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Do daughters with eating disorders agree with their parents' perception of family functioning?

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Abstract

Objective: The current study compared the perceptions of family functioning between daughters with eating disorders (EDs) and their parents. This investigation was an expansion of the Fornari et al (*Compr Psychiatry* 1999;40:434-441) study, which investigated the relationship between the perceived family functioning and depressive symptoms in individuals with ED patients receiving outpatient services.
Method: One hundred twenty-six female subjects, ranging in age from 13 to 34 years (mean 18.3 years) completed the Beck Depression Inventory (BDI) (*Arch Gen Psychiatry* 1961;4:561-571) and the Family Assessment Device (FAD) (*J Marital Fam Ther* 1983;9:171-180) on admission to an outpatient ED program. The patient's parent(s) (118 mothers and 96 fathers) also completed the FAD. Eating disorder subgroup diagnosis and major depressive disorder diagnosis were established according to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, criteria, using the Schedule for Affective Disorders and Schizophrenia-Lifetime (*Arch Gen Psychiatry* 1987;35:837-844). Repeated measures analysis of covariance was performed comparing family members on each of the 7 subscales of the FAD with BDI entered as the covariate.
Results: Statistically significant differences were found between patient and parental perceptions of overall family functioning. Mothers rated family functioning as significantly healthier and less chaotic than their daughters did. There were fewer significant differences between maternal and paternal perceptions of family functioning, and no significant differences between fathers' and daughters' perceptions of the family. Eating disorder diagnosis did not contribute to these differences in perception of family functioning. In addition, high self-reported depressive symptoms of the daughters were related to the perception of high family dysfunction for all 3 informants; depressive symptoms did not, however, alter the differences in perception between family members.
Discussion: Differences in viewpoints between parents and daughters regarding the family environment may contribute to the continuation of a dysfunctional family pattern and maintenance of the ED and/or impact negatively on the course of treatment. Possible implications for treatment are discussed, particularly because of the differences of the mothers' views. The results of this study strongly support the importance of including the patient's family in the initial evaluation, regardless of the patient's age.

1. Introduction

Many researchers have emphasized the importance of the family in the development, maintenance, and understanding of eating-disordered behaviors. Family therapy has been an integral component of treatment since the earliest descriptions of anorexia nervosa (AN) and bulimia nervosa (BN) [1-4].

Research (assessment and evaluation) on families of patients with eating disorders (EDs) has been conducted using a range of approaches. These have included: observational methodologies [5-9], structured clinical interviews [10], and a variety of self-report instruments. The most widely used self-report instruments are Family Adaptability and Cohesion Evaluation Scale (FACES) [11], Family Assessment Device (FAD) [28], Family Assessment Measure (FAM) [12], and Family Environment Scale (FES) [13].

Overall, empirical evidence has led to inconsistent findings about specific family profiles or patterns of family

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interaction that would differentiate the families of patients with AN and/or BN [9,10,14,15]. In addition, in a nonclinical, community sample of college students with compulsive eating or severe dieting behavior, the students' perceptions of family cohesion and adaptability were totally unrelated to the disordered eating, indicating that there was not increased family pathology reported by the students [16].

Previous research has provided some descriptions of mothers and fathers in ED families. Mothers have often been described as overinvolved and enmeshed, and fathers described as cold and distant [2]. Little is known about the differences between how mothers and fathers view family functioning. Only a handful of studies have examined self-reported family functioning by both the patients with EDs and their parents [17-19], and results from these studies have been inconsistent. Some studies report that patients see more family dysfunction than their mothers and/or fathers. Some studies report on mothers only; fewer also report on fathers' perceptions. In addition, many of these studies had small sample sizes.

One previous study [18] described the perception of family functioning, using the FAD, for both the child and the parents and reported that there were no significant differences. There were also no significant differences among the ED diagnostic groups. However, this study did not indicate whether it was the mother or father who had been the reporter. In addition, these researchers used only one of the 7 subscales from the FAD (the General Functioning subscale). Furthermore, this study presented an early adolescent age sample, with a mean age of 14.5 years.

Gowers and North [17] reported on 35 adolescents with AN and their mothers, and found that results of the FAD were different between daughters and mothers. Daughters reported more family dysfunction overall than their mothers did, and the level of perceived dysfunction was not related to the severity of the AN.

Woodside et al [19], using the FAM, reported that older patients (mean age of 24 years) with BN consistently reported higher family dysfunction than their parents. Also, mothers and fathers did not differ but showed the same patterns on the self-report measure. Fornari et al [26] found that self-reported depressive symptoms, but not ED diagnosis, predicted the level of perceived family dysfunction reported by subjects with EDs.

The current investigation was an expansion of the Fornari et al [26] research to include the self-reported perceptions of the parents in comparison with those of the patients with ED. It was the purpose of the present study to compare the perceptions of family functioning between daughters with EDs and their mothers and their fathers. Furthermore, we examined whether the participants' perceptions of family functioning were related to the ED subtype or the degree of depressive symptoms in the patient with ED.

2. Method

2.1. Subjects

Of the 236 patients who were consecutively evaluated in the outpatient ED program at North Shore University Hospital (see Fornari et al [26]) during a 5-year period, a subset of 126 females were selected for this study because their mother, father, or both had completed the parental self-report family measure (FAD [28]). There were 118 mothers and 96 fathers who participated.

Demographic characteristics of the patient sample are shown in Table 1. The ED subjects were primarily Caucasians (96%) and were between the ages 13 to 34 years. They were primarily single (96%), with 2% married, and 2% divorced. The majority (53%) were high school graduates. Some (26%) had some college education, and 10% completed college or had attended graduate school.

2.2. Procedure

Informed consent was obtained from patients over 18; parental informed consent and assent were obtained from patients under age 18. All patients with ED were interviewed on admission to the ED outpatient clinic using the Schedule for Affective Disorders and Schizophrenia-Lifetime (SADS-L) [29]. Patients also completed the Beck Depression Inventory (BDI) [27] at that time (see Table 1); their scores ranged from 0 to 53. The BDI is a valid and reliable self-report questionnaire that has been used extensively to assess the cognitive and behavioral aspects of depression. The BDI measures self-perceived intensity of depressive symptoms but is not equivalent to a diagnosis of major depression. All subjects and parents also completed the McMaster FAD [28] at admission.

The FAD is a self-report instrument developed to measure perception of family functioning. The 60 items describe 7 dimensions of family functioning: Problem Solving is a family's style of problem resolution, that is, a family's ability to resolve problems to a level that maintains effective family functioning. Communication refers to transmission of information, how information is verbally exchanged within a family. Roles describe the differentiation of tasks, recurrent patterns of behavior by which

Table 1
Demographic characteristics

	Mean (± SD)
Age	18.3 (± 4.54)
BDI	21.05 (± 11.70)
ED subtype[a] (n)	
Anorexia, restricting type	24
Anorexia, bingeing/purging type	23
Bulimia	41
EDNOS	38
Lifetime major depressive disorder[a]	70

[a] According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, criteria (using the Schedule for Affective Disorders and Schizophrenia-Lifetime [29].