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Original article

Father–daughter relationship and the severity of eating disorders

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ABSTRACT

Background: Mother–daughter relationship was the focus of studies on the development of eating disorders (ED) for many years. This study aimed to examine the association between the father–daughter relationship and ED and depressive symptoms.
Methods: Fifty-three women diagnosed with ED were compared to a psychiatric control group ($n = 26$) and to healthy participants ($n = 60$) regarding their perception of their fathers and the relationship with them. Assessments were done using the Parental Bonding Instrument, the Eating Disorders Questionnaire, the Body Shape Questionnaire, the Eating Attitude Test, and the Beck Depression Inventory as well as narrative-based methods.
Results: Fathers' negative attributes were significantly associated with ED and depressive symptom. Two profiles of father–daughter relationship were found, the "caring and benevolent" relationship and the "overprotective and avoidant" one. In the latter, patients displayed significantly higher levels of food-restraint, more concerns about eating and about their body shape and appearance, and higher levels of depression.
Discussion: Negative perception of the father's parenting style as well as the quality of the relationship with him are crucial for the understanding of the development and persistence of ED. Therapeutic programs for ED should focus not only on the relationship with the mother but must also address the relationship with the father.

1. Introduction

Family risk factors have been suggested in the understanding of eating disorder pathology [9,36,42]. Most studies and theories however, have focused extensively on the daughter–mother relationship [3,5,12,30,32]. Recently, data have shown that the father's parental style is also related to eating behavior. For example, among healthy young adolescent girls, paternal support was found to be associated with promotion of positive self-esteem and healthy eating attitudes, and to constitute a protective factor with regard to disordered eating during times of stress [11,27,37,45].

The association between daughter–father relationship variables and disordered eating was attained also in clinical samples. For example, Rowa et al. [39] found that anorectic women described their fathers as intrusive, overprotective, and as turning often to their daughters for nurturance and support. In another study [26], female patients with eating psychopathology were found to experience less paternal warmth and more paternal rejection than control group women. In addition, paternal rejection was found to be associated with striving for thinness, tending to bulimia, and with body dissatisfaction.

Most of these studies examined the father's role in eating disorders by assessing his parenting style. Other studies approached this issue in terms of the daughter's attachment orientation, and explored the relationship between insecure attachment and eating pathology. According to attachment theory

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[for review see 29], insecure attachment-orientations are conceptualized as either attachment anxiety or attachment avoidance. The anxiety dimension is defined as a negative perception of self and an excessive need for approval from others and worries about separation, rejection, and abandonment. Attachment avoidance is defined as a negative perception of others, combined with suppression of intimacy, dependency and interpersonal closeness. Secure individuals are conceptualized as having low levels of both anxiety and avoidance. Although most studies did not look at the attachment of daughters to their fathers in particular, insecure attachment styles were found to be prevalent among women with eating disorders [33,38,47,50]. In addition, while attachment avoidance was found to be directly associated with eating psychopathology, the relationship between attachment anxiety and eating pathology seems to be mediated by social comparison or by emotional reactivity [4,46]. The few studies that investigated the role of attachment to the father in ED did find a relationship between insecure attachment to fathers and eating dysfunctions in young women [14,24].

All the above studies indicate that the quality of the relationship with their father may be an important factor in the development of girls' and women's attitudes towards themselves and their bodies. However, most of these studies:

- were based on non-clinical samples, or on samples of participants with self-defined eating disorders;
- relied on self-reported measures of paternal rearing behaviors, emotional warmth, support or protection;
- compared ED patients only to a control group of healthy controls and not also to another clinical patient group.

Following these limitations, our study aimed to further examine the ways ED patients perceive their fathers and the relationships with them, by comparing ED patients who were diagnosed by professionals in an outpatient unit, with two control groups: a group of healthy volunteers and a group of psychiatric patients diagnosed with anxiety or depressive disorders but no ED. In addition, we assessed the daughter–father relationship by combining two different methods of assessment: daughters' self-report measures regarding the parenting of their fathers and the relationship with them, and narrative-based methods, which allow evaluation of more unconscious or implicit cognitions and emotions about the father figure [10,43,49]. These measures were then used in order to create two profiles of daughter–father relationships and to evaluate the associations between the attributes of the daughter–father relationship and the levels of ED and depressive symptoms among ED patients.

Specifically, daughters' perceptions of their fathers' parental style (i.e., the extent of care and overprotection in fathering), as well as daughters' attachment-orientations, specifically in the relationship with their father (i.e., attachment anxiety and avoidance), were assessed by using validated self-report measures of these constructs. In addition, we combined two validated narrative-based methods (i.e., the Social Cognition and Object Relations Scale, and the Object Representation Inventory) to these self-report measures in order to assess the quality of the mental representations of the paternal figure. The integration of narrative-based methods and self-report measures in the same study is discussed in the literature as being used in health sciences in order to allow for a more comprehensive understanding of complex human phenomena [16,40]. To the best of our knowledge, this approach has not been applied before in studies on the relationship of ED patients with their father. Since the present study was aimed at investigating the association between symptom severity and both explicit and implicit aspects of participants' perceptions regarding the relationship with the father, data from both methods were collected concurrently and merged [16].

Our general assumption was that ED patients would describe their relationships with their fathers as having more negative attributes as compared to the descriptions in the two control groups. Specifically, we assumed that ED patients would be found to perceive their fathers' parental attitudes towards them as including lower levels of care and higher levels of over-protection, and of displaying higher levels of anxiety and avoidance in their attachment to their fathers. In addition, we expected that the object representations of ED patients regarding the father figure and the daughter–father relationship would be characterized by poorer qualities, in comparison to the two control groups. Finally, we assumed that we would find an association between the severity of negative attributes of the relationship of ED patients with their fathers and the severity of their ED and depressive symptoms.

2. Method

2.1. Participants

Both clinical participant groups (psychiatric patients with or without ED) consisted of patients admitted consecutively to an outpatient psychiatric clinic at a university affiliated mental health

Table 1
Demographic data of the three research groups.

Variable	ED patients ($n=53$)	Psychiatric control patients ($n=26$)	Healthy volunteers ($n=60$)	Statistics
Age[a]	22.34 (3.98)	23.85 (3.10)	23.10 (3.55)	NS
Education[a]	12.26 (2.19)	13.04 (1.34)	13.73 (2.04)	NS
Religion[b]				$\chi^2=5.74$, df = 4, NS
Secular	43 (81.1%)	24 (92.3%)	48 (80%)	
Traditional	9 (17%)	2 (7.7%)	7 (11.7%)	
Religious	1 (1.9%)	0 (0%)	5 (8.3%)	
Parents' status[b]				$\chi^2=7.43$, df = 4, NS
Married	43 (81.1%)	21 (80.8%)	55 (91.7%)	
Divorced	8 (15.1%)	5 (19.2%)	2 (3.3%)	
Widowed	2 (3.8%)	0 (0%)	3 (5%)	
Parents' education[b]				$\chi^2=0.16$, df = 2, NS
Academic	33 (62.3%)	15 (57.7%)	36 (60%)	
Secondary	20 (37.7%)	11 (42.3%)	24 (40%)	

ED: eating disorders; NS: not significant; df: degrees of freedom; SD: standard deviations.
[a] Cells contain means and in parentheses SD.
[b] Cells contain numbers and in parentheses %.