clear differentiation in view and the evaluation of oneself and the remaining members of the family.

Perception of oneself is to a greater degree positive, while, however, the evaluation of one's partner, children or family as a whole is viewed more negatively. This could possibly be a source of difficulties, and shows a tendency to pass over respon-

sibility, or mutual accusations, and to locate a problem not in relations but in individuals.

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