

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

Barbara Józefik, Maciej Wojciech Pilecki

SUMMARY

Aim. The aim of the study was to assess the dimensions of family autonomy and intimacy in families of origin of patients with eating disorders, depression and in families of healthy girls.

Method. We used the Autonomy and Intimacy scales of the Family of Origin Scale (FOS) to compare 112 females having different types of eating disorders with 40 depressed females and 85 schoolgirls in the Polish cultural context.

Results. Bulimic and depressed females had statistically poorer results for FOS major scales and subscales compared with schoolgirls. Bulimic females had statistically poorer results than anorexia restrictive-type females for both FOS major scales, the intimacy subscales, and the autonomy subscales of clarity of expression, responsibility, and respect for others. Anorexia nervosa binge/purge-type patients had poorer results than schoolgirls on the autonomy subscale of responsibility and the intimacy subscale of responsibility but better results on the intimacy major scale and the subscale range of feelings compared with bulimic patients.

Conclusions. These results suggest that difficulties in achieving autonomy and intimacy are not specific to eating disorder. The positive results for anorexia restrictive-type females suggests a defensiveness in the family relationships description.

anorexia / bulimia / depression / transgenerational autonomy / intimacy

INTRODUCTION

Difficulty in achieving autonomy in the context of family relationships of patients with eating disorders are described by system para-

digm clinical models [1, 2, 3, 4, 5, 6, 7], classical psychoanalytical concepts [8, 9, 10, 11], and a feminist researcher [12]. Attention within these models is drawn to various aspects of family dynamics and family relationship perceptions that may hamper autonomy. Autonomy is defined as maintaining relationships with others that enable one to be guided by one's own needs and values [13]. The development of autonomy is linked to relationships that are based on intimacy. Hence, at both individual and family levels, close relationships with others may be acknowledged as both a condition and as a derivative of autonomy.

Despite complex theories surrounding therapeutic approaches, few empirical studies exist

Barbara Józefik¹, Maciej Wojciech Pilecki^{1,2}: ¹Department of Child and Adolescent Psychiatry, the Jagiellonian University, Medical College, Kraków, Poland; ²Division of Child and Adolescent Psychiatry, Queens University, Kingston, Canada. Correspondence address: Barbara Józefik, 21a Kopernika St., 31-501 Kraków, Polska. E-mail: bjozefik@cm-uj.krakow.pl

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that examine the role of autonomy disturbances in anorexia and bulimia nervosa [14]. Additionally, the clinical models previously mentioned have only been partially verified due to their complexity. Despite a 30-year history and interest in the role of the family in eating disorders within the context of autonomy, many challenging questions remain unanswered for researchers. One of these concerns is the extent to which the difficulties in achieving autonomy are characteristic of patients with eating disorders rather than patients with emotional difficulties and mental health problems in general. Nor is it clear whether the above difficulties are more typical for patients with anorexia nervosa or bulimia nervosa. Greater difficulties for patients with anorexia are suggested because the onset of anorexia occurs typically during early or middle adolescence, whereas the onset of bulimia occurs during late adolescence. In turn, the symptomatology of bulimia suggests that patient difficulties are grounded in earlier developmental phases as compared to patients with anorexia [15]. Questions also arise as to differences in family autonomy between anorexia nervosa binge/purge type and anorexia nervosa restrictive type.

Transcultural studies have revealed diversity among separation/individuation across various cultures and ethnic groups [16, 17]. In Poland, traditionally strong intergenerational bonds in families are demonstrated variously by parent interference in adolescent and adult children affairs, frequent parent-children contact, financial assistance, and an obligation to care for sick or ageing parents. However, the last two decades have been marked by intensive political, economic, and socio-cultural transformation in Poland. These societal changes have influenced the style of parenting, mutual expectations, and delegation of duties, all of which have impacted the evolution of the family system [18]. Notably, since the Polish sociopolitical transformations that took place in Poland in 1989, eating disorders have become one of the fastest growing mental problems observed and diagnosed amongst teenage girls and young women [19].

The aim of the present study was to describe the dimensions of family autonomy and intimacy within the Polish cultural context in families of origin of patients with eating disorders (part

I) and the families of their parents (part II). This research structure enabled comparison among three family generations. We hypothesized that patients with eating disorders, and their parents, would have distorted views of family autonomy and intimacy as compared to healthy females and their parents and patients with diagnosed depression and their parents.

METHODS

Sample

Participants in the study were adolescent girls being seen at the Department of Child and Adolescent Psychiatry, the Jagiellonian University, Medical College in Kraków¹, for first-time diagnosis of eating disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV; 1994). Patients were classified into appropriate study groups according to their basic eating disorder diagnosis including anorexia nervosa restrictive type (ANR), anorexia nervosa binge/purge type (ANBP), and bulimia nervosa (BUL). Several patients with subclinical syndrome symptoms were classified into appropriate clinical groups [ANR (n=2), ANBP (n=6), BUL (n=2)]. All female patients diagnosed with eating disorder required treatment.

Patients with eating disorders were compared with two control groups: 1) females diagnosed with depression (DEP) including diagnoses of depressive episode, dysthymia, and adjustment disorder with depressed mood as determined by the DSM IV (1994), and 2) normal age-matched female pupils from Kraków schools (NOR). Females having a previous mania episode were excluded from the DEP control group. Other exclusion criteria included an emergency psychiatric consultation, lack of contact with either parent, females living in foster homes, emergency care centers, or being raised by grandparents, and mentally retarded individuals or with diagnostic uncertainties.

Data obtained for 112 female patients aged 13 to 20 with eating disorders, 40 patients with diagnosed depression, and 85 female pupils from Kraków schools were subjected to statistical analysis. The group sample sizes are presented in Tab. 1. The family structures of the various study groups are presented in Tab. 2.

¹ Consent of the Bioethics Commission the Jagiellonian University No: KBET/26/B/2001

Table 1. Sample size per group

Studied persons	NOR	ANR	ANBP	BUL	DEP
Females	85	54	22	36	40

NOR = Kraków school female pupils;
 ANR = anorexia nervosa restrictive type;
 ANBP = anorexia nervosa binge/purge type;
 BUL = bulimia nervosa;
 DEP = depression.

Table 2. Family structure per group

Family structure		Diagnosis				
		NOR	ANR	ANBP	BUL	DEP
Complete family	Sample size	70	45	18	21	30
	Percent per group	89.7%	83.3%	85.7%	65.6%	78.9%
Incomplete family	Sample size	4	8	2	11	8
	Percent per group	5.1%	14.8%	9.5%	34.4%	21.1%
Reconstructed family	Sample size	4	1	1	0	0
	Percent per group	5.1%	1.9%	4.8%	0.0%	0.0%

NOR = Kraków school female pupils;
 ANR = anorexia nervosa restrictive type;
 ANBP = anorexia nervosa binge/purge type;
 BUL = bulimia nervosa;
 DEP = depression.

Measures

Patients’ clinical diagnosis was made using the Polish version of the Eating Disorder Examination Interview (EDE) [19]. This instrument studies specifics of eating disorder psychopathology [20]. Additionally, a structured clinical interview was conducted to collect demographic, developmental, family, and environmental data. Girls from NOR group were not assessed psychiatrically.

Autonomy and intimacy of patients and their families of origin were studied using the Family of Origin Scale (FOS). This instrument, which is based on the two relationship concepts of autonomy and intimacy, uses family relationship intergenerational models [21]. The authors of the FOS instrument consider autonomy and intimacy intertwined concepts that are involved in the healthy functioning of a family. Autonomy is a process where an individual modifies their childhood relationship with their parents to define their own identity and achieve independence. Intimacy expresses the possibility of maintaining ties with parents based on trust and mutual respect of boundaries.

The Scale of Autonomy (AUTON) is divided into five subscales: 1)

Clarity of expression (CE)—thoughts and feelings are clear in the family; 2) Responsibility (R)—family members claim responsibility for their own actions; 3) Respect for others (RO)—family members are respectful of one another; 4) Openness to others (OO)—family members are allowed to speak for themselves; 5) Acceptance of separation (AS)—separation and loss

are dealt with openly in the family. The Scale of Intimacy (INT) is also divided into five subscales: 1) Range of feelings (RF)—family members express a wide range of feelings; 2) Mood and tone (MT)—warm positive atmosphere exists in the family; 3) Conflict resolution

(CR)—normal conflicts are resolved without undue stress; 4) Empathy (E)—family members are sensitive of one another; 5) Trust (T)—the family sees human nature as basically good.

The FOS was standardised for Polish conditions by Fajkowska-Stanik [22]. The mean values obtained for particular scales in Polish studies were similar to results obtained by the authors of the scale [21]. 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 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

The ages, in years, of the females participating in the present study were: NOR= 16.9 ± 1.5 ;

ANR=16.4±1.5; ANBP=16.9±1.3; BUL=17.4±1.0; and DEP=16.7±1.6. ANR females were statistically younger than BUL females ($F_{2, 718}=24.27$; $P<0.05$). There was no statistical difference between any of the groups in duration of illness, parent age, parent education, or number of children in the family. Statistically, BUL females were from single-parent families more often than the other groups ($\chi^2(8)=17.81$, $P=0.023$).

Autonomy and intimacy in families of origin

Autonomy Scale

BUL and DEP females differed significantly from NOR females on the major scale of autonomy and its subscales (Tab. 3), suggesting that BUL and DEP females have difficulties in autonomous functioning within their families of ori-

Table 3. Differences between female groups on subscales of the major scale of autonomy

	Mean					SD					F	P	Inter/group diff.
	(NOR)	(ANR)	(ANBP)	(BUL)	(DEP)	(NOR)	(ANR)	(ANBP)	(BUL)	(DEP)			
Autonomy	71.64	68.24	64.27	57.97	61.28	13.64	12.55	13.01	15.27	15.34	7.85	< 0.01	BUL/ANR, NOR DEP/NOR
Clarity of expression	14.49	13.20	12.95	10.71	11.95	2.94	3.52	2.80	3.21	3.70	9.60	< 0.01	BUL/ANR,NOR DEP/NOR
Responsibility	14.12	13.04	11.95	10.54	11.63	2.92	2.91	3.08	3.36	3.48	10.18	<0.01	BUL/ANR, NOR DEP/NOR ANBP/NOR
Respect for others	14.45	14.06	12.59	11.34	12.13	3.41	3.46	3.22	4.13	4.12	6.30	< 0.01	BUL/ANR, NOR DEP/NOR
Openness to others	14.78	13.80	13.32	12.83	12.58	3.24	2.89	3.01	3.41	3.29	4.31	< 0.01	DEP/NOR BUL/NOR
Acceptance of separation and loss	13.77	14.35	13.45	12.46	12.72	4.25	3.40	4.26	3.73	4.38	1.58	0.18	

gin. In contrast, ANR females did not statistically differ from the NOR females in their range of autonomy experienced within family relationships (Tab. 3). ANBP females were different from NOR females only on the responsibility subscale, suggesting difficulties in independent decision making in their families of origin.

There were statistical differences between ANR and BUL females on the major scale of autonomy and its three subscales of CE, R, and RO (Tab. 3). These data suggest that females with BUL perceive differences in autonomic function as compared to ANR females.

Intimacy Scale

There was no statistically significant difference between ANR and NOR females on the major scale of intimacy or any related subscales (Tab. 4 – *next page*). These results are in contrast to those seen in the BUL and DEP females who differed statistically from the NOR group on both the major scale of intimacy and all related subscales (Tab. 4). BUL females had statistically poorer intimacy and related subscale results compared with ANR females. DEP females differed from ANR females by having statistically poorer results on the major scale of intimacy and its three subscales CR, E, T (Tab. 4).

ANBP females had significantly poorer results than NOR and ANR females on the subscale of CR. However, ANBP females had significantly better results than BUL females on the major scale of intimacy and the associated subscale RF (Tab. 4).

DISCUSSION

The objective of the present study was to describe, in the Polish cultural context, the perception of autonomy and intimacy in families of origin of eating disorder patients, depressed patients, and normal female students. The results obtained indicate that ANR and NOR females do not differ statistically in terms of perception of autonomy and intimacy in their families of origin. These patients rate family autonomic functioning and intimacy significantly higher than females from the other clinical groups. ANBP fe-

males have certain but not major difficulties in the studied areas, which are linked to high stress during family conflicts and struggles with responsibility for decisions making.

BUL and DEP females perceive significant difficulties in family autonomic function and family relationship intimacy as compared to NOR and ANR females. BUL and DEP females feel that their families perceive a narrower range of expressed feelings, understand each others' intentions and feelings only to a small extent, and less positively rate the family atmosphere. These patients rate to a worse extent the degree to which family members express their own opinion, respect the opinions of other family members, and take responsibility for decisions. They also perceive that their family members have a low level of trust in other people. BUL and DEP females perceive less family member mutual sensitivity in family relationships as compared to NOR and ANR females.

Results obtained from BUL females are consistent with clinical models and empirical studies assessing attachment patterns [3, 5, 2, 1, 23, 24, 25, 26]. However, there are inconsistencies with the results obtained from the ANR group. In numerous studies there were difficulties in autonomy development in anorexic patients as confirmed by various theories, research methodologies, and diagnostic tools [14, 27, 26, 24, 28, 29, 30, 25, 31, 32]. Wechselblatt et al. [14] confirmed difficulties in autonomy development in anorexic patients using qualitative research based on the "grounded" theory. Their results [14] suggest that autonomy should be considered one of the most significant factors in anorexia development. Similarly, Sugerman et al. [15] used Rorschach Tests and found that anorexic patients had disorders on the ego borders as compared to healthy females, which they interpreted as methods of achieving autonomy.

In this context, the present study results, demonstrating no statistical difference in any tested area for ANR females, are confusing. A lack of significant results should be interpreted more carefully than the presence of such associations. Positive results seen in ANR females juxtaposed with their health- and life-threatening symptoms may suggest an inability to adequately assess themselves. Research completed by Żechowski [33] demonstrates a mechanism of denial in early

Table 4. Differences between groups of patients and Krakow schoolgirls on subscales of the major scale of intimacy

	Mean					SD					F	P	Inter/group diff.
	(NOR)	(ANR)	(ANBP)	(BUL)	(DEP)	(NOR)	(ANR)	(ANBP)	(BUL)	(DEP)			
Autonomy	71.64	68.24	64.27	57.97	61.28	13.64	12.55	13.01	15.27	15.34	7.85	< 0.01	BUL/ANR, NOR DEP/NOR
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Responsibility	14.12	13.04	11.95	10.54	11.63	2.92	2.91	3.08	3.36	3.48	10.18	< 0.01	BUL/ANR,NOR DEP/NOR ANBP/ NOR
Respect for others	14.45	14.06	12.59	11.34	12.13	3.41	3.46	3.22	4.13	4.12	6.30	< 0.01	BUL/ANR,NOR DEP/NOR
Openness to others	14.78	13.80	13.32	12.83	12.58	3.24	2.89	3.01	3.41	3.29	4.31	< 0.01	DEP/NOR BUL/NOR
Acceptance of separation and loss	13.77	14.35	13.45	12.46	12.72	4.25	3.40	4.26	3.73	4.38	1.58	0.18	

phases of ANR treatment of illness. Żechowski [33] describes the phenomenon of “worsening of results” in self-assessment surveys carried out amongst ANR patients as treatment and therapy continues. In his opinion, this worsening reflects a weakening of denial and linkage with increased readiness to perceive problems and cooperate in providing more credible and deep-

er answers about experiences and feelings. In present study, the influence of therapy on studied variables was avoided by conducting the studies before patients began treatment. However, by using this study design, the perception of autonomy and intimacy in family relationships may have been modified by the subject’s current mental state, treatment expectation, and

fear of excessively revealing oneself. All clinical groups should have experienced these phenomena, however. Additionally, Vandereycken [34] used self-reported data to reveal that patients, especially those with ANR, often achieve similar results to those of the control group. Vandereycken [34] explains these results among ANR patients as a mechanism of denial, negation, and difficulty in confronting problems. These results are consistent with those obtained by Ward et al. [35], who identified anorexic patients as possessing high levels of insecure attachment and idealization accompanied by low levels of reflective functioning. Idealisation is considered a fundamental defence mechanism of ANR and other eating disorders in both individual and family contexts [36].

This interpretation is brought forth when juxtaposing the discussed results with results from other tests completed in patient study groups. ANR females achieved similar results to NOR females on the Eating Disorders Inventory (EDI), which evaluates psychopathological symptoms, the Offers Self Image Questionnaire (OSIQ), which describes self-image, and the Family Assessment Measure (FAM III), which describes current family relationships [37, 38]. As many as 50% of the ANR females obtained scores that indicated low risk for eating disorders on the Eating Attitudes Test (EAT26) [39]. Undoubtedly, the described difficulties are factors that may modify the interpretations of obtained results and limit the application of self-report studies in these subjects. Caution should also be taken when literally interpreting study results and drawing far-reaching conclusions as to the intensity of the psychopathology observed in ANR females as compared to other groups.

When analysing the present study results, it should also be noted that researchers often do not separate types of anorexia and instead consider both ANR and ANBP groups together. Not dividing anorexia into two types is consistent with the diagnostic and research criteria presented in the International Classification of Diseases (ICD-10). However, study results have indicated that anorexia type is a significant variable. In empirical studies, placing both anorexia types into one group often results in a disturbance of the studied dimensions because ANBP patients often have poorer results [34, 38, 40, 41].

The relatively small number of ANBP patients is one limitation of the present research. Additionally, further analysis is needed to determine the influence of intensity of symptoms including weight loss and frequency of binge/purge episodes on the studied dimensions. The finding that bulimic females often came from single-parent families would be not without meaning. This can influence the manner in which the relationship is evaluated with each parent. The age differences between the ANR and BUL groups can influence this evaluation too.

Finally, it should be noted that the family of origin of girls, included in research is still a generational family, which they have not yet left, and in which both developmental phenomena and those linked with the burden of the illness occur together.

CONCLUSIONS

BUL and DEP females perceive significant difficulties in autonomic functioning and intimacy in family relationships. ANBP females have specific but not major difficulties in the studied areas. These results suggest that difficulties in achieving autonomy and intimacy are not specific to eating disorder patients but may be linked with various psychopathologies. The positive results seen in ANR females juxtaposed with their health- and life-threatening symptoms suggest a lack of adequate self-assessment and defensiveness in the family relationships description.

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