Psychiatr. Pol. 2015; 49(4): 731–746
PL ISSN 0033-2674 (PRINT), ISSN 2391-5854 (ONLINE)
www.psychiatriapolska.pl
DOI: http://dx.doi.org/10.12740/PP/32796

The perception of relations in the family of origin of patients with eating disorders and the perception of relations in families of origin of their parents

Maciej W. Pilecki[1], Barbara Józefik[2], Marta Kościelniak[3]

[1]Department of Child and Adolescent Psychiatry, Jagiellonian University Medical College
[2]Laboratory of Psychology and Systemic Psychotherapy, Department of Child and Adolescent Psychiatry, Jagiellonian University Medical College
[3]Department of Adult, Child and Adolescent Psychiatry, University Hospital in Krakow

Summary

Aim. Analysis of the correlation between the assessment of current family relations in families of patients diagnosed with eating disorders and the assessment of the relations in the family of origin of their parents.

Material. 54 female patients with restrictive anorexia nervosa, 22 female patients with binge-purge anorexia, 36 female patients with bulimia. Two control groups were included: 36 female patients with depressive disorders and 85 schoolgirls from Krakow. The study also covered the girls' parents.

Method. Family of Origin Scale and FAM Family Assessment Measure (Polish version).

Results. In the families of schoolgirls from Krakow better evaluation of the experience of intimacy and autonomy in the family of origin of parents of the investigated girls was associated with their and their children more favourable perception of relations in the present nuclear family. What proved particularly significant were perception of transgenerational experiences of the fathers. Only a few statistically significant correlations were observed in all clinical groups. In the parents of the investigated patients a weak correlation was observed between the current marital relations perception and transgenerational experiences evaluation and a significant correlation between parents' transgenerational experience evaluation and the assessment of the relations with their daughters.

Conclusions. No specific correlations were found between the perception of the transgenerational experience of parents and evaluation of current relations in the nuclear

The study was conducted using KBN funds (Grant no.: 6 POSE 09021) and JUCM own funds (Grant 501/NKL/269/L).
The study was conducted with the approval of the Bioethics Committee of Jagiellonian University Medical College (KBET/26/B/2001).

family of their children with eating disorders. The results in the group with eating disorders suggest that the relations between parents and daughters are more intense than marital relations.

Key words: anorexia nervosa, bulimia nervosa, transgenerational transmission

Introduction

In the area of research on the family, transgenerational problems are an important yet unsatisfactorily explored issue including the way in which the experiences of the families of origin affect the development of relationships with partners and later relationships with children in the procreative family [1].

Empirical studies show how different patterns of interaction between parents (regardless of other variables) affect the functioning of children in their married life. It is evident for instance in the context of the stability of relationships, communication patterns, ways of controlling emotions, conflict resolution, degree of marital satisfaction, commitment to the relationship, level of distress or relationship diagrams [2–4]. The data also indicate that the experience of warmth, support or low level of hostility in the family of origin are positively correlated with their children's behaviour in intimate relationships [3]. Research on the transgenerational context provides a series of conceptualisations related in their psychological layer to issues such as the impact of disturbances in the process of separation and individuation and differentiation disorders on the ability to build intimate relationships in adulthood [5–7]. These concepts indicate a correlation between the level of variously defined emotional independence from the family of origin and the level of adaptation in relationships with partners and in married life [8–10]. Gender turns out to be an important variable here. Women have a higher potential for abstracting from their transgenerational experiences than men [10]. All cited empirical results confirm that the patterns learned in the family of origin are repeated in later intimate relationships.

Eating disorders constitute a significant study area concerning transgenerational issues. Family relationships are considered among others as factors predisposing to the development of anorexia and bulimia nervosa as well as having a significant impact on their course and prognosis. To illustrate this thesis, one may recall classic psychoanalytic concepts of Bruch [11], Selvini Palazzoli [12] and Masterson [13], systemic models of Weber and Stierlin, [14], Reich and Cierpka [15], White [16], Gröne [17] and feminist concepts of Chodorow [18] and Chernin [19]. Clinical models developed for various therapeutic schools are not supported by many scientific studies to prove the therapists' conceptualisations. There are also doubts about the research methodologies of some of them. A publication by Le Grange, Lock, Loeb and Nicholls [20], which provides a summary of publications based on reliable scientific methodology of family risk factors for eating disorders, lists the following aspects of relations with parents: (1) Excessive protection/high degree of concern or insufficient involvement of parents in the upbringing of the child, low attachment (affection) levels, insensitivity, indifference and lack of care; (2) Family discord, many problems between parents: separation, quarrels; (3) Numerous changes in the family structure before the child's illness (e.g., separation/leaving of a parent, stepmother/stepfather joining the family); (4) High parental expectations; (5) More critical comments on the figure and weight of the child.

The correlations between family relationships and eating disorders require further study, including ones associated with various cultural contexts. Such considerations

are not merely theoretical. Family therapy is an important treatment method in eating disorders and especially in anorexia nervosa [21], hence the importance of any data which could methodologically and reliably determine the direction and scope of therapeutic interventions.

Aim

In this project we have decided to assess the correlation between transgenerational transmission of experience of autonomy and intimacy in families of origin of parents of patients diagnosed with eating disorders and the assessment of family relationships in their (the parents') generational family and the assessment of family relationships by their daughters. Autonomy and intimacy are two correlated dimensions of transgenerational family process significantly influencing early childhood bonding, intrapsychic world and family relations. Autonomy is understood as intrapsychic and relational ability for self-determination, setting borders and for achieving independence. Intimacy means being able to remain in close relationships which provide support and a sense of understanding. Autonomy and intimacy complement each other constituting a condition for the stability of mental structures and relationships; lack of them is a sensitive indicator of potential difficulties in the transgenerational process [22, 23].

In the present study the following research questions were formulated:

1. Is there a correlation between the experiences of parents in their families of origin and the way in which they assess their partners and their children?
2. Is the way in which one is assessed in one's family by the partner and children related to one's own transgenerational experiences?
3. Are there characteristic correlations of the above dependencies for different types of eating disorders?

Material

The statistical analyses underlying this publication applied data of 54 patients diagnosed according to DSM-IV [24] with restrictive anorexia nervosa (ANR), 22 with binge-purge anorexia (ANBP), 36 with bulimia (BUL), consulted first-time in the outpatient clinic of Department of Child and Adolescent Psychiatry, University Hospital in Krakow between 2002 and 2004. The study had two control groups: 36 patients diagnosed with a major depressive disorder (DEP), i.e. an episode of severe depression, dysthymia, situational reaction with depressed mood according to DSM-IV [24] and 85 schoolgirls from Krakow (NOR).

The study also covered the patients' parents. The analyses applied the data of 107 mothers and 76 fathers (ANRmothers, n = 54; ANBPmothers, n = 22; BULmothers, n = 31; ANRfathers, n = 38; ANBPfathers, n = 15; BULfathers, n = 23), 36 mothers and 24 fathers of girls from the DEP group, and 80 mothers and 77 fathers from NOR group were used for statistical analyses.

The adolescent female patients and their parents were asked to take home and fill in questionnaires used in the course of the study and to post them or hand them back

during their next visit. In addition, a clinical interview was conducted to obtain clinical data on symptoms, demographics, development, family and social factors. Consultation in the clinic was based on a medical recommendation from a psychologist, either employed at school or selected by the parents. Mentally handicapped persons, or those brought up in institutions were not included in the study. No one refused to participate in the study. The analysis excluded 4 girls who had severe depression accompanied by slightly increased symptoms of bulimia. Persons presenting subclinical symptoms according to DSM-IV (significant weight loss within normal range, vomiting less frequently than twice a week, vomiting after subjective overeating episodes) were included in the relevant main groups (ANR (n = 7), ANBP (n = 6), BUL (n = 2)). All the study subjects required psychiatric treatment.

To investigate the evaluation of autonomy and intimacy in the family of origin of parents of the investigated girls, Family of Origin Scale (FOS) by Hovestadt, Anderson, Piercy, Cochran and Fine [25] was applied. This tool consists of 10 subscales and two aggregate scales: Autonomy Scale (AUT) and Intimacy Scale (INTIM). It was covered by the standardisation procedure to the Polish conditions by Fajkowska-Stanik [26]. The higher the score in the scales, the greater the autonomy and intimacy.

In the study of perception of marital relationships of the patients' and schoolgirls' parents and the relationship between parents and their daughters, the dyadic Family Assessment Measure (KRD FAM) was applied in a version that allows to describe the mutual relations of the respondents. The Group of FAM Questionnaires is an adaptation to the Polish conditions [27] of the German version [28] of the Family Assessment Measure III (FAM-III) by Steinhauer, Santa Barbara and Skinner [29].

The FAM Questionnaire consists of the following seven subscales:

- Task Completion (TC);
- Role Performance (RP);
- Communication (COM);
- Emotionality (E);
- Affective Involvement (AI);
- Control (CON);
- Values and norms (VN).

The questionnaires also contain a general scale (GEN). In all of these scales, higher scores represent in fact, more unfavourable assessment of the dyadic relations (deviating from the desired ones).

Statistical analysis and the data presentation

Assessment of the correlations between various FOS and FAM scales was based on a correlation analysis. Pearson's linear correlation coefficient or Spearman's rank correlation coefficient, in the absence of compliance in the distribution of even one of the studied features with normal distribution – was applied. In the tables below the correlation coefficient (the upper number in the table with an asterisk when Pearson' coefficient was used) and exact p value (the lower number in the table) were presented as the result of significant correlations between the studied features. However, if the correlation was insignificant, a blank was left in the table.

Results

The correlation analyses only applied the data with results from both research tools. In individual correlation analyses the following data were used: of 35 mothers and 36 fathers from the ANR group, 12 mothers and 14 fathers from the BUL group, 21 mothers and 22 fathers from the DEP group, 70 mothers and 74 fathers from the NOR group. In single-parent families the results from both parents were obtained in the ANR group in two cases, in the BUL group in one case, in the NOR group in 5 cases. None of the analysed pairs of results came from single-parent families from the DEP group. It was decided that only the results which were statistically significant would be presented.

The correlation between the Family of Origin Scale (FOS) and the Family Assessment Measure (FAM) in the group of schoolgirls (NOR)

The study of correlations between the results of FOS subscales and FAM subscales in a group of schoolgirls and their mothers and fathers revealed a number of significant dependencies. Statistically significant correlations were found in almost all subscales between how the mother and father perceive their family of origin and how the mother assesses her relationship with her daughter (Table 1). In all individual FAM subscales there is a connection between the experiences from the father's family of origin and how he assesses his relationship with his daughter (Table 2). It is worth noting that there were no correlations between how the father assesses his daughter and the experiences from the mother's family of origin (Table 2).

In almost all the FAM subscales there were correlations between how the mother and father perceive the family of origin and how the mother assesses her relationship with her husband (Table 1). In all the subscales there is a correlation between how the father perceives the family of origin, and how he assesses his relationship with his wife (Table 2). Again, there was almost complete lack of correlation between maternal experiences from her family of origin and how she is assessed by her husband (Table 2).

No correlation was found between how the daughters assess their relationship with the mothers and the scores of mothers and fathers in FOS. The statistically significant correlations were observed in all the individual subscales of FOS between how the girls assess their relationship with the fathers and the experiences of fathers from their family of origin (Table 3). No correlation between the assessment of the fathers made by daughters and the experiences from the mother's family of origin was observed (Table 3) .

Table 1. **Correlation between FOS and FAM scales; assessments of mothers from the NOR group**

		Family Assessment Measure							
		TC	RP	COM	E	AI	CON	VN	GEN
		Mother assesses daughter							
Family of Origin Scale	AutM	-0.370 0.001	-0.376 0.001	-0.379 0.001	-0.306 0.006	-0.342 0.002	-0.351 0.002	-0.280 0.012	-0.448 0.000
	IntimM	-0.356 0.001	-0.310 0.005	-0.372 0.001	-0.238 0.035	-0.374 0.001	-0.313 0.005	-0.306 0.006	-0.417 0.000

table continued on the next page

Family of Origin Scale	AutF		-0.323 0.004	-0.251 0.029			-0.354 0.002	-0.354 0.002	-0.364 0.001
	IntimF		-0.303 0.007	-0.283 0.013			-0.330 0.003	-0.329 0.003	-0.340 0.003
		Wife assesses husband							
	AutM	-0.292 0.010		-0.255 0.025		-0.249 0.029	-0.229 0.045	-0.224 0.049	-0.263 0.023
	IntimM	-0.298 0.009	-0.243 0.032	-0.295 0.009		-0.274 0.016	-0.232 0.042	-0.267 0.018	-0.284 0.014
	AutF		-0.356 0.002	-0.273 0.018		-0.352 0.002		-0.408 0.000	-0.319 0.006
	IntimF	-0.285 0.013	-0.416 0.000	-0.344 0.003		-0.298 0.009		-0.392 0.000	-0.364 0.002

TC – task completion; RP – role performance; COM – communication; E – emotionality; AI – affective involvement; CON – control; VN – values and norms; GEN – general score; Aut – autonomy; Intim – intimacy; M – mother's; F – father's

Table 2. **Correlation between FOS and FAM scales (assessments of fathers from the NOR group)**

		Family Assessment Measure							
		TC	RP	COM	E	AI	CON	VN	GEN
		Father assesses daughter							
Family of Origin Scale	AutM								
	IntimM								
	AutF	-0.293 0.010	-0.267 0.019	-0.251 0.030	-0.377 0.001	-0.286 0.012	-0.459 0.000	-0.330 0.003	-0.319* 0.006
	IntimF	-0.323 0.004	-0.309 0.006	-0.272 0.018	-0.336 0.003	-0.289 0.011	-0.487 0.000	-0.337 0.001	-0.420 0.000
		Husband assesses wife							
	AutM								
	IntimM						-0.242 0.043		
	AutF	-0.341 0.003	-0.405 0.000	-0.356 0.002	-0.335 0.003	-0.276 0.017	-0.303 0.009	-0.284 0.014	-0.404 0.000
	IntimF	-0.294 0.012	-0.456 0.000	-0.315 0.006	-0.246 0.034	-0.301 0.009	-0.335 0.004	-0.337 0.003	-0.410 0.000

Table 3. **Correlation between FOS and FAM scales (assessments of the daughters from the NOR group)**

		Family Assessment Measure							
		TC	RP	COM	E	AI	CON	VN	GEN
		Daughter assesses mother							
Family of Origin Scale	AutM								
	IntimM								
	AutF								
	IntimF								
		Daughter assesses father							
	AutM								
	IntimM								
	AutF	-0.319* 0.005	-0.307 0.007	-0.305 0.007	-0.264* 0.021	-0.342 0.002	-0.287 0.011	-0.258 0.023	-0.386* 0.001
	IntimF	-0.242 0.034	-0.297 0.009	-0.345 0.002	-0.276 0.016	-0.309 0.006	-0.289 0.011	-0.265 0.020	-0.324 0.005

The correlation between Family of Origin Scale (FOS) and Family Assessment Measure (FAM) in girls with restrictive anorexia (ANR)

The study of correlations between the scores of FOS and FAM in girls with restrictive anorexia and their mothers and fathers revealed significant dependencies. In almost all the subscales statistically significant correlations were found between how the mother sees her family of origin and how she assesses the relationship with her daughter (Table 4). There were also very few statistically significant correlations between how the father and mother perceive their families of origin and how the father assesses the relationship with his daughter (Table 5).

In ANR group there were no correlations between how the mother and father sees their families of origin and how they assesses current marital relations (Table 4 and 5).

No correlation was found between the daughters' assessment of their relationship with the mother and the scores of mothers and fathers in FOS. Only in two subscales was a correlation between how the girls assess their relationship with the father and the experiences of fathers from their family of origin (Table 6).

Table 4. **Correlation between FOS and FAM scales (assessments of the mothers from the ANR group)**

		Family Assessment Measure							
		TC	RP	COM	E	AI	CON	VN	GEN
		Mother assesses daughter							
Family of Origin Scale	AutM	-0.410* 0.003	-0.338 0.016	-0.427* 0.002		-0.294 0.038	-0.437 0.002	-0.373* 0.008	-0.472* 0.001
	IntimM	-0.328* 0.021	-0.373 0.008	-0.402* 0.004		-0.426 0.002	-0.378 0.007	-0.387* 0.005	-0.439* 0.003
	AutF								

table continued on the next page

Family of Origin Scale	IntimF								
		Wife assesses husband							
	AutM								
	IntimM								
	AutF								
	IntimF								

Table 5. **Correlation between FOS and FAM scales (assessments of fathers from the ANR group)**

		Family Assessment Measure							
		TC	RP	COM	E	AI	CON	VN	GEN
		Father assesses daughter							
Family of Origin Scale	AutM	-0.357* 0.038							
	IntimM								
	AutF	-0.423* 0.014							
	IntimF								
		Husband assesses wife							
	AutM								
	IntimM								
	AutF								
	IntimF								

Table 6. **Correlation between FOS and FAM scales (assessments of the girls from the ANR group)**

		Family Assessment Measure							
		TC	RP	COM	E	AI	CON	VN	GEN
		Daughter assesses father							
Family of Origin Scale	AutM								
	IntimM								
	AutF						-0.433 0.008		-0.360* 0.043
	IntimF						-0.458 0.005		
		Daughter assesses mother							
	AutM								
	IntimM								
	AutF								
	IntimF								

The correlation between Family of Origin Scale (FOS) and Family Assessment Measure (FAM) in the group of girls with bulimia (BUL)

Similarly to the group with anorexia, in almost all the subscales of FAM in the bulimia group statistically significant correlations were found between how the mother perceives the family of origin and how she assesses her relationship with her daughter (Table 7). There were also statistically significant correlations in 4 FAM scales between how the father sees the family of origin and how he assesses his relationship with his daughter (Table 8). Similarly as in the ANR group, there are no statistically significant correlations between how the mother and her husband assess their family of origin and how the mother assesses her relationship with her husband (Table 7). Only two statistically significant correlations were found between how the father perceives intimacy in the family of origin and how he assesses his relationship with the wife (Table 8).

A small number of significant correlations were reported between how the daughters assess their relationship with the mother and the father and the scores of the fathers in FOS. There was no such correlations with the mother's results (Table 9).

Table 7. Correlation between FOS and FAM scales; assessments of the mothers from the BUL group

		Family Assessment Measure							
		TC	RP	COM	E	AI	CON	VN	GEN
		Mother assesses daughter							
Family of Origin Scale	AutM	-0.454* 0.012		-0.362 0.049	-0.467* 0.009	-0.501 0.007	-0.497* 0.005	-0.358* 0.052	-0.447* 0.017
	IntimM	-0.502* 0.005			-0.499* 0.005	-0.447 0.017	-0.515* 0.004	-0.412* 0.024	-0.465* 0.013
	AutF								
	IntimF								
		Wife assesses husband							
	AutM								
	IntimM								
	AutF								
	IntimF								

Table 8. **Correlation between FOS and FAM scales (assessments of fathers from the BUL group)**

		Family Assessment Measure							
		TC	RP	COM	E	AI	CON	VN	GEN
		Husband assesses wife							
Family of Origin Scale	AutM								
	IntimM								
	AutF								
	IntimF			-0.468* 0.032				-0.471* 0.027	

Family of Origin Scale		Father assesses daughter							
	AutM								
	IntimM								
	AutF		-0.536* 0.008	-0.624* 0.002				-0.622* 0.002	-0.580* 0.005
	IntimF		-0.506* 0.014	-0.564* 0.006				-0.537* 0.008	-0.497* 0.019

Table 9. **Correlation between FOS and FAM scales (assessments of the girls from the BUL group)**

		Family Assessment Measure							
		TC	RP	COM	E	AI	CON	VN	GEN
		Daughter assesses mother							
Family of Origin Scale	AutM								
	IntimM								
	AutF		-0.535* 0.010						
	IntimF		-0.495* 0.019						
		Daughter assesses father							
	AutM								
	IntimM								
	AutF	-0.486* 0.022							
	IntimF								

The correlation between Family of Origin Scale (FOS) and Family Assessment Measure (FAM) in the group of girls with depression (DEP)

There were no correlations between how the mother or father assesses the experiences from the family of origin and how mother assesses her relationship with her daughter or her husband. Only in one FAM scale statistically significant correlation was found between how the father perceives the family of origin and how he assesses his relationship with his daughter (Table 10).

There were single correlations between how the patients assess mothers and their mothers' scores in FOS (Table 11).

Table 10. **Correlation between FOS and FAM scales (assessments of fathers from the DEP group)**

		Family Assessment Measure							
		TC	RP	COM	E	AI	CON	VN	GEN
		Father assesses daughter							
Family of Origin Scale	AutM								
	IntimM								
	AutF							-0.461* 0.027	
	IntimF							-0.455* 0.029	
		Husband assesses wife							
	AutM								
	IntimM								
	AutF								
	IntimF								

Table 11. **Correlation between FOS and FAM scales (assessments of the girls from the DEP group)**

		Family Assessment Measure							
		TC	RP	COM	E	AI	CON	VN	GEN
		Daughter assesses mother							
Family of Origin Scale	AutM				-0.420* 0.013				
	IntimM				-0.383 0.023				
	AutF								
	IntimF								
		Daughter assesses father							
	AutM								
	IntimM								
	AutF								
	IntimF								

Discussion

The aim of this study was to evaluate the correlation between the assessment of procreative family relations and the perception of relations in the families of origin of parents of patients with eating disorders. The study included two control groups: families with depressive patients and families of Krakow schoolgirls selected according to age.

All observed dependencies pointed to the fact that the more positively mothers and fathers evaluate their past experiences of the families of origin, the better the image of the current family relationships of examined fathers and mothers and their daughters is.

However, significant differences in the interactions between SRP and the FAM were observed between the examined groups. In the group of teenage schoolgirls there were significant correlations between evaluation of transgenerational experiences of their fathers and how the men assess their current relationships with their wives and daughters. In the fathers' assessments there was no correlation with their wives' evaluation of transgenerational experiences (with one exception in the Control). When the women assessed their husbands and daughters, the correlations regarded both their husbands' and their own evaluation of trangenerational experiences. The schoolgirls' assessments turned out to be only correlated with evaluation of the transgenerational experiences of their fathers.

These results indicate differences in the significance of the transgenerational context for men and women. They are also confirmed by other studies demonstrating greater impact of the transgenerational context on marital relationships in the case of men than women in the general populations [10, 30, 31].

In clinical groups few statistically significant correlations were detected. For both women and men, parents of the investigated patients, only few interactions between marital relations perception and evaluation of the transgenerational experiences were observed. These results confirm lack of specificity of transgenerational transmission in eating disorders in the context of relations [32] and attitudes towards the body [33], which is evident in other studies. However, any conclusions resulting from lack of statistical relationships should be approached cautiously. In clinical groups, lack of significant correlation may result from the fact that the quality of the marital relationship is affected not only by intimacy but also by the discrepancy between the current and the desired degree of intimacy in the husbands and the wives [34]. It seems justified to assume that marital relationships in clinical groups may be characterised by mutual distance, lack of emotional intimacy which corresponds to the descriptions of Minuchin, Rosman and Baker [35] as well as Selvini Palazzoli and Viaro [36], who characterised the marriage of families with patients diagnosed with eating disorders as based on mutual dislike, insufficient commitment but also avoidance of conflicts and maintaining unified veneer. It is worth noting that in the study group the images of the parents' marital relationship measured using FAM in the case of Krakow schoolgirls were characterised by a strong correlation in contrast to the images of the relationship of parents of patients diagnosed with eating disorders [37, 38].

Lack of correlation between the investigated dimensions of assessment of family relationships in the clinical group does not mean that they are not disturbed. Women from the BUL group, unlike the wives from the NOR group, assessed more harshly the overall functioning of their husbands in their married life, their fulfilment of their tasks, affective commitment, integrity of their system of values and rules of conduct. Wives from the ANR group compared with wives from the NOR group negatively assessed the emotional commitment of their husbands in the marital relationship [37]. Women from the BUL group also negatively assessed both the experience of autonomy and intimacy from their families of origin. Negative assessment of the experience of autonomy in families of origin was also given by fathers of patients from the BUL group [39]. Bulimic

patients also provided a negative image of family relations compared with the group of schoolgirls [40]. Mothers of these patients come from families which they themselves assess negatively and they are negatively perceived by their daughters. The similarity between the results in the group with eating disorders and depression does not allow, however, suggesting that the observed relationships are specific to eating disorders. In the case of parents of patients with eating disorders, there was no connection between the assessment of their marital relationships and transgenerational experiences. Nevertheless, in the bulimia group there was a correlation between how the mother and father perceive their relationship with their daughter and how they perceive relationships in their family of origin. In addition, in the group with anorexia there were correlations between how the mother perceives her relationship with her daughter and her own transgenerational experiences. One possible explanation for assessing a relationship with the partner without applying transgenerational experiences but doing so when assessing their relationship with their daughters may be that the relationships with their daughters are more important to them, and that they are more intense than relationships with their partners. This interpretation is similar to the observation of Selvini Palazzoli and Viaro [36] that mothers in anorexic families set their relations with the daughters above intimacy in their married life. It is worth noting that a similar phenomenon of connecting the assessment of the relationship with the child with the assessment of their own family history also occurred in the NOR group indicating a lack of specificity of observation.

The described study has several methodological weaknesses which may affect the obtained results. A complex issue was described using a relatively simple statistical method. The correlation between the experiences from the family of origin and assessment of current family relations may also contain variables not included in this study, associated with the daughters' presented clinical symptoms, the duration of their condition, their self-image. More complex, multi-dimensional correlations between the experience of relations in the families of origin and mutual assessment of family relations may also be of significance. Correlation does not designate a causal relationship. Assessments of the past can both affect current relationships and ongoing relationships may alter the perception of the past.

The study used two control groups: families with depressive patients and families of students of Krakow schools, matched by age. The purpose of a choice of two control groups was to have chance to analyse the characteristics of transgenerational process specific for eating disorders. It was assumed that if similar results will be obtained in the group of girls with eating disorders and depression in contrast to the students it will mean that the observed interactions are nonspecific. This is particularly important in the context of an eating disorder in which to the transgenerational process – as set forth in the preamble – a significant role is assigned.

Both control groups used in the study have, however, significant limitations. In the group of students the possibility of presence of an eating disorder was not excluded. They can not therefore be considered as healthy, although the prevalence of eating disorders in the general population is low [41]. The similarity between the results in the group with eating disorders and depression may indicate common family etiological mechanism in both disorders [42]. This plea can be put to many other mental disorders.

It should also be noted that in the conducted analyses there were virtually no data from the fathers of single-parent families. The analyses concerning the relations

of mothers and daughters took into account the scores of all mothers and daughters. The analyses of the relations with their fathers included data virtually only from complete families. Thus, all analyzes can only refer to such families.

Another significant doubt concerning the presented material is the inclusion of people from subclinical groups in the corresponding clinical groups although all the patients covered by the study required treatment. The decision taken in this regard is consistent with the direction of changes in the fifth edition of the DSM [43].

Conclusions

The obtained results indicated that in families of Krakow schoolgirls there are correlations between the positive transgenerational experiences of parents of the investigated girls and the perception of relations in the nuclear family as satisfying and healthy. The transgenerational experiences of fathers from complete families proved particularly significant. In the investigated families strong connections were found to exist between how the girls' fathers assess their relationship with their wives and how they perceive the functioning of their families of origin in the areas of intimacy and autonomy. The existence of a correlation between the assessment of the teenage schoolgirls' relations with the fathers and fathers' perception of relations in theirs families of origin was also confirmed. The assessment of the relations between the mothers of Krakow schoolgirls and their husbands and daughters is related to the perception of the mothers' families of origin and also how their husbands perceive the relations in their families of origin.

Only a few observations which overlapped with those in the control group were observed in the clinical groups. They did not prove to be specific for eating disorders. An interesting fact in the group of eating disorders is that although the parents of the investigated patients did not connect their current marital relationships with transgenerational experiences, experience of intimacy and autonomy from their families of origin was nevertheless significant in their perception of the relations with the daughters.

References

1. Bowen M. *Family therapy in clinical practice.* Northvale, NJ: Jason Aronson; 1978.
2. Amato PR. *Explaining the intergenerational transmission of divorce*. J. Marr. Fam. 1996; 58: 628–640.
3. Conger RD, Cui M, Bryant CM, Elder GH Jr. *Competence in early adult romantic relationships: a developmental perspective on family influences*. J. Pers. Soc. Psychol. 2000; 79: 224–237.
4. Amato PR, Booth A. *The legacy of parents' marital discord: consequences for children's marital quality*. J. Pers. Soc. Psychol. 2001; 81: 627–638.
5. Williamson DS. *The intimacy paradox: authority in the family system.* New York: Guilford Press; 1991.
6. Erikson EH. *Identity: youth and crisis.* New York: Norton; 1968.
7. Mahler MS. *On the first three subphases of the separation-individuation process*. Int. J. Psychoanal. 1972; 53: 333–338.

8. Skowron EA. *The role of differentiation of self in marital adjustment*. J. Couns. Psychol. 2000; 47: 229–237.
9. Gubbins CA, Perosa LM, Bartle-Haring S. *Relationships between married couples' self-differentiation/individuation and Gottman's model of marital interactions*. Contemp. Fam. Ther. 2010; 32(4): 383–395.
10. Haws AW, Mallinckrodt B. *Separation-individuation from family of origin and marital adjustment of recently married couples*. Am. J. Fam. Ther. 1998; 26: 293–306.
11. Bruch H. *Anorexia nervosa: therapy and theory*. Am. J. Psychiatry 1982; 139(12): 1531–1538.
12. Selvini Palazzoli M. *Self-starvation: from the intrapsychic to transpersonal approach.* London: Chaucer; 1974.
13. Masterson JF. *Primary anorexia nervosa in the borderline adolescent – an object relations view*. In: Hartocolis P. ed. *Borderline personality disorders*. New York: International University Press; 1977. p. 475–494.
14. Weber G, Stierlin H. *In liebe entzweit. Ein systemischer ansatz zum verständnis und zur behandlung der magersuchtfamilie*. Reinbek: Rowohlt Verlag; 1991.
15. Reich G, Cierpka M. *Psychotherapie der eßstörungen: krankheitsmodelle und therapiepraxis-störungsspezifisch und schulübergreifend*. Stuttgart, New York: Georg Thieme Verlag; 1997.
16. White M. *Selected papers*. Adelaide: Dulwich Centre Publications; 1989.
17. Gröne M. *Wie lasse ich meine bulimie verhungern? Ein systemischer ansatz zur beschreibung und behandlung de bulimie. Vierte, korrigierte auflage.* Heidelberg: Carl-Auer-Systeme; 2003.
18. Chodorow N. *The reproduction of mothering*. Berkeley: University of California Press; 1978.
19. Chernin K. *The hungry self: women, eating and identity*. London: Virago; 1986.
20. Le Grange D, Lock J, Loeb K, Nicholls D. *Academy for eating disorders position paper: The role of the family in eating disorders*. Int. J. Eat. Disord. 2010; 43(1): 1–5.
21. Sadock BJ. *Kaplan and Sadock's synopsis of psychiatry*. Philadelphia: Wolters Kluwer Health; 2007.
22. Holmes J. *Attachment, autonomy, intimacy: some clinical implications of attachment theory.* Br. J. Med. Psychol. 1977; 70: 231–248.
23. Hemming ME, Blackmer V, Searight HR. *The Family-of-Origin-Scale: a psychometric review and factor analytic study*. Int. J. Psychol. Stud. 2012; 4(3): 34-42
24. *Diagnostic and statistical manual of mental disorders*. Fourth edition (DSM-IV). Washington, DC: American Psychiatric Association; 1994.
25. Hovestadt AJ, Anderson WT, Piercy FP, Cochran SW, Fine M. *A Family-of-Origin-Scale*. J. Mar. Fam. Ther. 1985; 11(3): 287–297.
26. Fajkowska-Stanik M. *Polska adaptacja Skali Rodziny Pochodzenia Hovestadta, Andersona, Piercy'ego, Cochrana i Fine'a*. Przegl. Psychol. 1999; 3: 51–67.
27. Beauvale A, de Barbaro B, Namysłowska I, Furgał M. *Niektóre psychometryczne własności Kwestionariusza do Oceny Rodziny*. Psychiatr. Pol. 2002; 1: 29–40.
28. Cierpka M, Frevert G. *Die Familienbogen*. Gottingen, Hogrefe; 1994
29. Steinhauer PD, Santa Barbara J, Skinner HA. *The process model of family functioning.* Can. J. Psychiatry 1984; 29: 77–88.
30. Ghoroghi S, Hassan SA, Baba M. *Function of family-of-origin experiences and marital adjustment among married Iranian students of Universiti Putra Malaysia*. Int. J. Psychol. Stud. 2012; 4(3): 94, DOI: 105539/ijps.v4n3p94
31. Falcke D, Wagner A, Mosmann CP. *The relationship between family-of-origin and marital adjustment for couples in Brazil*. J. Fam. Psychother. 2008; 19(2): 170–186.

32. Pilecki MW, Józefik B. *Perception of transgenerational family relationships: Comparison of eating-disordered patients and their parents*. Med. Sci. Monit. 2013; 19:1114-1124 DOI: 10.12659/MSM.889432.
33. Pilecki MW, Józefik B, Sałapa K. *Disordered eating among mothers of Polish patients with eating disorders.* Med. Sci. Monit. 2012: Vol. 18, no. 12, p. CR758-CR764.
34. Harper JM, Elliott ML. *Can there be too much of a good thing? The relationship between desired level of intimacy and marital adjustment*. Am. J. Fam. Ther. 1988, 16(4): 351–360.
35. Minuchin S, Rosman BL, Baker L. *Psychosomatic families: anorexia nervosa in context*. Cambridge, MA: Harvard University Press; 1978.
36. Selvini Palazzoli M, Viaro M. *The anorectic process in the family. a six stage model as a guide for individual therapy.* Fam. Proc. 1988; 27(2): 129–148.
37. Józefik B, Pilecki MW, Matusiak F. *Mutual assessment of their marital relationship by parents of female patients with eating disorders.* Psychiatr. Pol. 2014; 48(4): 809–822.
38. Józefik B. *Anoreksja i bulimia psychiczna*. Krakow: Jagiellonian University Press; 1999.
39. Józefik B, Pilecki MW. *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*. Arch. Psychiatr. Psychother. 2010, 4: 79–86.
40. Józefik B, Pilecki MW. *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.* Arch. Psychiatr. Psychother. 2010; 4: 69–77.
41. Mitchison D, Hay P. *The epidemiology of eating disorders: genetic, environmental, and societal factors.* Clin. Epidemiol. 2014; 6: 89–97.
42. Pilecki MW, Józefik B, Sałapa K. *The relationship between assessment of family relationships and depression in girls with various types of eating disorders*. Psychiatr. Pol. 2013; 3: 385–395.
43. Fairburn CG, Cooper Z. *Eating disorders, DSM-5 and clinical reality*. Br. J. Psychiatry 2011; 198: 8–10.

Address: Maciej Pilecki
Department of Child and Adolescent Psychiatry
Jagiellonian University Medical College
31-501 Kraków, Kopernika Street 21a