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The perception of maternal and paternal rejection in anorexic patients

La percezione del rifiuto materno e paterno in pazienti anoressici

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Parole chiave: Rifiuto genitoriale, Anoressia Nervosa, BMI, immagine corporea

Abstract

Aims. To study the relationship between: a) AN and perceived maternal and paternal feelings of rejection; b) AN clinical features and the perception of the sense of rejection.

Methods. The study has cross-sectional design, the sample was selected among 92 consecutives in and out-patients, aged from 14-35 years referred to two Eating Disorder Services, 23 patients (25%, ME 20 ±5.7) completed the full assessment for AN and were enrolled for the study. The diagnosis of AN was assigned according to the DSM 5 criteria after an accurate psychiatric clinical evaluation, integrated with tools for EDs.

Results. The 95% of the SS with AN reported a sense of maternal and paternal rejection. SS with normal or better BMI expresses more maternal/paternal sense of rejection; older SS reported more perceived sense of maternal refusal.

Data suggest that: a) better organic conditions and age could allow a greater mentalization of the relational difficulties of AN SS with parental figures and the expansion of the themes of the psychological distress expressed; b) SS in better weight conditions are able to free themselves from the monothematic discomfort relating to body image; c) he sense of maternal rejection requires a greater age to be perceived than the sense of paternal rejection.

Riassunto

Lo studio esplora la relazione tra AN e sentimenti di rifiuto percepiti materni e paterni e tra le caratteristiche cliniche dell'AN e percezione del senso di rifiuto.

Metodi. Il campione è stato selezionato tra 92 pazienti, di età compresa tra 14 e 35 anni,interni ed esterni, afferiti consecutivamente a due servizi universitari e territoriali per DCA, 23 pazienti (25%, EM20 ±5.7) hanno completato la valutazione per AN e sono stati arruolati per lo studio. La diagnosi di AN è stata

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assegnata secondo i criteri del DSM 5 dopo un'accurata valutazione clinica psichiatrica, integrata con strumenti per DCA.

Risultati. Il 95% dei SS con AN riporta un senso di rifiuto materno e paterno. I SS con BMI normale o migliore esprimono un maggior senso di rifiuto materno/paterno; i SS di maggiore età riferivano un maggior senso percepito di rifiuto materno.

I dati suggeriscono che: a) migliori condizioni organiche e l'età più avanzata potrebbero consentire una maggiore mentalizzazione delle difficoltà relazionali dei SS con AN verso le figure genitoriali con l'ampliamento delle tematiche relative al disagio psicologico; b) i SS in migliori condizioni di peso hanno meno frequentemente contenuti monotematici relativi all'immagine corporea; c) il senso di rifiuto materno richiede un'età maggiore per essere percepito rispetto al senso di rifiuto paterno.

Introduction

The extensive literature on eating disorders (ED) paid particular attention to the study of the role of patients' family context. The studies published so farhave explored three dimensions: a) parental bonds, i.e. the attachment that develops between parents and their baby; b) parenting, i.e the activities that are involved in raising a child; and c) rearing, i.e bring up and care for a child. These studies provided a series of indications on the complex risk factors underlying ED but it is worth noting a heterogeneity between the methods used ranging from standardized tools to clinical reports.

Findings converged on the role of family factors as potentially associated with the onset of ED, for example, parental maltreatment or life traumatic events have been descripted as risk factors for ED (Solmi et al., 1999; Monteleone et al, 2020).

Moreover, another main topic could be the patient's subjective experience of the quality of his family emotional environment. Subjective experience is not the exact reconstruction of child/adolescent relationship with parents. A subjective experience is someone's personal psychological response to an event, it depends on each person's own emotions and beliefs. An event shape both subjective (i.e. personal) experience and an objective one, which is common to the people exposed to the event.

The knowledge of the quality of the perceived relationship with one's parents enriches the understanding of eating disordered behaviors, in fact we obtain information on the patient's emotional dimension, that plays a role in family dynamics. Moreover, family dynamics are patterns of interactions among relatives which include various conscious and unconscious factors. The objective and subjective perception of the others are intertwined in human and family relationships, both influencing behaviors, especially in childhood and adolescence.

Family systems theorists, first, identified, in anorexic patients, patterns of disturbed family interactions (Minuchin et al, 1978, Liebman, 1983). Subsequent studies attempting to investigate family patterns of anorexia have come to contradictory conclusions. Kog & Vandereycken (1985) pointed out, among

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salient family features, a controlling interdependent family relationships pattern together with parental discordance. Selvini Palazzoli & Viaro (1988), describe a family organization characterized by an intrusive, intolerant, and hypercritical mother and by a father who is often brilliant but absent from the family. Holtom-Viesel & Allan (2014) reported worse family functioning than control families but little evidence for a typical pattern of family dysfunction. Langdon-Daly & Serpell (2017) confirmed no empirical evidence of a specific dysfunctional pattern for families with ED, even more so when referring to the different diagnostic categories of ED. Erriu et al. (2020) reviewed the state of the research and concluded that, although a great deal of studies has generally highlighted the relevance of family relationships in the offspring disease, results concerning the role of family factors are so divergent that, nowadays, definitive statements about direct causation cannot be drawn. Furthermore, the areas of family malfunctioning identified are so varied that it is not possible to identify, with certainty, either the family structure or, above all, the dysfunctional patterns typical for the populations of the different ED.

An additional psychological dimension, precisely the construct of rejection sensitivity (RS), has been applied to researches on ED. The rejection sensitivity could be defined asthe tendency to anxiously or angrily expect, perceive, and react to (alleged) rejection.

In this regard, a study that analyzed rearing styles in adolescents with ED found that participants remembered growing up with less ‘emotional warmth’ and more ‘rejection’ by their mother as well as more paternal ‘rejection’ than adolescents in the control group (Castro, 2000).

Data from cohorts and experimental setting confirm high rates of RS in such patients. Shell (2023) demonstrated that anticipating or perceiving rejection may be sufficient to play a role ED in woman with binge eating disorder (BED). Rebecca Bondü studied the longitudinal association between rejection sensitivity, justice sensitivity and ED, in a sample of 769 SS. Patients reported higher scores for RS that controls, and results showed longitudinal and bidirectional relationship between anxious rejection sensitivity and ED pathology, suggesting a self-maintaining circle between rejection sensitivity, justice sensitivity, and ED pathology (Bondü, 2020). Al-Salom (2019) studied the association between a diagnosis of bipolar personality disorder (BPD) in adolescents and disordered eating and rejection sensitivity. Dara from this research suggest that rejection sensitivity significantly mediated the relationship between BPD symptoms and ED.

Dominy et al. (2000) explored the perceived parental acceptance in obese women with and withoutBED compared with a control group. Results showed that obese women with BED perceived their fathers as more rejecting if compared to other groups.

Maternal rejection also related with drive for thinness, interoceptive awareness and impulse regulation. Patients with bulimia nervosa or eating disorders not otherwise specified (ED-NOS) perceived greater rejection, less affection and a greater overprotection than patients with anorexia nervosa (AN) and healthy controls (Herraiz-Serrano et al., 2015; Casper et al., 2001). Therefore, it is possible that the different maladaptive behaviors related to ED and aspects of

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body weight may be linked to the ways in which the sense of rejection is expressed.

The rejection sensitivity in patients with ED is the topic of the present study. The study aims to identify if there is a relationship between the perception of parenting and the clinical characteristics of ED in a sample of ED patients. In detail we hypothesize that 1) subjects with AN had a greater sense of maternal and paternal rejection; 2) there is an association between the sense of rejection and weight conditions.

Materials and methods

The study has cross-sectional design, the sample was selected among 92 consecutives in and out-patients, aged from 14-35 years (F=89, 96.7%, M:20yrs, SD: 5.7) referred to clinical services for children/adolescents and adults[1] affected by ED, lasting December 2021 to June 2022.

Among 92 participants, 23 patients (25%)completed the full assessment for AN andwere enrolled for the study.

The diagnosis of AN was assigned according to the DSM 5 criteria after an accurate psychiatric clinical evaluation, integrated with tools for EDs.

Measures

Data of patients' clinical conditions was obtained from medical records. ED features, body image and parental rejection data were collected with self-report scales.

The participants completedthe Eating Attitude Test 26 (EAT-26) and the Body Uneasiness Test (BUT), both routinely used by the services for ED standard assessment. To assess adults' retrospective memories of experienced parental (maternal and paternal) acceptance or rejection in childhood the short form of the Parental Acceptance-Rejection Questionnaire (PARQ) was used.

The Eating Attitude Test 26 (EAT-26) is a self-report measure of symptoms and concerns characteristic of ED, including weight and body shape. It consists of 26 questions with a cutoff of 20 (Garner et al. 1982).

The Body Uneasiness Test (BUT) was used to evaluate the presence of discomfort related to body image. The BUT is a self-assessment test made up of two parts, the first is made up of 34 clinical items while the second of 37 questions relating to the perception of individual parts of the body, which detects a global severity index (GSI). Body discomfort is considered clinically significant with a GSI score >1.2 (Cuzzolaro, M., 2006).

The Parental Acceptance-Rejection Questionnaire (PARQ) is a self-report questionnaire that contains 24 items and the scores range from a minimum of 24 (maximum perceived acceptance) to a maximum of 96 (maximum perceived rejection).

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Statistical analysis

Descriptive analyses were carried out to describe the sample in terms of frequencies, percentages, means and standard deviations for categorical and dimensional variables.

A Pearson correlation analysis was carried out to highlight the association between the collected variables.

In order to test the difference between the perception of paternal/maternal sense of rejection/acceptance a T-Test analysis was performed between numerical variables.

Results

23 SS. (F=22, 95.6%; age range 14-35; M=20, SD=5.7) constituted the sample. The average Body Mass Index (BMI) was 17.61, SD 2.18. About ED features and body image concerns, 95.45% of the subjects obtained a clinical score when completing the BUT (mean 3.19, SD: 1.02) and 95.45% obtained a clinical score when completing the EAT-26 (mean, 82.08, SD: 30.18).

On regard the sense of rejection and acceptance by the maternal figure, subjects obtained a mean of 42.21 (SD 12.56). On the other hand, participants displayed a mean score of 45.95 (SD 15.14) for the rejection and acceptance by the paternal figure. No significant difference emerged between the perceived sense of maternal/paternal rejection and acceptance.

Table 3 show correlation between the investigated variables. A slight significant correlation was found between age and perception of maternal sense of rejection/acceptance and between BMI and perception of paternal/maternal sense of rejection/acceptance. Data suggest that older age was correlated with higher expression of the maternal sense of rejection whereas greater BMI was correlated with greater paternal/maternal sense of rejection.

Discussion

This study aimed to analyze the relationship between the clinical features and perceived parental acceptance/rejection in a sample of subjects with AN. This relationship has been little investigated in the literature despite the fact that the construct of parental acceptance/rejection can potentially be included in the complex multifactorial system that underlies EDs.

Descriptive data show in almost all of the sample the presence of awareness and expression of discomfort relating to body image and concern about body shape and weight.

Our data fail to demonstrate a statistically significant difference between the perceived sense of maternal versus paternal acceptance/rejection and hence mothers and fathers have an equal impact on the sense of rejection generally found. In the previous studies greater emphasis has been placed on the role of the mother, even if in the role of the father in the onset and maintenance of

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anorexia was highlighted (Gale, 2013). Our results confirm the need for more studies on paternal care in the anorexic scenario.

Correlation analyses demonstrate that age was correlated with higher expression of the maternal sense of rejection and that BMI was correlated with greater paternal/maternal sense of rejection.

These data could be interpreted in relation to the patients' ability to express both the maternal and paternal sense of rejection perceived. In fact, it is possible to speculate that older age and the restoration of appropriate clinical conditions can promote greater awareness of experiences of parental acceptance/rejection.

BMI is associated with higher scores on both maternal and paternal perceived parental rejection. This finding could be explained by the fact that the improvement of organic conditions (increase in BMI) in anorexic subjects allows the shift of psychological distress from issues solely focused on discomfort relating to body image to those relating to conflict with parental figures, in other words, allows the transition from the withdrawal into the body to an interpersonal and conflictual dimension. However, a longitudinal study is necessary in order to test that the improvement and cessation of the acute phase of the disease allows that sense of maternal and paternal rejection to be verbalized and possibly processed.

The absence of a correlation between discomfort relating to body image and the sense of maternal and paternal rejection is unclear. Surely problems with body image are central to the disorder, but in owner sample this issue seems to be independent from the perceived parental rejection, further investigations are request.

This study has some limits. First of all, the design is cross-sectional with also sample selection bias and this limits the possibility to generate results. Secondly, self-report measures can impact data quality due to the presence of response bias. Finally, the interpretations of the results are at a speculative level in the absence of other more consistent data from the literature and of a longitudinal design in which the detection of parental acceptance/rejection can be assessed in the various stages of AN.

These results should be interpreted with caution due to some study limitations. First, the sample size was small and the age range was large, including subjects aged from early adolescence to adult. The study lack to explore the comorbidity between ED and other mental disorders, psychiatric comorbidity can affect influence patients' responses to the self-reported tools.

Conclusions

The main objective of our study was based on identifying a relationship between AN and perceived maternal and paternal feelings of rejection. Secondly, it aimed to investigate the relationship between AN clinical features and the perception of the sense of rejection.

The results showed that 95% of the subjects in the sample with AN reported a sense of maternal and paternal rejection. Subjects with normal or better BMI expresses more maternal/paternal sense of rejection; furthermore, older subjects reported more perceived sense of maternal refusal.

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Better organic conditions and age could therefore allow a greater mentalization of the relational difficulties of AN subjects with parental figures and the expansion of the themes of the psychological distress expressed.

The AN subject in better weight conditions is able to free himself from the monothematic discomfort relating to body image.

Lastly, it is likely that the sense of maternal rejection requires a greater age to be perceived than the sense of paternal rejection.

Further studies should confirm the data of this research.

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APPENDIX

Table I. Sample description and mean scores

Age	20 ±5.7
BMI	17.61±2.18
Sex	97%F; 3%M
BUT	95% clinico; 3.19±1.02
EAT 26	95% clinico; 82.08 ± 30.18
PARQ M	42.21± 12.56
PARQ P	45.95±15.14

Table II. Difference in the perception of a sense of rejection/acceptance by the maternal and paternal figure

	T student
PARQ M e PARQ F	P.0.36

Table III. Correlation test results

	PARQ (M)	PARQ (P)	p.
BMI	+0.32*	+0.23*	0.005
Age	+0.29*	-0.0005	0.005
BUT	+0.07	+0.12	0.005
EAT-26	-0.06	-0.21	0.005