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Mutual assessment of their marital relationship by parents of female patients with eating disorders

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Summary

Aim: The goal of this study was to assess the perception of marital relationship and its mutual connections by parents of (female) patients diagnosed with eating disorders. Data from: 54 (female) patients diagnosed with restrictive anorexia nervosa (ANR), 22 with binge-purge anorexia nervosa (ANBP), 36 with bulimia (BUL), and two control groups: 36 (female) patients diagnosed with depressive disorders (DEP) and 85 Krakow schoolgirls (NOR).

Material and method: The study employed the Dyadic Relations Scale, a part of the Family Assessment Measure (Polish version).

Results: Wives in the BUL group, compared to wives in the NOR group, rated their hus- bands worse when assessing their husbands in terms of how well they functioned in the marital relationship, their performance of duties, affective involvement, and the integrity of values and rules of conduct. Wives in the ANR group, compared to wives in the NOR group, nega- tively rated the affective involvement of their husbands in the marital relationship. Husbands in the DEP group, compared to husbands in the NOR group, rated their wives worse when assessing their wives' general functioning in the marital relationship, degree of communication within it, degree of understanding, how well they performed their spousal duties, and the coherence of their system of values and rules of conduct. The image of the marital relationship held by parents of Krakow schoolgirls was char- acterized by a strong correlation, in contrast to the image of the relationship held by parents of (female) patients, regardless of the nature of the diagnosis.

Conclusions: Comparison of the results of parents of (female) patients with eating disorders and parents of (female) patients with a diagnosis of major depressive disorder revealed no difference in the image of the marital relationship, whether in the mutual assessment of spouses towards each other or in connection with the assessments**.**

Key words: anorexia nervosa, bulimia nervosa, husband, wife, marital relationship, FAM III

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Introduction

A majority of classical clinical models stress the importance of the marriage relationship in the dynamics of the development of eating disorders and the mechanisms sustaining the course of the illness. Even though contemporary research may have departed from attempting to uncover the aetiological factors motivating eating disorders, the impact a child's chronic mental disorder may have on the functioning of the family, including marital relationships, is something that is still emphasized. The authors of clinical models of eating disorders draw particular attention to the specific character of marital bonds, styles of communication, methods of conflict resolution, and patterns of involving children in these relationships. With regard to parents of anorexic (female) patients, we may here recall the view of Weber and Stierlina [1], which points out a characteristic weakness of the marital subsystem, expressed by a preference for the parental role over a close marital bond. One may also recall the classical views of Minuchin et al. [2], which suggest difficulties with resolving situations of conflict and a tendency to involve the child in the marital relationship are characteristic of the functioning of a married couple. As a result, couples do not confront problems in their relationship, and tension is relieved in triangulation with the child. In turn, Palazzoli et al [3] describe the marital relationships of parents of anorexic (female) patients as grounded in mutual disappointment and resentment, while at the same time preserving the facade of a unified relationship. The authors suggest a game played unconsciously, which depends on mutual provocation and the failure to meet expectations, is one of the significant elements involving the child in the unspoken marital conflict, in particular a child who later becomes a patient.

Despite the emphasis clinical models place on the marital relationship for the development of eating disorders, we only have a low number of empirical studies verifying these clinical observations. The bulk of research is devoted to the functioning of a patient's entire family, without considering the dynamic of a married couple's dyadic relationship. These observations only partially justify formulating hypotheses concerning the relationship between the parents, based on the coherence of family descriptions they present.

In their research on the families of anorexic (female) patients, Wallin and Hansson [4] described the mutual enmeshment of family members evaluated by independent observers, a conclusion consistent with Minuchin's conception. The parents of (female) patients from the clinical group in the FARS test (Family Relation Scale), like the observers, rated their families as very enmeshed. Latzer et al [5] draw attention, in turn, to the weaker cohesion and expressivity of families of anorexic (female) patients compared to the control group, as measured by the FES (Family Environment Scale); they also noted the limited support given to (female) patients' personal development, which was interpreted by the authors as interfering with the process of separation-individuation.

Dancyger et al [6], in their assessment of family functioning, portray subtle differences between the fathers of (female) patients and their mothers. In FAD tests (Family Assessment Device), fathers scored significantly higher on scales rating their ability to solve problems and their emotional responsiveness. Fathers and their ill daughters perceived greater dysfunction in the family than did mothers. In addition, a higher

level of depression in research subjects measured by BDI was associated with a more negative assessment of the family's functioning. The research of Nitendel-Bujak and Szewczyk [7], which includes the marital relationship of parents of (female) patients with restricted anorexia nervosa, reveals differences in the mutual perception of spouses, in comparison with the control group. Compared to what their husbands believed of themselves, the mothers of (female) patients perceived their husbands as more dominant, while at the same time believing their husbands exercised less control and were less open to others. Similarly, compared to what the wives believed of themselves, fathers of (female) patients ascribed greater dominance to their wives, greater attractiveness and popularity, less depressiveness and fewer tendencies to shut themselves off. The authors note that, among the examined dimensions of family functioning, the greatest discrepancies occur between how a wife perceives her husband and how he himself views his own functioning. Lask [8], relying on a review of the academic literature concerning marriages of parents of anorexic (female) patients, points to difficulties with communication, intensifying conflicts, a lack of cohesion between the spouses, and difficulties in performing duties.

Studies of families that have a problem with bulimia also reveal difficulties in marital relationships. Johnson and Flasch [9] found, based on studies of families of bulimic (female) patients, greater difficulty in the marital relationship, which was expressed by high intensity marital conflict and little emphasis on expressing feelings openly compared to the control group. The research of Stasch and Reich [10] suggests that, in families of bulimic (female) patients, the parental marital relationship was the most conflictual of all dyadic relationships in the family. In the marital relationship of parents of bulimic (female) patients, other authors stress the tumultuous and unstable character of bonds, the difficulty couples have taking responsibility for their own relationship, as well as the atmosphere in the family. They point to an incoherent system of values, inconsistent rules of conduct, as well as difficulty in communicating feelings and displaying empathic understanding [1, 11, 12].

In an article describing research involving 180 (female) patients with eating disorders that was based on the self-report test FACES (Family Adaptation and Cohesion Scales), Tachi [13] proposed a continuum ranging from the absence of internal cohesion in a family (disconnection), which characterizes (female) patients diagnosed with binge-eating syndrome, through increasing cohesion in families of (female) patients with bulimia and binge-purge anorexia, to the enmeshment that characterizes families of (female) patients with restricting type of anorexia.

The studies of Latzer, Lavee and Gal [14] found parents of (female) patients with eating disorders experienced a significantly lower quality of married life compared to the control group. Greater satisfaction in the relationship between parents was associated with better dyadic relations between (female) patients and their parents, and a lower level of the pathological symptoms associated with eating disorders. In the literature on the subject, one may also encounter studies that do not confirm the presence of marital problems in families that have the problem of eating disorders [15]. In studies on the functioning of families with children suffering from eating disorder, it appears difficult to separate out how much of the current pattern of a family's or couple's function-

ing is rooted in its history and how much this pattern has been changed by the child's illness. Gilbert Shaw and Notar [16] conducted quantitative and qualitative research of a group of 52 mothers of (female) patients with eating disorders in which they examined the impact of the disease on the functioning of the family. On the one hand, the results revealed a higher level of anger and tension in relationships, associated with less time spent together with the husband; on the other hand, a number of the mothers reported they experienced a greater degree of closeness in the marital dyad.

Witney and Eisler in their article [17] refer to the concept of a "reorganization" of the family stemming from the manifestation of the eating disorder within it, thereby inverting the understanding of factor of the family as something that can play a distinct role in the aetiology of the disorders. They point out the illness of the child may fulfil a role as regulator of closeness in the marital relationship, while not being the cause of the emergence of disorder in the family. In his analysis of Minuchin's model psychosomatic illness, Wood [18] also notes, on the basis of his own research, that triangulation and marital conflict are relevant factors associated with the emergence of somatic illness, while the remaining characteristics, such as enmeshment, overprotectiveness and rigid functioning, are rather more adaptive behaviours, which are triggered in a family in the situation of the child's illness.

Studies concerning the impact of eating disorders on the functioning of the family appear to align well with the position taken by the Academy for Eating Disorders AED in 2009 [19], which strongly accents the lack of unambiguous data addressing the occurrence of the etiological factors underlying eating disorders in the family life of (female) patients. At the same time, these authors stress the importance of including the family in the process of treating teenage (female) patients as a factor that can improve and accelerate rehabilitation and recovery.

Goal of the study

The goal of this study was to attempt to describe how the parents of (female) patients diagnosed with different types of eating disorders perceive their own marital relationship compared to how the parents of female schoolgirls and the parents of depressed (female) patients describe their own relationship, and also to determine to what degree the image of this relationship as presented by the husband and by the wife are mutually interconnected.

Material

In the statistical analysis, the data used was of the parents of 54 (female) patients diagnosed according to DSM-IV [20] with restricted anorexia (ANR), 22 diagnosed with binge-purge anorexia nervosa (ANBP), 36 diagnosed with bulimia (BUL); all of these (female) patients consulted from 2002–2004 with the outpatient clinic of the Clinical Department of the Child and Adolescent Psychiatric Clinic, University Hospital in Krakow. Two control groups were included in the studies: the parents of 36 (female) patients diagnosed with depressive disorders (major depressive episode,

dysthymia, situational reaction with depressed mood) (DEP) according to DSM-IV [20] and parents of 85 schoolgirls of Krakow schools (NOR). The selection of the two control groups was motivated by a desire to determine the differences characteristic of eating disorders, and not by the non-specific factors associated with the presence of psychopathology and its impact on the marital relationship. Patients with subclinical syndrome symptoms, according to DSM-IV, were classified into the appropriate clinical groups [ANR (n = 7), ANBP (n = 6), BUL (n = 2)]. The detailed criteria for including or excluding groups, as well as their socio-demographic characteristics, are described in other reports [21, 22, 23]. The following is the percentage of girls originating from two-parent families: 89.7% of girls from the NOR group; 83.3% of the girls from the ANR group; 85.7% of the girls from the ANBP group; 65.6% of the girls from the BUL group; and 78.9% of girls from the DEP group.

Method

Research instruments

The dyadic Family Assessment Questionnaire (FAMAQ) was used to study the marital relationship of the parents of (female) patients and schoolgirls, in a version that allows one to describe the mutual relations of wife and husband. The group of Family Assessment Questionnaires (FAMAQ) is an adaptation to Polish conditions [24] of the German version of the Family Assessment Measure III questionnaire developed by Steinhauer, Santa Barbara and Skinner [25]. The German version of FAM III, referred to as the *Famielienbogen*, was adapted and standardized by Cierpka and Frevert [26]. Given the proximity of the cultural context, it was thought the German version of FAM III would provide a better basis for adapting and standardizing to Polish circumstances than the English language version.

The FAMAQ questionnaire generates the following seven scales:

- Task Accomplishment (TA),
- Role Performance (RP),
- Communication (COM)
- Affective Expression (AE),
- Involvement (I),
- Control (CON)
- Values and norms (VN)

The questionnaires also include three scales: Social expectations (SE), Defence (DEF) and the General scale (GEN). The first two examine the willingness of family members to meet social expectations and their tendency to present a better family image. The following labels are used in the description of the text: FMTA – father rates mother in terms of her task accomplishment, MFTA – mother rates father in terms of his task accomplishment.

FAMAQ questionnaires were subject to a standardization procedure in Poland [24]. The results obtained in the form of Cronbach's alpha coefficients were consistent with the English and German version and were above the value $\alpha = 0.50$ for particular scales.

Based on statistical analyses, the concept of a criterion was introduced, i.e., the desired state of family functioning corresponding to a result that is worse than the arithmetic mean by one standard deviation in the 557 families making up the study. In all scales except for SE and DEF, higher scores in reality mean a more negative assessment of family relationships (deviating from the desired state), and lower scores mean a more favourable assessment of family relationships (closer to the desired state). On the SE and DEF scales, the interpretation of the results is the reverse.

Results

In comparisons of the differences between the groups, the data relied on was from all the fathers and mothers who completed the tests. In the ANR group, the calculations take into account the results of 45 mothers and 38 fathers; in the ANBP group, 18 mothers and 14 fathers; in the BUL group, 21 mothers and 22 fathers; in the DEP group, 34 mothers and 24 fathers; and in the NOR group, 79 mothers and 74 fathers. In analyses of correlation, only those data were used that yielded results from both parents. In separate analyses of correlation, the data used was of 35 mothers and 36 fathers from the ANR group, 12 mothers and 14 fathers from the ANBP group, 12 mothers and 14 fathers from the BUL group, 21 mothers and 22 fathers from the DEP group, and 70 mothers and 74 fathers from the NOR group.

In single-parent families, results from both parents were obtained for group ANR in two cases; in group BUL, in one case; and in group NOR, in five cases. None of the analyzed pairs of results came from single-parent families from the ANBP and DEP groups.

Table 1. **The number of participants in separate clinical groups**

No.	subjects	ANR	ANBP	BUL	DEP	NOR	TOTAL
1	girls	54	22	36	36	85	237
2	mothers	53	21	34	36	85	223
3	fathers	49	19	31	36	81	185

Functioning of husbands in the marital relationship in the assessment of wives/mothers of respondent (female) patients

The study of the differences in average results in separate scales in the analyzed groups was conducted using the Kruskal-Wallis test. Due to the failure to meet assumptions of normality, it was not possible to perform a one-way analysis of variance (ANOVA). The results are presented in Table 2.

Table 2. **Results of comparing differences in the functioning of fathers in the marital relationship as assessed by mothers in the respondent groups.**

	p	post-hoc
Task accomplishment	**0.007**	NOR-BUL p = 0.006
Role Performance	0.168	---

table continued on the next page

Communication	0.123	---
Affective expression	0,108	---
Involvement	**0,010**	NOR-ANR p = 0.066 NOR-BUL p = 0.027
Control	0.250	---
Values and norms	**0.049**	NOR-BUL p = 0.049
General score	0.052	---
Positive statements	0.240	---
Negative statements	**0.047**	NOR-BUL p = 0.098

in bold: statistically significant results

The results obtained showed that mothers of girls suffering from bulimia, compared to mothers of girls in the control group, rate their husbands worse when assessing their overall functioning in the marital relationship (MFNEG), how well they complete their tasks (MFTA), the degree of their affective involvement (MFI); these mothers also assess the coherence of their husbands' systems of values and rules of conduct (MFVN) more critically. The mothers of girls suffering from restricted anorexia more critically evaluate the affective involvement of their husbands in the marital relationship in comparison with the mothers of schoolgirls (MFI).

All calculations were run in SPSS V.20.

Functioning of wives in the marital relationship in the assessment of husbands/fathers of respondent (female) patients

In the case of the analysis of results obtained by the majority of men, the difference was examined with the aid of the Kruskal-Wallis test; only the differences in average negative statements were verified using one-way analysis of variance. The results are presented in table 3.

Table 3. **Results of comparing differences in the functioning of mothers in the marital relationship as assessed by fathers in the groups**

	p	post-hoc
Task Accomplishment	0.034	NOR-DEP p = 0.023
Role Performance	0.119	---
Communication	0.044	NOR-DEP p = 0.081
Affective expression	0.152	
Involvement	0102	
Control	0.275	
Values and Norms	0.032	NOR-DEP p = 0.087

General score	0.040	NOR-DEP p = 0.047
Positive statements	0.066	
Negative statements	0.026*	NOR-DEP p = 0.063

*ANOVA, in bold: statistically significant results

The results obtained in the group of husbands show that statistically significant differences between average results, compared to the group of fathers of schoolgirls, only appeared in the group of fathers of (female) patients who had been diagnosed with depression. The results showed that husbands worse rated the overall functioning of wives in marital relationships (FMNEG), the level of communication with the wife (FMCOM), the degree they felt understood in the relationship (FMCON), the manner in which the wife fulfilled her tasks (FMTA); they also critically assess the coherence of their wives' system of values and rules of conduct (FMVN).

All calculations were run in SPSS V.20.

Analysis of correlation

The correlations between the results of mothers and fathers of (female) patients were likewise subjected to analysis. Pearson's coefficient of linear correlation and Spearman's rank correlation coefficient were used to examine dependence between variables when the variables were not normally distributed.

All calculations were run in SPSS V.20.

Table 4. Correlations between the results of mothers and fathers of (female) patients diagnosed with restrictive anorexia

R value	MFTA	MFCOM	MFNEG
FMRP	0,373		0,362
FMI	0,367		
FMCON		0,664	0,416
FMVN		0,719	
FMGEN	0,358		0,350
FMPOS		0,746	
FMNEG	0,347		0,418

$p < 0,05$; N = 35-36

In the restrictive anorexia ANR group (table 4), dependence was achieved between the scale of the Task Accomplishment by the husband in the assessment of wives (MFTA) and various scales rating the wife's functioning in the husband's assessment. Role Performance(FMRP), Involvement (FMI), General (FMGEN) and Negative Statements (FMNEG) at a significance level of $p < 0.05$; Similarly, Role Performance

(FMRP), Control (FMCON), General Sum (FMGEN) and Negative Statements (FMNEG) at a significance level of $p < 0.05$; in the assessment of husbands correlate with the scale of Negative Statements (MFNEG) that are the sum of negative statements concerning husbands as formulated by wives.

The Communication scale (MFCOM) in the assessment of wives, at a significance level of $p < 0.05$, correlated positively with other scales. Controls (FMCON), Values and Norms (FMVN), and Positive Statements (FMPOS) in the assessment of husbands.

Table 5. **Correlations between the results of mothers and fathers of (female) patients diagnosed with binge-purge anorexia nervosa**

R Value	MFRP	MFCOM	MFI	MFCON	MFVN	MFGEN	MFPOS	MFNEG
FMI		0,571						
FMVN	0,566	0,585	0,610	0,693	0,640	0,596	0,619	0,553

$p < 0,05$; N = 12–14

In the binge-purge anorexia ANBP group (Table 5), dependence was achieved between the scale of the Values and Norms of wives in the assessment of husbands (FMVN) and various scales rating the husband's functioning in the assessment of wives. Role Performance (MFRP), Communication (MFCOM), Involvement (MFI), Control (MFCON), Values and Norms (MFVN), General Scale (FMGEN), Positive Statements (MFPOS) and Negative Statements (FMNEG) at a significance level of $p < 0.05$.

The Communication scale (MFCOM) in the assessment of wives, at a significance level of $p < 0.05$, correlated positively with the scale of Involvement (FMI). However, one should note that due to the very low number in the group, these results should be interpreted with caution.

Table 6. **Correlations between the results of mothers and fathers of (female) patients diagnosed with bulimia**

R Value	MFTA	MFRP
FMTA		-0,525
FMVN	-0,537	

$p < 0,05$; N =12–14

The bulimia BUL group (table 6) yielded a negative correlation between the scales: Role Performance (MFRP) and Task Accomplishment (FMTA), and also between Task Accomplishment (MFTA) and Values and Norms (FMVN) at a significance level of $p < 0.05$. Similar to what was the case for the binge-purge anorexia group, the bulimia group is characterized by low numbers.

Table 7. **Correlations between the results of mothers and fathers of (female) patients diagnosed with depression**

R Value	MFI	MFVN	MFGEN	MFNEG
FMI		0,431		0,465

table continued on the next page

FMVN			0,379	
FMPOZ	0,455			

$p < 0,05$; N = 21–22

In the depressive group DEP (Table 7), dependence was achieved between the scale of the Involvement by the husband in the assessment of wives (MFI) and a scale of Positive Statements (FMPOS) at a significance level of $p < 0.05$.

The scale of the Involvement of wives in the assessment of husbands (FMI), at a level of significance of $p < 0.05$, correlated positively with the scale of Values and Norms (MFVN) and Negative Statements (MFNEG) in the assessment of wives.

The scale of Values and Norms of the wives in the assessment of husbands (FMVN), at a level of significance of $p < 0.05$, correlated positively with the General scale (MFGEN) in the assessment of wives.

Table 8. **Correlations between the results of mothers and fathers of schoolgirls**

R Value	MFTA	MFRP	MFCOM	MFAE	MFI	MFCON	MFVN	MFGEN	MFPOS	MFNEG
FMTA	0,269			0,265	0,270		0,256	0,279	0,238	
FMRP	0,513	0,567	0,528	0,448	0,350	0,324	0,540	0,569	0,435	0,593
FMCOM	0,424	0,398	0,445	0,295	0,385	0,244	0,431	0,443	0,330	0,398
FMAE	0,334	0,259	0,275	0,341	0,369	0,334	0,344	0,367	0,318	0,304
FMI	0,470	0,424	0,477	0,361	0,528	0,329	0,544	0,516	0,423	0,463
FMCON	0,462	0,384	0,438	0,358	0,414	0,380	0,370	0,481	0,413	0,413
FMVN	0,427	0,395	0,461	0,353	0,347		0,496	0,459	0,422	0,394
FMGEN	0,517	0,497	0,500	0,420	0,472	0,364	0,532	0,565	0,472	0,499
FMPOS	0,369	0,369	0,324	0,271	0,382	0,187	0,466	0,392	0,416	0,281
FMNEG	0,496	0,437	0,482	0,385	0,401	0,348	0,420	0,513	0,369	0,499

$p < 0,05$; N = 70–74

In the group of schoolgirls NOR (Table 8), correlation analysis showed a reciprocal, significant relationship in the perceptions of parents of schoolgirls with respect to their marital relationship, in almost all the surveyed dimensions.

Discussion and summary

The results revealed a series of difficulties in the marital relations of parents of (female) patients with eating disorders and parents of (female) patients with depression, in contrast to the marital relationships of the parents of schoolgirls. The results, however, do not offer grounds for believing that the image of marital relationships is characterized by a definite pattern specific to eating disorders. A number of difficulties identified in the marital relationship by both parents of (female) patients with bulimia

and the mothers of (female) patients with restricted anorexia nervosa were also reported by the parents of (female) patients with depression.

As noted earlier, the literature on the problem of eating disorders stresses the importance of the marital difficulties of the parents of (female) patients with anorexia and bulimia to the rate of development of the disorder. This indicates that disruptions of communication occurring in the marital relationship of parents, unresolved difficulties, difficulties in performing roles, and displays of emotional support may encourage the triangulation of future (female) patients in marital relationships. Population studies by Wade et al [27] suggest that difficulties in the marital relationship of parents perceived by the daughter are a risk factor for the development of subclinical symptoms of bulimia.

In the light of the results obtained, it is difficult to maintain the hypothesis that difficulties in the marital relationship are specific to the problem of eating disorders. The similar, negative assessment of marital relationships in the group of parents of (female) patients with bulimia and depression indicates that the dynamics of the marital relationship may be associated with various psychiatric disorders. The negative impact a child's serious mental disorder can have on the marital relationships, regardless of their clinical nature, is also not without significance. In this case, difficulties in marital relationships would not be a risk factor for the appearance of disorders, but rather a consequence of their presence.

It was decided to exclude four (female) patients of the depressive group from this analysis who exhibited slightly increased subclinical symptoms of eating disorders. The severity of depression observed in the group of (female) patients diagnosed with eating disorders was greater than in the control group of schoolgirls [28]. Assuming the existence of a family background of mood disorders leads one to ask about the link between the negative image of the family relationship and depression among parents of the respondents, the more so as this link was observed in other clinical trials [29].

In the bulimia group, there was a discrepancy in the mutual assessment of spouses. Such results correspond with the appearance in the literature of descriptions of the marital relationship, which depict the parents of (female) patients as people fighting with each other; the mother expressing dissatisfaction, frustration, and the father avoiding confronting problems by withdrawing from the relationship [3]. In this context, the fathers' positive perception of their marital relations could represent a defensive posture, expressing an idealization of these relations.

An analysis of the correlation of mutual assessments of functioning in the marital relationship indicates their high degree of coherence in the control group. This result calls to mind family characteristics known from clinical practice in which a narrative, which is shared by individual members of the family and offers a multi-dimensional description of various areas of life, the functioning and history of the family, becomes a resource to help overcome crises and adapt to new challenges facing the family. A frequent goal of family therapy following the narrative trend is precisely to create a space for new narratives devoid of ascribed guilt and mutual grief [30]. Perhaps the large number of significant dependencies in the control group corresponds to the concept of family cohesion described in the literature, which is understood as a sense of community, allowing a family to obtain help and support. Studies have shown

there is a degree of cohesion associated, among other things, with satisfaction in the performance of parental roles in families with disabled child [31, 32], a self-confidence in the role of a parent of a child with chronic somatic difficulties [33, 34]. Research on a group of 111 children from problem families revealed that family cohesion was positively associated with life satisfaction and negatively associated with physical and verbal aggression [35].

The lower number of correlations observed in clinical groups may indicate a non-specific deficit in terms of family cohesion, related to the occurrence of diverse psychopathology. One should, however, note the reservation that the absence of statistical dependence should be interpreted much more cautiously than its presence. It may be a consequence of the smaller number of groups or the occurrence of correlations more complex than linear.

When comparing the results of the analysis of differences between the groups with the results of their correlation, we must always remember that the first included all mothers, whereas the second primarily included mothers remaining in a relation with the father of the respondent children. Especially in the bulimic group, where the highest number of divorces and single-parenthood was observed, this is an important factor influencing interpretation. Some of the women are assessing relations with the father of a child who is already no longer connected with them. The research of Booth and Amato [36] indicate that the heightened levels of psychological stress experienced as a result of divorce may persist for a period of approximately 2 years. On the other hand, the fact of divorce may result in a more positive assessment of the relationship than during the period of the marital conflict.

Results in the restrictive anorexia group cautiously incline to the conclusion that how the wife perceives the husband's fulfilment of his assigned duties and the total sum of her negative assessments appear to be a vital element in the husband's multidimensional assessment of the functioning of his wife in the marital relationship. This result appears to confirm the above-cited data from the review of literature concerning the marriages of parents of (female) patients with anorexia [8], in which the author, based on a review of research, pointed to difficulties in performing duties as one of the problem areas in the functioning of these pairs. The correlation results in the binge-purge anorexia group indicate the crucial importance the perception of the values and standards espoused by the wife has to the assessment by her of the husband's functioning in almost all of the areas researched. However, due to the low number in this group, the conclusions drawn should serve more as a guide to further research, than as a basis for describing its characteristics.

Finally, one should address the limitations of the present study. Although the authors do mention in the text that the selected study groups are of a small sample size, it seems important to once again emphasize that the results of the analyses performed on these groups, should be interpreted with caution. Another important limitation is associated with the research instruments themselves. A question is raised to what extent the results of the questionnaires are actually able to present the dynamic functioning of a family system in a way which is clinically useful.

Conclusions

1. The respondent parents of schoolgirls Krakow are characterized by a positive and strongly correlated image of marital relations.
2. An image of marital relations specific to parents of (female) patients diagnosed with eating disorders in comparison with the parents of (female) patients diagnosed with depressive disorders was not found, whether in the context of the mutual assessment of spouses or in connections between assessments.

Results

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