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Perception of autonomy and intimacy in families of origin of parents of patients with eating disorders, of parents of depressed patients and of parents of healthy controls. A Transgenerational perspective – Part II

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Summary

Aim. The aim of the study was to describe the dimensions of family autonomy and intimacy in families of parents of patients with eating disorders and depression in comparison with parents of healthy controls.
Method. We used the autonomy and intimacy scales of the Family of Origin Scale (FOS) to compare parents of 112 females having different types of eating disorders with parents of 40 depressed females and 85 schoolgirls in the Polish cultural context.
Results. Mothers of bulimic girls had poorer results on both FOS major scales as compared to schoolgirls' mothers. Mothers of anorexia nervosa binge/purge type patients had poorer results on three autonomy and two intimacy subscales as compared to schoolgirls' mothers. Fathers of restrictive anorexia patients had poorer results on both FOS major scales as compared to schoolgirls' fathers. Fathers of bulimic patients scored worse on general autonomy and its two subscales than schoolgirls' fathers, and fathers of depressed girls had poorer scores on two subscales as compared to schoolgirls' fathers.
Conclusions. Thus, parents of eating disorder patients had significant difficulties in autonomous functioning and intimacy as compared to parents of healthy females and of depressed females, respectively.

eating disorders / autonomy / intimacy in parents' families of origin

INTRODUCTION

Most clinical models that emphasise autonomy in the development of anorexia and bulimia nervosa suggest disturbances in the separation/individualisation process and difficulties in maintaining relationships based on empathy and intimacy in both the patient's family and preceding generations [1, 2, 3, 4, 5, 6, 7, 8, 9]. As suggested by Humphrey [7], family-wide and multigenerational environment failures are evident in clinical experiences with anorexic and bulimic families. These families attempt to overcome transgenerational difficulties that lead to developmental problems.

Various elements of transgenerational patterns that hinder development of autonomy and intimacy are often brought up when discussing eating disorders. For example, Weber and Stierlin [8] emphasised strong bonding mechanisms in families of anorexic and bulimic patients, suggesting that mourning, justice, and sacrifice are

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important elements of family dynamics. Laura Humphrey [7] suggested that parents of anorexic and bulimic patients failed to separate from their parents themselves, therefore they constantly strive to accomplish this developmental task. Unfinished separation means that the parents are not ready to support the separation process in their children. They perceive manifestations of their children's autonomy as a threat to their own stability and the functioning of the family. Humphrey [7] claimed that intergenerational experiences make it difficult to create a holding environment that is not deficient of nurturance, soothing, tension regulation, empathy, and affirmation of separate identities. As a consequence, family processes of co-individualisation and co-evolution are distorted. Humphrey [7] suggested that the family capacity to empathise with the need for separation is the most demanding part of the family holding environment, which if completed, enhances the family structure and relationships.

Previously outlined theoretical models derived from intergenerational clinical experience in families of bulimic and anorexic patients were not sufficiently verified. Thus, the present study evaluates a family system involving three generations. The aim of our present study was to describe the dimensions of family autonomy and intimacy in the Polish cultural context in families of origin of patients with eating disorders (part I) and the families of their parents (part II). The current article (part II) describes results obtained from the mothers and fathers of eating disorder patients in comparison with those of depressed and healthy females. We hypothesised that families of parents of patients with eating disorders would be characterised by autonomy and intimacy distortions as compared to families of parents of healthy females and patients with diagnosed depression.

METHODS

Sample

Participants in the study were parents of adolescent girls being seen at the Department of Child and Adolescent Psychiatry, the Jagiellonian University, Medical College in Kraków[1], for first-time diagnosis of eating disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM IV; 1994). Parents were classified into appropriate study groups based on their daughters' eating disorder diagnosis: anorexia nervosa restrictive type (ANRp); anorexia nervosa binge/purge type (ANBPp); bulimia nervosa (BULp).

Parents of patients with eating disorders were compared to two control groups: 1) parents of females diagnosed with depression (DEPp) including diagnoses of depressive episode, dysthymia, and adjustment disorder with depressed mood as determined by DSM-IV (1994), and 2) parents of normal age-matched female pupils from Kraków schools (NORp). Selection rules for the clinical groups and family structures are discussed in part I of the article.

Data obtained from mothers and fathers of patients with eating disorders, depression, and normal females from Kraków schools were subjected to statistical analysis. The sample size of mothers and fathers per group is presented in Tab 1.

Table 1. Sample size per group

Studied persons	NORp	ANRp	ANBPp	BULp	DEPp
Mothers	85	53	21	34	37
Fathers	81	49	19	31	37

Measures

The Family of Origin Scale (FOS) was used to study autonomy and intimacy in the families of the patients' parents. This instrument [10] uses family relationship intergenerational models. The FOS was standardised for Polish conditions by Fajkowska-Stanik [11]. Polish values for the particular scales were similar to results obtained by the authors of the scale. High indicators for accuracy (W=0.88; Cronbach's alpha=0.82) and reliability (Spearman-Brown prediction formula=0.92; Guttman's coefficient=0.92) were also obtained for the FOS.

Statistical Analysis

The statistical analysis was completed using the Statistical Package for the Social Sciences (SPSS 14.0.PL; Chicago, IL, USA). Analyses were

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completed using analysis of variance, Ryan-Einot-Gabriel-Welsch post-hoc F tests (F REGW), and chi-square tests for categorical variables.

RESULTS

Differences between groups

There was no statistically significant difference in age, education, or number of children in the family between parents from all groups. Statistically, BUL females were more likely to be from single-parent families compared with the other groups ($chi^2(8)=17.81$, P=0.023).

Autonomy and intimacy in families of origin of mothers

There was a statistically significant difference between BULp and NORp mothers in regards to the general autonomy scale and its four subscales (Tab. 2 – *next page*) and the general intimacy scale and its four subscales (Tab. 3 – *next page*). This suggests autonomy and intimacy distortions among the families of the mothers of bulimic patients. ANBPp mothers had poorer results as compared to NORp females on three autonomy subscales and two intimacy subscales (Tab. 2 and 3). However, there was no significant difference between ANBPp mothers and NORp mothers on general autonomy and intimacy scales (Tab. 2 and 3). Apart from one responsibility scale, where DEPp and NORp mothers statistically differed, there were no significant differences between the remaining clinical groups and the NORp group (Tab. 2 and 3).

Autonomy and intimacy in families of origin of fathers

ANRp fathers had poorer results on the general autonomy scale and its three subscales (Tab. 4 – *next page*) and on the general intimacy scale and its three subscales (Tab. 5 *next page*)) as compared to NORp fathers. This suggests autonomy and intimacy distortions in the families of the fathers of patients with anorexia nervosa restrictive type. Furthermore, BULp fathers scored statistically worse than NORp fathers on the general autonomy scale and its two subscales. By contrast, DEPp fathers had poorer scores on the openness to others and problem-solving subscales as compared to NORp fathers. Due to the relatively low number of ANBPp fathers, the statistical significance of any differences with other groups could not be determined. Finally, as was the case for the daughters (Part I), there were no statistically significant differences on the acceptance of separation scale between any group of mothers and fathers or between the clinical groups and the control group.

DISCUSSION

Parents' results

The results of the current study suggest a distortion in the processes of autonomy and intimacy in the families of mothers of bulimic patients. These results are in agreement with attachment patterns observed for families of patients and their parents by Tereno et al. [12]. A fear-avoidance attachment pattern was seen more often in mothers of bulimic patients as compared to the control group, implying autonomy and intimacy disturbances. The results also suggest certain difficulties in the families of mothers of patients with anorexia nervosa binge/purge type such as the inability to take responsibility for decisions, lack of respect for the opinions of other family members, lack of openness in mutual relationships, a limited spectrum of feelings expressed in the family, and an inability to solve conflicts.

Results obtained for mothers of patients with restrictive anorexia and depression did not differ statistically from results from mothers of healthy females. The hypothesis that autonomy and intimacy disturbances occur in families of mothers of patients with restrictive anorexia and depression was not confirmed, with the exception of difficulties in taking responsibility in the DEPp group. This suggests that autonomy and intimacy disturbances are specific to mothers of patients with bulimic symptoms.

Autonomy and intimacy distortions were reported in the families of fathers of patients with restrictive anorexia, whereas only autonomy distortions were reported in the families of fathers of bulimic patients. Small difficulties involving

Table 2. Autonomy: Differences among mothers

	Mean					Standard deviation					F	P	Inter-group diff.
	ORp	ANRp	ANBp	BULp	DEPp	NORp	ANRp	ANBp	ULp	DEPp			
Autonomy	73.2	68.7	65.8	64.2	68.7	14.4	14.2	1.8	13.2	13.5	3.1	0.02	BULp/NORp
Clarity of expression	14.8	13.6	13.1	12.7	14.2	3.6	3.2	3.0	3.8	3.4	2.6	0.04	BULp/NORp
Responsibility	14.3	13.2	12.7	12.2	12.8	3.2	2.6	2.4	3.1	3.7	3.5	0.01	BULp/NORp ANBPp/NORp DEPp/NORp
Respect for others	14.3	12.8	12.1	11.8	12.8	4.0	4.2	3.8	3.5	3.8	3.0	0.02	BULp/NORp, ANBPp/NORp
Openness to others	14.4	13.5	12.7	12.6	13.5	2.5	2.7	3.0	2.7	3.1	3.5	0.01	BULp/NORp ANBPp/NORp
Acceptance of separation and loss	15.6	15.4	15.3	15.1	15.3	3.6	3.7	4.1	3.4	3.8	0.2	0.96	

Table 3. Intimacy: Differences among mothers

	Mean					Standard deviation					F	P	Inter-group diff.
	ORp	ANRp	ANBp	BULp	DEPp	NORp	ANRp	ANBp	ULp	DEPp			
Intimacy	75.5	70.2	67.6	64.7	70.0	16.2	14.8	14.6	16.7	16.0	3.2	0.01	BULp/NORp
Range of feelings	15.2	13.9	13.0	13.5	14.4	3.8	4.0	3.4	3.6	3.7	2.5	0.04	ANBPp/NORp
Mood and tone	16.0	15.6	14.6	13.5	14.7	3.8	3.5	3.7	4.4	4.2	2.8	0.03	BULp/NORp
Conflict resolution	14.6	13.1	12.4	12.6	13.3	3.7	2.9	3.2	3.5	3.7	3.1	0.02	ANBPp/NORp BULp/NORp
Empathy	14.9	13.6	13.0	12.8	14.0	3.6	3.8	3.1	4.1	3.3	2.5	0.04	BULp/NORp
Trust	14.9	14.0	14.4	12.6	13.6	3.1	3.4	3.2	3.1	3.3	3.0	0.02	BULp/NORp

low levels of openness with others and problem solving were evident among fathers of females with depression. The current study supports the idea that significant differences in autonomy and intimacy occur in the families of parents of patients with eating disorders as compared to families of parents of healthy and depressed females. In both anorexic groups, autonomy and intimacy disturbances were identified in families of just one of the two parents, whereas in the families of bulimic patients' parents, both parents reported autonomy disorders and mothers reported intimacy disorders.

In general our results agree with clinical models, but the results for mothers of patients with restrictive anorexia are surprising. Work by Ward et al. [13], who evaluated transgenerational patterns of attachment, revealed difficulties in the attachment process in families of patients with anorexia nervosa. This research, carried out using Attachment Interviews, showed that just like their daughters, mothers of patients with anorexia were characterised by an insecure dismissive attachment style corresponding to autonomy and intimacy disturbances. Dismissive attitude of mothers represented by avoiding confrontation with potentially painful emotional matters mirrors their daughters' denial of hunger. The authors state that such dismissive behaviour limits a mother's responsiveness to emotional needs of a baby, especially if they trigger negative feelings, and hence some of the moth-

Table 4. Autonomy: Differences among fathers

	Mean					SD					F	P	Inter-group diff.
	NORp	ANRp	(AB)	BULp	DEPp	NORp	ANRp	(AB)	BULp	DEPp			
Autonomy	74.1	67.7	70.8	67.9	68.3	11.3	1.4	12.7	11.8	12.3	3.0	0.02	ANRp/NORp BULp/NORp
Clarity of expression	14.7	13.9	13.9	13.9	14.0	2.9	2.6	3.9	3.0	3.4	0.8	0.52	
Responsibility	14.7	12.9	13.7	12.7	13.1	2.7	2.7	2.9	3.3	2.7	4.3	< 0.01	BULp/NORp ANRp/NORp
Respect for others	14.6	12.6	13.2	13.0	13.2	3.1	3.4	3.6	2.8	3.3	3.2	0.02	ANRp/NORp
Openness to others	14.7	12.9	14.5	13.0	12.8	2.2	2.1	2.5	2.7	2.8	6.1	< 0.01	DEPp/NORp ANRp/NORp BULp/NORp
Acceptance of separation and loss	15.3	15.5	15.5	15.1	15.1	3.1	2.5	2.9	3.3	3.4	0.1	0.98	

Table 5. Intimacy: Differences among fathers

	Mean					SD					F	P	Inter-group diff.
	NORp	NRp	(AB)	ULp	EPp	ORp	ANRp	(AB)	ULp	EPp			
Intimacy	77.2	69.0	72.5	70.7	72.2	11.3	12.6	15.2	12.2	12.4	3.5	0.01	ANRp/NORp
Range of feelings	15.6	14.2	14.5	14.4	14.8	2.9	3.0	3.0	2.9	2.7	1.9	0.12	
Mood and tone	16.5	14.7	14.9	15.1	15.4	2.6	3.5	4.0	2.8	3.1	2.8	0.03	ANRp/NORp
Conflict resolution	15.1	12.9	13.6	13.6	13.5	2.6	3.3	3.6	2.4	3.0	4.3	< 0.01	ANRp/NORp DEPp/NORp
Empathy	15.1	13.6	14.7	14.1	14.3	2.9	2.8	4.0	3.2	3.3	1.7	0.15	
Trust	15.0	13.3	14.8	13.4	14.2	2.4	2.4	2.3	2.6	3.0	3.7	0.01	ANRp/NORp

er's experiences are likely to remain unprocessed, and such a baby will look to its mother for a sense of self. Interestingly, Ward et al. [13] showed that, just like their daughters, mothers were characterised by a low level of reflective functioning and high idealisation. These observations were interpreted as a sign of difficulties of mothers in processing emotions, illustrated, in particular, by unresolved loss. This point to a high rate of loss or trauma in the group of examined mothers. The authors conclude that this process can be involuntarily and unconsciously passed onto the daughters, increasing the risk of developing anorexia.

If this interpretation was assumed, the present study results could be interpreted in a different way. One could hypothesise that the findings of mothers of females with diagnosed restrictive anorexia, just as in the case of the daughters, result from defence mechanisms. Examination, especially using self-report tools, would be difficult in this group of patients and their mothers. Utilisation of a clinical interview as carried out by Ward et al. [13] would provide a more in-depth picture of family relationships in the mother's family of origin.

Daughters and their parents

A complex picture of the dependencies examined (Part I and Part II) can be seen when com-

paring the perception of family relationships among parents of females from the eating disorder and depressed clinical groups with parents of healthy females. The importance of the results obtained may be interpreted on several levels, as discussed below.

The family as a system

First, the results should be examined in the context of the family as an autonomous system. Transgenerational concepts such as those described by Murray Bowen [14], Ivan Boszormany-Nagy et al. [15], and Helm Siterlin [16, 17], which indicated the influence of autonomy disturbances of earlier generations on family system function and development of individual family members, may relate to our present results. It is possible that autonomy and intimacy difficulties in the families of parents of patients with eating disorders result from the inability of a family to function independently. The observation that families of patients with anorexia and bulimia possess a readiness to comply with social expectations may be a manifestation of difficulties in the formation of their own life targets and family's standards of conduct [3, 8, 18]. Individuals with anorexia and bulimia may desire social acceptance, which may interfere with their ability to express intimacy with family members. These families are often oriented towards the "outside". A particular "steering-outside" attitude may lead to significant restrictions in critical approach and cultural models, including "slim" appearance. Females raised in such families may experience particular difficulties in resisting cultural pressure, especially during life periods related to identity, self-esteem, self-image, and body-image. Families of anorexic and bulimic patients pay a lot of attention to the way they are perceived by others, including their physical appearance [3, 8, 4, 5, 18]. Overestimating the importance of physical appearance and body weight by the family has a direct impact on adolescent self-image dissatisfaction, which may directly influence eating disorder development [19]. Females from families that pay great attention to physical appearance and the opinions of others are at greater risk for the development of an eating disorder because they internalise the idea of a perfect self-image [20].

Mother-daughter and father-daughter relationships

Additionally, our results may be examined from the perspective of the patient-parent relationship. Difficulties in individualisation accompanied with a lack of intimacy, support, and trust in the families of mothers of females with bulimic symptoms, including bulimia and anorexia nervosa binge/purge type, could have created complications in the process of shaping daughters' identity and in establishing and maintaining stable and safe bonds. Experiences from the mother's family, including those related to the attachment and transgenerational models, are significant factors that shape the mother-child relationship. These factors may make it difficult for patients to develop their individuality and maintain a stable and supportive relationship. This process may be reinforced by the fathers of bulimic patients because they also have problems with autonomy. A parallel relationship can be seen between fathers and daughters. Fathers may experience difficulties in separation because they have never experienced support and security.

Marital relationships

Finally, our results can be analysed with reference to the marital relationship of a patient's parents. The previously described difficulties in the families of the parents of patients with eating disorders could also make it difficult to maintain, within the marital relationship, feelings of independence, emotional intimacy, and support. These factors may also prevent parents from effectively searching for help for their daughter's disorder and from taking appropriate treatment steps. Marital relationship difficulties occur in divergent mutual expectations of parents of patients with anorexia nervosa restrictive type and in a negative perception of the marital relationship and the other partner in parents of patients with bulimia nervosa [21].

FINAL REMARKS

The research summarised in this paper was inspired by clinical models because of their complexity and context, although they have limitations that include a lack of control groups consisting of healthy people and other clinical reference groups and their families. As a consequence of these limitations, research was hindered with regard to assessing the degree to which the observed difficulties are typical of anorexia and bulimia nervosa. Insufficiently selected control groups are justified in many cases of eating disorder empirical research [22, 23]. Although researchers usually have a healthy female control group, other diagnostic groups are seldom considered. The use of two control groups in our research seemed beneficial because it allowed comparison of healthy females and their parents to those of eating disorders while also providing a way to measure if such difficulties were specific to eating disorders or if they occurred in other patients, such as those with clinical depression.

Verification of hypotheses regarding autonomy and intimacy distortions in the families of parents of patients with eating disorders formulated using clinical analysis are valuable. Even though some clinical model aspects were not confirmed, this does not undermine their worth. Clinical observation and family member perception results do not have to be the same (and possibly cannot be the same). As a rule, the 'maps' prepared by researchers using clinical experience and knowledge of theory result in the creation of different family relationship pictures than if family members co-create the family system.

The present research is characterised by several limitations that are discussed in greater detail in part I of the article. Such limitations include: 1) doubts regarding self-report conclusion accuracy, especially among anorexia nervosa restrictive type patients and their families; 2) the influence of depression on one's perception of herself and her relationships, especially among patients with bulimia nervosa; 3) the low sample size among certain groups such as the anorexia nervosa binge/purge group; 4) the statistically significant differences in age and family structure between groups (Part I).

Some doubts could rise due to the DEP group selection. Authors made a decision to include in this group all patients with the diagnosis of the depression. Contemporary research on determinants of affective disorders are seizing border between the former division into "endogenous" and "exogenic" depression. Stressful live events could cause adjustment reaction with depressed mood and would be a trigger mechanism for major depression [24]. The distinction between these two syndromes could be especially difficult in the period of puberty when psycho-biosocial developmental challenges can cause serious adolescence turmoil [25]. All the above arguments suggest lack of certainty in the distinction between different types of depressiveness in adolescence and strongly support applied DEP group selection.

Our results also inspire new research directions. Among females with diagnosed anorexia nervosa restrictive type and their mothers, qualitative methods such as narration in-depth clinical interviews or projective methods may be the most reliable. Using these methods, the organisation of the responses besides the responses themselves, may then be analysed.

It is also interesting how and to what degree therapeutic interactions and influences can alter the relationships we examined, especially in the restrictive anorexia nervosa group. In further research it would also be interesting to examine the link between our results and eating disorder prognosis.

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