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Marital and Parent–Child Relationships in Families With Daughters Who Have Eating Disorders

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This study assesses and compares the relationship between parents’ marital quality, parent–child relationship, and severity of eating-related psychopathology in families with and without eating disorders. Data are collected from the mother, father, and daughter of 30 families with a daughter diagnosed with anorexia or bulimia and from 30 matched healthy control families. Results indicate that parents of daughters with anorexia or bulimia have significantly lower marital quality than the control group, and the daughters report lower relationship quality with their parents. Parent–child relationships serve as a mediating variable between parents’ marital quality and severity of the eating-related psychopathology. Results highlight that higher marital quality is associated with better parent–child relationships, which are related to a lower severity of eating-related psychopathology.

Keywords: eating disorders; marital quality; parent–child relationships

Over the last four decades, eating disorders have received increased attention in both professional and popular literature. This is due in part to the increased prevalence of eating disorders in the Western world and the high morbidity and mortality rates associated with them (Herzog et al., 2000). The etiology of eating disorders is thought to be multifactorial, with

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interacting biological, cultural, personality, and familial influences (Fairburn & Harrison, 2003).

This study focused on the association between eating disorders and relationships within the family, specifically, the two family subsystems: the parental marital system and the parent–child relationship. It aimed to examine families of children with eating disorders with different levels and types of parental marital quality and/or parent–child relationships, comparing them with families with healthy children. It also sought to assess the extent to which parental marital quality and parent–child relationships are related to the severity of a daughter’s eating disorders.

The role of the family in the etiology and maintenance of eating disorders has been emphasized in the theoretical, clinical, and research literature throughout the last four decades (Latzer & Gaber, 1998; LeGrange, 2005; McGrane & Carr, 2002; Minuchin, Rosman, & Baker, 1978). The association between family functioning and pathology of eating disorders has been widely documented by both researchers and clinicians. Studies in clinical samples found that dysfunctional family dynamics (Benninghoven, Schneider, Strack, Reich, & Cierpka, 2003; Latzer, Hochdorf, Bachar, & Conetti, 2002; Wisotsky et al., 2003) and dysfunctional parental characteristics (Davies & Forman, 2002; de Amusquibar & de Simone, 2003; LeGrange, 2005) are associated with eating disorders.

Girls with eating disorders are also associated with distress and conflict within their parents’ marital relationships. Parents whose daughters suffer from anorexia nervosa report difficulties in achieving intimacy and trust within their marital relationship (Bemporad & Ratey, 1985; Crisp, 1983) and have difficulty establishing appropriate boundaries with their children (Clopton, Haas, & Kent, 2001; Rowa, Kerig, & Geller, 2001). They also experience triangulation (Ema & Danielak, 1995; McDermott, Batik, Roberts, & Gibbon, 2002), overinvolvement, enmeshment, overprotectiveness, and poor problem solving (Blair, Freeman, & Cull, 1995). It is important to note, however, that although the level of family discord and the severity of eating disorders can be related, extreme caution is needed not to blame parents for their child’s eating disorders. Instead, one should look at parental dynamics as a means of better understanding the child and should utilize the parents as powerful treatment tools.

The association between poor parental marital quality and a child’s psychological and behavioral problems has been well documented in relation to other disorders. Exposure to high levels of interparental conflict places the child at increased risk for developing a wide range of psychological problems, including emotional, behavioral, social, and academic difficulties (Dunn & Davies, 2001; Grych & Fincham, 2001; Jouriles, Bourg, &
Farris, 1991; Reid & Crisafulli, 1990). An influencing factor is children’s increased sensitivity to their parents’ unspoken anger, repressed feelings, and negative interactions, which are often expressed through deviant behavior (Cummings, Ballard, & El-Sheikh, 1991).

It is also possible that the association between parents’ marital relationship and their child’s symptoms mediates the type of relationship parents have with their child (Black & Carroll, 1993; Fauber, Forehand, McCombs, & Wierson, 1990; Katz & Gottman, 1993; Stratton & Hammonds, 1999). Parental conflict appears to harm and decrease the closeness of the parent–child relationship (Belsky, Youngblade, Rovine, & Volling, 1991), which in turn may affect the child both emotionally and behaviorally (Crockenberg & Covey, 1992; Cummings & Davies, 1994). Other studies have shown that unhappy marriages often result in the father’s withdrawal from his spouse and children (Dickstein & Parke, 1988) and in direct and indirect expressions of negativity toward them (Crockenberg & Covey, 1992). Likewise, mother–child relationships in unhappy marriages are characterized by less involvement and increased expression of negative emotions (Erel & Burman, 1995; Stratton & Hammonds, 1999).

To the best of our knowledge, there is no documented research examining the association between parents’ marital quality, the parent–child relationship, and the severity of the child’s eating-related psychopathology. The aims of this study were therefore twofold: (a) to compare the marital quality and parent–child relationship among families with a child suffering from anorexia or bulimia with families in a healthy control group and (b) to examine the association between the parents’ marital quality, the parent–child relationship, and the severity of the eating-related psychopathology. It was hypothesized that families with a child suffering from anorexia or bulimia would display an increase in marital distress and would demonstrate a more dysfunctional parent–child relationship. It was also hypothesized that the association between the parents’ marital quality and the severity of the child’s eating-related psychopathology would be mediated by the parent–child relationship, and that a reduction in the marital quality would be associated with less favorable parent–child relationships. As such, these relationships would be associated with higher levels of eating-related psychopathology.

**Method**

**Participants**

The sample consisted of two groups: an eating disorder group and a control group. Participants in the eating disorder group included 30 family triads.
Each triad consisted of an adolescent or young adult daughter with an eating disorder diagnosis and her two biological parents. Of the 30 female eating disorder patients, 15 were diagnosed with anorexia nervosa and 15 with bulimia nervosa. All participants were Jewish and Israeli-born.

All participants in the eating disorder group were receiving active treatment at the Eating Disorders Clinic at the Rambam Medical Center in Haifa, Israel. Diagnoses were made according to the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.) (American Psychiatric Association [APA], 1994). Both the daughters and the parents were asked to sign a consent form confirming their willingness to participate in the study. The study was approved by the Helsinki Committee for Research on Human Subjects at Rambam Medical Center.

The control group consisted of 30 adolescents or young adult women, matched for age and socioeconomic background with the eating disorder group, and their biological parents. To select a comparison group that closely resembled the eating disorder group, each girl in the eating disorder group was asked to provide a list of names of her closest friends. The initial recruitment was performed according to this list, and 60 families were contacted and asked to participate in the study.

**Instruments**

All participants completed all questionnaires, including a demographic questionnaire. At this time, all participants were in an active phase of the illness and were undergoing different stages of treatment at the Eating Disorder Clinic. Each individual parent completed three questionnaires: the Family Functioning Questionnaire, the Perceived Marital Quality Questionnaire, and Level of Intimacy Questionnaire. The daughters completed the Eating Disorder Inventory (EDI) questionnaire (a scale measuring eating-related psychopathology) and a questionnaire about the parent–child relationship as well as a short questionnaire that assessed how they perceived their parents’ marital quality.

*Marital quality* was measured using a modified version of the short ENRICH scale (Fowers & Olson, 1993). The original instrument is a 10-item Likert-type scale that assesses the respondent’s perceived quality of his or her marriage across 10 dimensions of the relationship. Fowers and Olson (1993) reported good reliability estimates of the short ENRICH scale as well as high concurrent and predictive validity. In the modified version (Lavee, 1995), items and response categories were adapted to decrease the response set. Instead of the original Likert-type scale in which items are
ranked between fully agree and fully disagree, each item is given two extreme response categories and the respondent is asked to check a number on a scale ranging between these responses (e.g., “When we have conflicts or disagreements—[1] We always come to an agreement . . . [7] We are seldom able to bridge our differences”). This type of scale (see, e.g., Antonovsky, 1987) was found to be less affected by social desirability than a typical Likert-type scale. In the present study, the Cronbach alpha reliabilities were .85 and .87 for fathers and mothers, respectively. The total score is a mean of the 10 items, with higher scores representing higher evaluations of marital quality.

Adolescent’s perception of her parents’ marital quality was measured by a single item: “How would you describe your parents’ relationship?” Responses were rated on a 5-point Likert-type scale, ranging from 1 (very unhappy) to 5 (very happy).

Eating-related psychological problems were measured by the Eating Disorder Inventory (EDI; Garner, Olmsted, & Polivy, 1983). The EDI is a 64-item self-report questionnaire that measures the psychological and behavioral characteristics related to anorexia nervosa and bulimia nervosa. These characteristics are measured on eight subscales: drive for thinness, bulimic tendencies, body dissatisfaction, ineffectiveness, perfectionism, interpersonal distrust, interceptive awareness, and maturity fears. Responses were rated on a 6-point Likert-type scale, ranging from 1 (never) to 6 (always). Subscale scores are obtained by adding up its associated item response scores, and a total score of the severity of eating-related psychological problems is achieved by summing up all items. An EDI total score above 57 indicates psychopathology. In the present study, the internal consistency reliability (Cronbach alpha) of the eight subscales ranged between .61 and .93, and the reliability of the total scales was .94.

Parent–adolescent relationships were measured using a scale developed by Mayseless and Hai (1998), based on Schaefer’s (1965) parent–child relationship questionnaire. The original scale consists of 126 items, including two sets of 63 similar items, asking the adolescents to describe their relationship with their mother and father. The scale is composed of eight subscales: emotional closeness, supervision, autonomy, mutual relations, open confrontation, communication, rejection, and strangeness. Respondents are asked to indicate the extent to which each statement describes their relationship with their mother and father on a 6-point Likert-type scale, ranging from 1 (not at all) to 6 (very much). Higher scores indicate better parent–adolescent relationships. In this study, only four of the subscales
were included: emotional closeness, autonomy, supervision, and open confrontation. The other four subscales were not used owing to their high correlations with the emotional closeness subscale. The internal consistency reliability (Cronbach alpha) of the subscales ranged from .85 to .95.

Results

Table 1 presents the descriptive statistics of the adolescents or young adult women and their parents in both eating disorder and control groups. The two groups did not differ on any of the demographic characteristics. The age range for the adolescent females was 15 to 26 (eating disorder group, 20 ± 3.11, control group, 20 ± 3.18). Among the parents of the adolescents diagnosed with anorexia or bulimia, the mean parent age was 49 ± 6.9 and 51 ± 6.56 for mothers and fathers, respectively. In the control group, the mean parent age was 48 ± 4.9 and 50 ± 4.8 for mothers and fathers, respectively. Parents of both groups had been married for an average of 26 years (eating disorder group 26.9 ± 6.7, control group 25.8 ± 5.3) and had an average of three children (eating disorder group 3.4 ± 1, control group 3.2 ± 1.3). There was no difference between the parents of both groups in education level or employment status.

Table 2 provides demographic and clinical characteristics of the anorexic and bulimic patients and the control group. As expected (given the diagnostic criteria for anorexia and bulimia), the patients with anorexia nervosa were significantly younger than the patients with bulimia nervosa and weighed significantly less (a difference of more than 11 kg). The anorexia...
nervosa patients’ weight and body mass index were also significantly lower than those of the control group (BMI = weight in kg/[height in m]²). The patients with bulimia nervosa did not differ from those in the control group in measures of weight, but their body mass index was significantly higher.

Analyses were conducted in two steps. In the first step, the three groups (anorexia, bulimia, and control group) were compared with respect to their eating-related psychopathology indices, parent–child relationships, and the parents’ marital quality. In the second step, the relations among the study variables were examined and a model of the mediating role of parent–child relationships in the link between the parents’ marital quality and the adolescent’s eating-related psychopathology was tested.

**Group Differences in Eating-Related Psychopathology Indices**

To compare the three groups (anorexia, bulimia, and control group) in the eating-related psychopathology index (EDI), a one-way analysis of variance was conducted. The findings indicated a significant difference between groups, $F(2, 57) = 26.48$, $p < .01$, with the bulimic patients scoring highest ($M = 91.00$, $SD = 32.45$), followed by the anorexic patients ($M = 63.69$, $SD = 20.38$), and the control group ($M = 38.28$, $SD = 16.30$).
SD = 39.34) and then the control group (M = 29.54, SD = 13.92). These findings corroborate the EDI norms, according to which a total score of 57 or above signifies an eating-related psychopathology.

A multivariate analysis of variance (MANOVA) was conducted to compare the three groups in the eight subscales of the EDI. The findings indicated an overall difference between groups, $F(8, 51) = 13.23, p < .01$. The analysis (see Table 3) showed that both eating disorder groups scored significantly higher than the control group in six of the eight subscales: drive for thinness, ineffectiveness, perfectionism, interpersonal distrust, interceptive awareness, and maturity fears. The patients suffering from bulimia nervosa scored higher in bulimic tendencies and body dissatisfaction than those with anorexia nervosa and the control groups. However, no significant difference in body dissatisfaction was found between the anorexia group and the control group.

### Table 3

Means, Standard Deviations, and Multivariate Analyses of Variance for Differences Between the Eating Disorder Groups and the Control Group in Eating Disorder Indices

<table>
<thead>
<tr>
<th>Subscale</th>
<th>Anorexia (n = 15)</th>
<th>Bulimia (n = 15)</th>
<th>Control (n = 30)</th>
<th>F(2, 57)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drive for thinness</td>
<td>1.66&lt;sub&gt;a&lt;/sub&gt;, 1.04</td>
<td>2.14&lt;sub&gt;a&lt;/sub&gt;, 0.97</td>
<td>0.73&lt;sub&gt;b&lt;/sub&gt;, 0.76</td>
<td>14.07**</td>
</tr>
<tr>
<td>Bulimic tendencies</td>
<td>0.35&lt;sub&gt;b&lt;/sub&gt;, 0.40</td>
<td>1.50&lt;sub&gt;a&lt;/sub&gt;, 0.70</td>
<td>0.16&lt;sub&gt;b&lt;/sub&gt;, 0.33</td>
<td>43.63**</td>
</tr>
<tr>
<td>Body dissatisfaction</td>
<td>1.20&lt;sub&gt;ab&lt;/sub&gt;, 1.07</td>
<td>2.06&lt;sub&gt;a&lt;/sub&gt;, 0.83</td>
<td>0.76&lt;sub&gt;b&lt;/sub&gt;, 0.74</td>
<td>11.64**</td>
</tr>
<tr>
<td>Ineffectiveness</td>
<td>1.38&lt;sub&gt;a&lt;/sub&gt;, 0.95</td>
<td>1.33&lt;sub&gt;a&lt;/sub&gt;, 0.71</td>
<td>0.25&lt;sub&gt;b&lt;/sub&gt;, 0.21</td>
<td>24.94**</td>
</tr>
<tr>
<td>Perfectionism</td>
<td>1.22&lt;sub&gt;a&lt;/sub&gt;, 0.93</td>
<td>1.61&lt;sub&gt;a&lt;/sub&gt;, 0.77</td>
<td>0.82&lt;sub&gt;b&lt;/sub&gt;, 0.68</td>
<td>5.53**</td>
</tr>
<tr>
<td>Interpersonal distrust</td>
<td>0.76&lt;sub&gt;a&lt;/sub&gt;, 0.77</td>
<td>0.85&lt;sub&gt;a&lt;/sub&gt;, 0.57</td>
<td>0.19&lt;sub&gt;b&lt;/sub&gt;, 0.38</td>
<td>9.54**</td>
</tr>
<tr>
<td>Interceptive awareness</td>
<td>1.05&lt;sub&gt;a&lt;/sub&gt;, 0.55</td>
<td>1.26&lt;sub&gt;a&lt;/sub&gt;, 0.56</td>
<td>0.54&lt;sub&gt;b&lt;/sub&gt;, 0.19</td>
<td>17.69**</td>
</tr>
<tr>
<td>Maturity fears</td>
<td>0.84&lt;sub&gt;a&lt;/sub&gt;, 0.64</td>
<td>1.03&lt;sub&gt;a&lt;/sub&gt;, 0.80</td>
<td>0.38&lt;sub&gt;b&lt;/sub&gt;, 0.26</td>
<td>8.14**</td>
</tr>
</tbody>
</table>

Note: Means with different subscripts within a row are significantly different at $p < .05$ with Tukey’s post hoc test.

**$p < .01$.**

Group Differences in Parents’ Marital Quality and Parent–Child Relationships

Table 4 depicts means, standard deviations, and analyses for differences between the three groups in the parents’ marital quality and parent–child
A MANOVA for group differences in the parents’ marital quality indicated an overall difference between groups, $F(3, 56) = 6.23$, $p < .01$. Post hoc tests for group differences on each measure (see Table 4) show that both mothers and fathers in the two eating disorder groups reported lower levels of marital quality than parents in the control group. The daughters in both eating disorder groups perceived their parents’ marriages as less happy than did those in the control group.

A MANOVA on the four mother–daughter and the four father–daughter relationship variables indicated an overall difference between groups, $F(8, 51) = 6.94$, $p < .01$. As Table 4 shows, group differences were found

Table 4
Means, Standard Deviations, and Multivariate Analyses of Variance for Differences Between the Eating Disorder Groups and the Control Group in Parents’ Marital Quality and Parent–Child Relationships

<table>
<thead>
<tr>
<th>Variable</th>
<th>Anorexia $(n = 15)$</th>
<th>Bulimia $(n = 15)$</th>
<th>Control $(n = 30)$</th>
<th>$F(2, 57)$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents’ marital quality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father’s report</td>
<td>$4.99_b$ 1.26</td>
<td>$5.03_b$ 1.12</td>
<td>$5.87_a$ 0.78</td>
<td>$5.42^{**}$</td>
</tr>
<tr>
<td>Mother’s report</td>
<td>$4.91_b$ 1.09</td>
<td>$5.20_b$ 1.02</td>
<td>$5.74_a$ 0.91</td>
<td>$3.90^*$</td>
</tr>
<tr>
<td>Daughter’s report</td>
<td>$3.40_b$ 1.18</td>
<td>$3.13_b$ 1.13</td>
<td>$4.20_a$ 0.71</td>
<td>$7.44^{**}$</td>
</tr>
<tr>
<td>Mother–child relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional closeness</td>
<td>$3.84_b$ 1.20</td>
<td>$3.87_b$ 1.24</td>
<td>$5.16_a$ 0.89</td>
<td>$11.13^{**}$</td>
</tr>
<tr>
<td>Confrontation</td>
<td>$3.79_a$ 1.16</td>
<td>$3.97_a$ 0.92</td>
<td>$2.24_b$ 0.93</td>
<td>$20.61^{**}$</td>
</tr>
<tr>
<td>Autonomy</td>
<td>$4.21_{ab}$ 0.96</td>
<td>$3.82_b$ 1.21</td>
<td>$4.87_a$ 0.90</td>
<td>$6.10^{**}$</td>
</tr>
<tr>
<td>Supervision</td>
<td>$2.98_a$ 1.10</td>
<td>$3.07_a$ 0.96</td>
<td>$2.15_b$ 0.75</td>
<td>$7.20^{**}$</td>
</tr>
<tr>
<td>Father–child relationship</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emotional closeness</td>
<td>$3.77_b$ 1.34</td>
<td>$3.62_b$ 1.19</td>
<td>$4.70_a$ 0.90</td>
<td>$6.36^{**}$</td>
</tr>
<tr>
<td>Confrontation</td>
<td>$3.34_a$ 1.21</td>
<td>$3.17_a$ 1.21</td>
<td>$1.98_b$ 0.76</td>
<td>$12.22^{**}$</td>
</tr>
<tr>
<td>Autonomy</td>
<td>$4.50_a$ 0.98</td>
<td>$3.71_b$ 0.84</td>
<td>$4.92_a$ 0.90</td>
<td>$8.82^{**}$</td>
</tr>
<tr>
<td>Supervision</td>
<td>$2.77_a$ 1.27</td>
<td>$2.79_a$ 0.87</td>
<td>$2.00_b$ 0.68</td>
<td>$5.52^{**}$</td>
</tr>
</tbody>
</table>

Note: Means with different subscripts within a row are significantly different at $p < .05$ with Tukey’s post hoc test.

$^{**}p < .05$. 

relationships.
in all measures of parent–child relationships. Post hoc tests did not identify differences between the two eating disorder groups, with the exception of perceived autonomy in father–daughter relationships. This finding indicates that the two groups are quite similar with regard to parent–child relationships. However, the two eating disorder groups (bulimia and anorexia) differed from the control group on three of the four subscales for both father–daughter and mother–daughter relationships: emotional closeness, confrontation, and supervision. Only in autonomy and relations with both parents did adolescents in the control group differ significantly from those with bulimia, but were similar to those with anorexia.

### Links Between the Parents’ Marital Quality, Parent–Child Relationships, and Eating-Related Psychopathology

To examine the associations between the parents’ marital quality, the parent–child relationships, and the adolescents’ eating-related psychopathology, we examined the pattern of associations between the study variables for all participants and assessed a structural equation model of the links between these variables. The correlation matrix, as depicted in Table 5, shows that father–daughter relationships were associated with both parents’ perceptions of their marital quality and that mother–daughter
relationships were associated with the fathers’ reports of marital quality. Parent–child relationships were also associated with the daughters’ perceptions of their parents’ marital relationship. Eating-related psychological problems was negatively related to the adolescents’ relationships with the father and the mother \( (r = -0.36 \text{ and } r = -0.47, \text{ respectively, } p < .01) \) and to a lesser degree to the father’s \( (r = -0.27, p < .05) \) and the mother’s \( (r = -0.14, ns) \) perceptions of the marital quality. The level of eating-related psychopathology was however strongly related to the daughters’ perceptions of the parents’ marital quality. Altogether, these findings suggest that parent–child relationships mediate between the parents’ marital quality and the daughters’ eating-related psychopathology.

To test the mediating model, we estimated a structural equation model, as depicted in Figure 1. In this model, the parents’ marital quality, parent–child relationships, and daughters’ level of eating-related psychopathology are specified as latent variables, with each defined by a set of observed (measured) indicators. Marital quality is specified by three indicators: the mother’s, the father’s, and the daughter’s perception of the marriage. Parent–child relationships are specified by two indicators: the daughter’s reports of her relationships with her mother and with her father. Eating-related psychopathology is specified by two randomly split halves of the EDI scale. This was done to obtain more than one indicator for a latent variable. Given that the scale is randomly split, both subindices are assumed to be expressions of the same basic latent construct (see, e.g., Lavee & Katz, 2002; Vinokur, Price, & Caplan, 1996). The correlation between these indicators was .80 \( (p < .01) \). In the structural model, parent–child relationships are specified as a mediating factor between the parents’ marital quality and the daughter’s level of eating-related psychopathology.

The model was analyzed using LISREL 8.5 program (Jöreskog & Sörbom, 2001). Analysis of the model indicated a very good fit to the data. The minimum fit function chi-square, with 11 degrees of freedom, was 10.17 \( (p = .50) \), and the root mean square error of approximation (RMSEA) was less than 0.001, with a 90% confidence interval ranging from 0.0 to 0.059. All other fit statistics also indicated a good fit to the data (normed fit index [NFI] = .99; comparative fit index [CFI] = 1.00; relative fit index [RFI] = .98).

Analysis of the model indicated that parent–child relationships mediate the link between the parents’ marital quality and the daughter’s level of eating-related psychopathology. In this model, the direct link between marital quality and eating-related psychopathology approaches zero. Higher level of marital quality is associated with better parent–child relationships, which are in turn related to a lower level of eating-related psychopathology.
The role of the family in the etiology and maintenance of eating disorders has been documented in clinical, theoretical, and research reports through several decades (Dare, Le Grange, Eisler, & Rutherford, 1994; LeGrange, 2005, Minuchin et al., 1978, North, Giwers, & Brian, 1995). Although current research discusses the presence of marital and parent–child difficulties within families who have a daughter suffering from anorexia or bulimia, there is still a dearth of research linking the two factors. The aims of the present study were to compare the marital relationship and parent–child relationship in these families with those of families with a healthy

Figure 1
Standardized Coefficients for a Structural Equation Model of Parent–Child Relationships as a Mediator Between the Parents’ Marital Quality and the Child’s Eating-Related Psychopathology

Note: All coefficients are significant at \( p < .05 \) except those shown in dashed arrow. EDI-1 and EDI-2 are split halves of the Eating Disorder Index scale. AGFI = adjusted goodness of fit index; NNFI = Tucker–Lewis non-normed fit index; RMSEA = root mean square error of approximation.

Discussion

The role of the family in the etiology and maintenance of eating disorders has been documented in clinical, theoretical, and research reports through several decades (Dare, Le Grange, Eisler, & Rutherford, 1994; LeGrange, 2005, Minuchin et al., 1978, North, Giwers, & Brian, 1995). Although current research discusses the presence of marital and parent–child difficulties within families who have a daughter suffering from anorexia or bulimia, there is still a dearth of research linking the two factors. The aims of the present study were to compare the marital relationship and parent–child relationship in these families with those of families with a healthy
daughter and to examine the association between the parents’ marital quality, the parent–child relationship, and the severity of the eating-related psychopathology.

A finding that deserves special attention is that no significant differences were found between patients who suffered from anorexia nervosa and those who suffered from bulimia nervosa. These results support recent conceptualization of the diagnostic characteristics of eating disorders. Whereas anorexia nervosa and bulimia nervosa may differ in their external manifestation, there may be no essential difference between them in their underlying psychopathology. It has been suggested that eating disorders exist on a continuum and that individuals may oscillate between anorexia and bulimia characteristics throughout the illness process (Fairburn & Harrison, 2003). Furthermore, current conceptions view eating disorders as an umbrella term for several kinds of eating problems (APA, 1994). According to this view, all eating disorders share certain commonalities, and symptoms of both disturbances may be found concurrently in a particular individual (Garner & Garfinkel, 1997; Treasure & Campbell, 1994).

As hypothesized, these findings revealed that families with a daughter suffering from anorexia or bulimia are characterized by significantly higher levels of distress within their marital relationships and less favorable parent–child relationships than nonsymptomatic families. This is consistent with previous studies that have also found that families with a daughter suffering from anorexia nervosa experience increased levels of conflict, difficulties in achieving intimacy and trust, and a lack of harmony between the parents (Bemporad & Ratey, 1985; Crisp, 1983; Yager, 1982). These findings provide empirical support for continued clinical observations and further research of disturbed relationships within families with a daughter suffering from anorexia or bulimia (Blair et al., 1995; Ema & Danielak, 1995; Kog, Vandereycken, & Vertommen, 1989; Minuchin et al., 1978; Rowa et al., 2001).

Evidence of greater marital distress among parents of patients with eating disorders, as supported by the present and previous studies, does not appear to support a clinical conceptualization of a child’s psychological symptoms serving as a protective factor for the parental relationship and marital quality. This theoretical concept is based on the premise that a child’s illness indirectly unites the parents, specifically that the parents will suppress their own conflicts and focus on their child’s problems, thereby bringing them together (Dare et al., 1994; Davies & Forman, 2002; Kog et al., 1989; Minuchin et al., 1978; Yahav & Sharlin, 2000). The fact that in the present study, both the parents and the daughters who suffer from anorexia
or bulimia perceived the marital relationship as less happy, as compared to nonsymptomatic families, suggests that a child’s symptoms did not create a closer marital relationship between the parents, rather that the parents’ closeness is a temporary state to better provide for their child but not an indicator of increased marital happiness or functioning.

The study results also confirm that the parent–child relationship among families of adolescents with anorexia or bulimia may present more tension and distress than those found in nonsymptomatic families. The conflict and relationship differences between the two groups of families were apparent on all four factors related to daughter–parent relationships: emotional closeness, open confrontation, autonomy, and supervision. This supports previous research that indicated that parents of adolescents with anorexia or bulimia supervise them more strictly, limit their autonomy, and provide less encouragement for their development of internal resources, thereby hindering their overall process of individuation and personal growth (Dancyger, Fornari, Scionti, Wisotsky, & Mandel, 2003; Latzer et al., 2002; Mujtaba & Furnham, 2001; Solomon, Klump, McGue, Iacono, & Elkins, 2003).

**Links Between the Parents’ Marital Quality, Parent–Child Relationships, and Eating-Related Psychopathology**

Analysis of the results suggests an emerging model that represents families with a daughter suffering from anorexia or bulimia. This model conceptualizes that the parents’ marital quality and the severity of eating-related psychopathology is mediated by the parent–child relationship. A lower level of marital quality is associated with a less favorable parent–child relationship, which in turn is associated with a higher level of eating-related psychopathology. These findings suggest that difficulties in a parent’s marital quality have a negative impact on the parent–daughter relationship, which consequently augments and may maintain the daughter’s eating disorder.

This suggested sequence of effects is guided primarily by theory and previous research on the effects that marital relationships have on a child’s psychological well-being and outcome (Katz & Gottman, 1996). Katz and Gottman identified marital processes that are associated with spillover from unhappiness in the marriage to the way in which mothers and fathers parent and coparent their children. They found that mother–child and father–child relationships mediate the link between specific qualities in the marriage and child outcomes. Our findings are similar to other studies examining the
relationship between a disturbed couple’s marital functioning and its child’s negative behaviors (Jouriles, Borg, & Farris, 1991; Reid & Crisafulli, 1990). These studies indicate that exposure to high levels of interparental conflict may increase a child’s psychological problems, including emotional, behavioral, social, and academic difficulties (Dunn & Davies, 2001; Grych & Fincham, 2001).

This study adds an important dimension to previous research, by examining the parents’ marital quality and parent–child relationship from both the parents’ and daughters’ perspectives and the influence of these relationships on the presence of anorexia or bulimia and its severity. It is important to bear in mind that because of the cross-sectional nature of the study, any assertion about the causal effects of the marital relationship on the parent–child relationship and the level of eating disorder severity should be made with caution. It may well be that the relation between these variables are more complex and circular. It could be argued, for example, that an adolescent’s eating disorder affects the relationship with her parents and her perception of her parent’s marital relationship and that the problems in the parent–child relationship influence the parents’ marital relationship. In any case, the current study unequivocally shows that the association between a child’s eating-related psychopathology and the parents’ marital quality is mediated by the parent–child relationship.

The current research findings strengthen the concepts found within the family systems theory, especially among families with a child who suffers from anorexic or bulimic symptoms. Most notably, the family systems concept of boundaries and flexibility emphasizes the importance of clear and strong boundaries between the parent and children subsystems, while maintaining flexibility within these boundaries to allow open and direct communication between the two subsystems (Minuchin et al., 1978). The results show that the mediating factor is the parent–child relationship, a strong parent–child relationship built on clear boundaries and open and supportive communication. And even if the marital relationship is in distress, they are able to function as a unified parental unit, thereby reducing the likelihood of symptom presentation.

**Study Limitations and Strengths**

A few caveats should be noted in interpreting and generalizing the findings of the study. First, because the sample was relatively small, one should exercise caution when generalizing the findings to a population of patients.
with eating disorder. However, despite the sample size, significant differences were found between the two clinical groups and the control group, in addition to significant associations between the study variables. These findings attest to the magnitude of effects and strengthen our confidence in these findings.

The small sample size affects the structural equation model analysis. Generally speaking, structural equation models with latent variables are considered to be more stable with a larger sample size. In this study, we chose to conduct such an analysis despite the sample size, because it has numerous advantages over a bivariate correlation analysis and standard regression and path analysis (Lavee, 1988).

A second consideration in interpreting the findings relates to the cross-sectional nature of the study. As noted above, any conclusions about the causal effects of the marital relationship on parent–child relationships and on eating disorders cannot be validly drawn. Some of the shortcomings of cross-sectional designs were circumvented by the collection of data from multiple family members, namely, both the parents and the daughters. The estimation of associations between variables that are measured by different raters help overcome biased effects due to common method variance, which is a prevalent problem in cross-sectional self-report studies (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003). More specifically, the relations found between the parents’ marital quality and the parent–child relationships and the associations between the parents’ marital quality and eating disorders could not have been inflated by a common method variance.

An additional limitation is that this study only consisted of families in which the daughter was living with both biological parents—which is an unusual occurrence in the United States and other Westernized societies today. Thus, an important area for future research might be the study of diverse family forms.

**Recommendations for Future Research**

This study dealt with the relationship between individuals suffering from an eating disorder and their parents as well as the independent parental relationship. Although this research indicated that marital quality has the potential to mediate eating disorder severity, further examination is required regarding the exact factors within the parents’ relationship that are helping to mediate eating disorder severity. This study examined the parent–child relationship solely from the adolescent’s perspective. Future research should also include the parent’s perception of the parent–child relationship.
to assess for any discrepancy and to determine how possible differing perceptions are mediating the level of eating disorders and marital quality. It is also important to examine the siblings in families with anorexia or bulimia patients to determine if they perceive the parents’ marital relationship in the same way as the sibling with eating disorder and if they report similar or different relationships with their parents. However, caution should be exercised in situations where there is a suspicion of sexual abuse within the family. Whereas the current study focused only on female adolescents, future research should examine the links between the parents’ marital relationship, the parent–child relationship, and the severity of eating disorders among sons rather than daughters. It would also be interesting to track the progression of the eating disorder severity in relation to the positive or negative progression of marital and parent–child relationship and quality.

Clinical Implications

This study may have several treatment implications. Most importantly, the findings regarding the marital and parent–child relationships in the families of patients with eating disorders support the notion that intervention programs should be directed at the family as a system rather than focusing solely on the individual patient. Moreover, given the mediating role that marital relationships play in eating disorder severity, it would be important for parents experiencing marital strife to seek independent marital counseling. It is recommended that all three components included in this study (i.e., the parents’ marital relationship, the parent–child relationships, and the perception of patients with anorexia or bulimia) should be included in the assessment at the beginning of treatment and throughout the treatment process. Furthermore, we recommend that clinicians assess all relevant family members’ perceptions of family relations, both marital and parent–child. The use of both standardized assessment instruments and qualitative assessment procedures may be helpful in constructing an effective intervention (Sperry, 2004).

The finding that parent–child relationships may mediate the link between the parents’ marriage and the severity of eating disorder may suggest that treatment would be more effective if clinicians attended to the parents’ overall marital relationship, the spillover of emotions from marital conflict to parent–child relationships, and the ways in which patients with anorexia or bulimia perceive and react to their parents’ marital relationship and their own relationships with them.
References


