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Paper

Dyadic Adjustment in Parents of Daughters with an Eating Disorder

Alberto Espina*, Iñigo Ochoa de Alda and Asunción Ortego
Family Therapy, Personality, Assessment and Psychological Treatments Department, Faculty of Psychology, University of the Basque Country, Spain

Objective: *To study the dyadic adjustment in parents of daughters with an eating disorder (ED).*
Method: *147 couples, 74 with a daughter with an ED: 20 with anorexia nervosa, restricting subtype (ANR), 23 with anorexia nervosa, bulimic subtype (ANB), and 31 with bulimia nervosa purging subtype (BN), and two control groups: 41 couples without pathology (CN group) and 32 couples with pathology (CNP group), evaluated with the General Health Questionnaire (GHQ-28), were assessed with the Dyadic Adjustment Scale, the Beck Depression Inventory and the Self-Rating Anxiety Scale.*
Results: *The parents of daughters with an ED evidenced significantly worse dyadic adjustment than did the normal controls. When controlling for anxiety and depression, the dyadic satisfaction was lower in the mothers of daughters with ANR and BN, when compared to controls without pathology. The dyadic cohesion was lower in mothers of daughters with ANB, and the total adjustment was lower in the mothers of the ANB and BN groups versus CN group.*
Conclusion: *These findings do not permit the attribution of the ED to the parents, because the poor dyadic adjustment could be an effect of the family burden. However, these findings suggest that treatment on ED should be supplemented by interventions aimed at the parents' dyadic adjustment.*

Keywords: dyadic adjustment; parents; couple; eating disorders; anorexia nervosa; bulimia nervosa

* Correspondence to: Dr A. Espina, Faculty of Psychology, Department of Personality, Assessment and Psychological Treatment, Avenida de Tolosa 70, 20018 San Sebastián, Guipúzcoa, Spain.
Tel: (34) 943 01 83 17. E-mail: ptpeseia@ss.ehu.es

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INTRODUCTION

The poor dyadic adjustment in parents of children with various kinds of pathology has been pointed out by numerous authors. Some of them have suggested that a bad dyadic relationship could be an aetiological factor in the pathology of their children (Haley, 1980; Minuchin, 1975). Aquilino (1986) found that the children of couples with low cohesion and affectional expression perceived worse parental support than the children of couples with high cohesion and affectional expression. Stoneman, Brody, and Burke (1989) found that the parents appeared to be more inadequate in their role as they felt less satisfied with their marriage. Other authors have proposed that dyadic difficulties could be due to the burden involved in having an ill child (Brown & Rutter, 1966). Objective burden refers to practical problems, such as disruption of family relationships, constraints in social activities, and financial difficulties. Subjective burden refers to the psychological reactions that family members experience, e.g. depression, anxiety and feeling of loss. The burden may be associated with couple difficulties that lead to a rise in the divorce rate (Fadden, Bebbington, & Kuipers, 1987). Orford et al. (1992) considered that the burden involved in having a drug-addicted child could damage the couple relationship and Brook, Whiteman, and Gordon (1983) agree that the conjugal conflict has negative effects on the child and that it plays an important role in the addiction. Olin and Fenell (1989) suggested that anxiety and depression negatively influence the dyadic adjustment.

In the case of eating disorders (ED), investigators have suggested that the relationship between the parents of patients with an eating disorder are characterized by conflict. Minuchin, Rossman, and Baker (1978) described over-involved relationships between the patient and one parent coinciding with a poor conjugal relationship. Crisp, Hsu, Harding, and Hartshorn (1980) found that the bad relationship of the anorexic patient with one of the parents coexisted with problems between the couple. Strober (1981) pointed out that there were significant differences in conjugal disappointment between the parents of bulimic anorexics and of restrictive anorexics, finding a significantly higher degree of disappointment between the parents of bulimic anorexics. Humphrey (1988) compared families with daughters with an eating disorder and controls, and found that the marital relationship was worse and that the mothers reported more dissatisfaction in the first group. The fathers of bulimics were more positive and the fathers of bulimic anorexics were hostile to their wives. Vandereycken (1994), using the Maudsley Marital Questionnaire, found that the mothers of daughters with an eating disorder had a higher level of marital

dissatisfaction. This author pointed out a lack of united authority of the parents in the families of patients with eating disorders and related it to the failure in reaching a basic agreement on parenting which could reflect problems in the marital relationship. Crisp (1995) described the marital disagreement as a possible causative factor of the illness and affirmed that there is a major conflict between the parents of anorexics which could favour or not a possible separation. Selvini, Cirillo, Selvini, and Sorretino (1998) also emphasized the bad relationship between parents of daughters with ED.

The aim of this report was to study the dyadic adjustment in parents of a daughter with an eating disorder, restricting anorexia, bulimic anorexia and purging bulimia, compared to two control groups with and without pathology.

METHOD

Subjects

The sample consisted of 147 couples: 74 with a daughter who presented an eating disorder (ED), 20 with anorexia nervosa, restricting subtype (ANR), 23 with anorexia nervosa, bulimic subtype (ANB), and 31 with bulimia nervosa purging subtype (BN). The 74 families were referred to us by an association linked to the Public Health Service. The diagnoses of eating disorder were made according to criteria from the *Diagnostic and statistical manual of mental disorders*, 4th edition (DSM-IV); American Psychiatric Association (APA), 1994). The criteria for selecting the experimental sample were: families with a daughter with an ED (ANR, ANB or BN), whose age was between 15 and 25 years, single and living in the family home, and not having received any kind of family or couple therapy. The clinical characteristics of the patients were: months of illness, mean 35.9 months (SD = 0.32), range 6–198 months; total scores on the Eating Attitude Test (Garner & Garfinkel, 1979), mean 58.2 (SD = 0.13). The families did not include other family members with severe physical or mental disorders (except one case in which two daughters presented with an ED) although several parents suffered from anxiety and depressive symptoms.

The other 73 couples were recruited from the general population as a control group that was homogenous with the experimental group in the socio-demographic variables such as sex, age, environment, economic level, job and studies. Those with severe physical or mental disorders in any of the members of the nuclear family were excluded. The control group was also divided into two groups: a control group without

pathology (CN; $n=41$) and a control group with pathology (CNP; $n=32$). In this second group one of the dyad presented a score ≥ 6 on the General Health Questionnaire (GHQ-28; Goldberg & Hillier, 1979), and/or ≥ 11 on the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), and/or ≥ 45 on the Self-Rating Anxiety Scale (SAS; Zung, 1971). Thus the overall sample was divided in to five groups: (ANR, ANB, BN, CN and CNP) homogeneous in socio-demographic variables.

The socio-demographic characteristics of the 147 couples were: age of the husbands, mean 51.1 (SD.5.8) years; age of the wives, mean 49.3 (SD.5.9) years; number of children, mean 2.9 (SD.0.9); urban environment (91.1 per cent); low socio-economic level, 18.4 per cent; medium, 42.9 per cent; and high, 39.8 per cent. A total of 48.3 per cent of the husbands and 70.1 per cent of the wives had primary or lower studies and 60.3 per cent of the husbands and 24.5 per cent of the wives 'were professional medium degree or qualified worker' and 44.4 per cent were housewives.

Instruments

General Health Questionnaire (GHQ-28; Goldberg & Hillier, 1979)

The GHQ-28 is a 28-item self-report with four optional answers that has been designed to assess general mental health. The cut-off score used was 6, as has already been recommended by Lobo, Pérez-Echeverría, and Artal (1986) for Spanish populations. It was administered only to the families of the CN and CNP groups.

The Eating Attitudes Test (EAT; Garner & Garfinkel, 1979)

The EAT is a 40-item self-report questionnaire that evaluates attitudes, feelings and concerns related to food, weight and exercise. Scores under 30 are considered to represent normality.

The Beck Depression Inventory (BDI; Beck et al., 1961)

The BDI is a 21-item self-report questionnaire. The cut-off score used was 11.

The Self-Rating Anxiety Scale (SAS; Zung, 1971)

The SAS is a 20-item self-report questionnaire with statements on a 4-point scale of severity. The cut-off score used was 45.

The Dyadic Adjustment Scale (DAS; Spanier, 1976, 1989)

This scale is a 32-item questionnaire designed to measure relational adjustment and satisfaction in intimate couples, and has a range of 0 to

151 for both sexes. Content, criterion-related and construct validity, as well as internal consistency reliability are adequate (Spanier, 1976). The scale measures dyadic adjustment along the following four components: degree of consensus, cohesion, general relational satisfaction and affectional expression. Dyadic consensus is the degree of agreement that couples hold on issues of importance such as handling family finances or making major decisions. Dyadic cohesion refers to how often a couple engages in activities together (for example: 'Do you and your mate engage in outside interests together?'). Affectional expression concerns how often a couple expresses love for each other (for example: 'Do you kiss your mate?'). Dyadic satisfaction examines the degree of happiness in the relationship, as well as the frequency of conflicts experienced in the relationship. A global quality measure in dyadic adjustment for each member of the couple was used with a cut-off score of 107 as proposed by Crane, Middleton, and Bean (2000) as an indicator of distress and non-distress for married individuals. These authors suggested that this cut-off is equivalent to the criterion score of 100 for the Marital Adjustment Test (Locke & Wallace, 1974). The DAS is the most widely used scale for the evaluation of marital characteristics in clinical and research settings (Piotrowski, 1999).

Procedure

We contacted the association linked to the Public Health Service, in order to request their collaboration in the study. We informed them about the selection criteria and gave them information for the patients' relatives. The families that were interested were referred to us, contacting us directly after an initial telephone call when they were given a date for verification of the diagnosis and the selection criteria. If they passed the selection criteria, then the study variables were evaluated. Four clinical psychologists, who were trained in the administration of the assessment measures, evaluated the families. A psychologist in the unit, trained in the evaluation of eating disorder measures, interviewed the patient to gather information about the history of the illness, weight and height and he administered the scales of symptoms to the patient. The questionnaires to evaluate the study variables were also administered to the parents separately.

The control group was recruited from the general population after they had been informed that we were carrying out a study in the University about the impact of the illness on the family and that we needed families without physical or 'psychical' pathology to serve as a control group. If they wanted to participate, they were given a date whether they had fulfilled the selection criteria. If they met the criteria,

we evaluated the study variables as we did with the experimental group. Subjects participated voluntarily after informed consent was obtained.

The statistical analyses used were: multivariate analysis of variance (MANOVA), univariate analysis of variance (ANOVA) with Scheffe's *post hoc* multiple comparisons, analysis of covariance (ANCOVA), chi-square test, *t*-tests, logistic regression and Pearson correlations. Before performing the parametric tests, the distribution of the variables was shown to be normal by the Kolmogorov–Smirnov test. We also performed non-parametric analyses with the Kruskal–Wallis test and the Mann–Whitney test, due to the reduced number of cases in some groups. The analyses were conducted with the Statistical Package for the Social Sciences (SPSS) V. 10.

RESULTS

For the DAS the Cronbach's alpha coefficient for the whole sample ($N = 147$ couples) was: on the total DAS $\alpha = 0.86$ for both parents, and with regard to scales, the values for the husbands were: consensus, $\alpha = 0.83$; cohesion, $\alpha = 0.78$; satisfaction, $\alpha = 0.76$; and affectional expression, $\alpha = 0.70$; for the wives the values were: consensus, $\alpha = 0.81$; cohesion, $\alpha = 0.79$; satisfaction, $\alpha = 0.77$; and affectional expression, $\alpha = 0.71$. These findings are similar to other studies (Spanier, 1976; Spanier & Thomson, 1982).

Correlations

Table 1 shows positive correlations among nearly all scales of the DAS in husbands and wives, except for the cohesion and consensus in both partners and for the cohesion of husbands with the consensus of wives. Negative correlations were found between anxiety and depression and with dyadic adjustment. Positive correlations were found between parents' and daughters' anxiety and depression. No significant correlations were found between dyadic adjustment and chronicity (months of illness) or severity (Eating Attitude Test scores) of daughters' eating disorder.

Comparison between groups

We compared the dyadic adjustment quality of the husbands among the five groups (non-distress DAS ≥ 107) and we found statistically significant differences among the groups ($\chi^2 = 14.519$, $df = 4$,

Table 1. Intercorrelations among DAS and subscales, SAS, BDI ($n = 147$ families), EAT and months of illness ($n = 74$ families)

	HCON	WCON	HSA	WSA	HAE	WAE	HCOH	WCOH	HDAS	WDAS	MON	EAT	DSAS	DBDI	HSAS	HBDI	WSAS
WCON	0.363**																
HAS	0.606**	0.276**															
WSA	0.297**	0.525**	0.560**														
HAE	0.532**	0.208**	0.654**	0.392**													
WAE	0.405**	0.519**	0.498**	0.559**	0.487**												
HCOH	0.139	0.089	0.378**	0.264**	0.375**	0.187*											
WCOH	0.217**	0.152	0.319**	0.361**	0.280**	0.300**	0.481**										
HDAS	0.831**	0.335**	0.849**	0.475**	0.754**	0.500**	0.578**	0.414**									
WDAS	0.418**	0.816**	0.517**	0.828**	0.407**	0.700**	0.326**	0.579**	0.547**								
MON	0.124	0.138	0.221	0.174	0.212	0.123	0.165	−0.097	0.218	0.124							
EAT	0.095	0.081	−0.056	−0.153	−0.022	−0.012	−0.212	−0.032	−0.033	−0.026	−0.030						
DSAS	−0.078	−0.177*	−0.144	−0.310**	−0.171*	−0.179*	−0.167*	−0.185*	−0.166*	−0.289**	−0.148	0.355**					
DBDI	−0.089	−0.156	−0.200*	−0.272**	−0.193*	−0.177*	−0.158	−0.158	−0.190*	−0.255**	−0.081	0.477**	0.870**				
HSAS	−0.089	−0.060	−0.273**	−0.109	−0.215**	−0.174*	−0.149	−0.262**	−0.213*	−0.180*	−0.117	0.055	0.195*	0.140			
HBDI	−0.100	−0.148	−0.310**	−0.213*	−0.344**	−0.264**	−0.225**	−0.281**	−0.275**	−0.281**	−0.133	0.131	0.361**	0.342**	0.568**		
WSAS	−0.236**	−0.246**	−0.304**	−0.371**	−0.376**	−0.351**	−0.095	−0.137	−0.304**	−0.353**	−0.097	0.177	0.343**	0.305**	0.362**	0.245**	
WBDI	−0.091	−0.151	−0.243**	−0.255**	−0.214**	−0.227**	−0.137	−0.253**	−0.201*	−0.284**	−0.256*	0.119	0.403**	0.428**	0.360**	0.335**	0.523**

DAS, Dyadic Adjustment Scale; WCON, consensus wife; HSA, satisfaction husband; WSA, satisfaction wife; HAE, affectional expression husband; WAE, affectional expression wife; HCOH, cohesion husband; WCOH, cohesion wife; HDAS, total DAS husband; WDAS, total DAS wife; MON, months of illness; EAT, Eating Attitudes Test; SAS, Self Anxiety Scale; DSAS, total SAS daughter; BDI, Beck Depression Inventory; DBDI, total BDI daughter; HSAS, total SAS husband; HBDI, total BDI husband; WSAS, total SAS wife; WBDI, total BDI wife. $^{**}p < 0.01$; $^{*}p < 0.05$.

$p = 0.006$). Pairwise group comparisons were also performed using the Bonferroni correction; the alpha level was set at $p < 0.005$ (0.05/10), showing significant differences between ANR versus CN groups ($\chi^2 = 9.698$, df = 1, $p = 0.004$). The percentage of husbands presented non-distressed adjustment was: 13 (65 per cent) in ANR, 16 (69.6 per cent) in ANB, 22 (71 per cent) in BN, 39 (95 per cent) in CN and 29 (90.6 per cent) in CNP groups. In wives we found statistically significant differences among the groups ($\chi^2 = 13.332$, df = 4, $p = 0.010$). Pairwise group comparisons were also performed using the Bonferroni correction; the alpha level was set at $p < 0.005$ (0.05/10), showing significant differences between ANR versus CN groups ($\chi^2 = 9.715$, df = 1, $p = 0.004$), BN versus CN ($\chi^2 = 10.548$, df = 1, $p = 0.001$), and near significance between ANB and CN ($\chi^2 = 7.809$, df = 1, $p = 0.005$), with worse adjustment in the groups with ED. The percentage of wives who presented non-distressed adjustment was: 12 (60 per cent) in ANR, 15 (65.2 per cent) in ANB, 19 (61.3 per cent) in BN, 38 (92.7 per cent) in CN and 25 (78.1 per cent) in CNP groups.

In order to study quantitative variables, a multivariate analysis of variance (MANOVA) was conducted on the DAS and its scales. The overall group effect was significant when introducing the group variable as an inter-group factor (Wilks' lambda = 0.713, $F(32, 449.451) = 1.501$, $p = 0.041$). After obtaining the results of the MANOVA, and in order to evaluate whether there were differences among groups, a univariate analysis of variance (ANOVA) was carried out in order to study if there were statistically significant differences among the five groups on the DAS and its scales. Tables 2 and 3 indicate the existence of differences among groups on the total DAS and the relational satisfaction subscale in both partners, as well as on the cohesion in mothers and the affectional expression in fathers. When performing multiple comparisons with the Scheffé's *post hoc* test, the following significant differences were found: between the groups CN and ANB on the relational satisfaction subscale in husbands ($p = 0.034$) with less satisfaction in the ANB group. In wives, we found differences on relational satisfaction between the groups CN and ANR ($p = 0.043$) and BN ($p = 0.028$), with less satisfaction in ANR and BN groups. In wives we also found significant differences on the Cohesion subscale between the groups CN and ANB ($p = 0.020$) with less cohesion in the ANB group, and on the total adjustment between the groups CN and ANB ($p = 0.033$) and with BN ($p = 0.026$) with worse adjustment in the groups ANB and BN. When we performed an inter-group comparison analysis with the non-parametric Kruskal–Wallis test and a pair-wise group comparison with the non-parametric Mann–Witney's *U*-test, we found similar results.

Table 2. Comparison among the five groups in the Dyadic Adjustment Scale and its scales in the husbands

	Group	*N*	Mean	SD	*F*(df = 4)	*p*
Husband's consensus	ANR	20	52.05	8.96		
	ANB	23	50.30	8.33		
	BN	31	50.45	8.56		
	CN	41	52.56	6.78		
	CNP	32	54.09	5.54		
	Total	147	52.02	7.55	1.295	0.275
Husband's satisfaction	ANR	20	38.50	6.30		
	ANB	23	37.95	4.30		
	BN	31	39.22	4.64		
	CN	41	41.73	3.68		
	CNP	32	40.40	3.74		
	Total	147	39.88	4.58	3.641	0.007*
Husband's affectional expression	ANR	20	8.30	2.86		
	ANB	23	8.65	2.55		
	BN	31	9.19	2.24		
	CN	41	10.00	1.44		
	CNP	32	9.93	1.89		
	Total	147	9.37	2.20	3.422	0.011
Husband's cohesion	ANR	20	11.45	4.70		
	ANB	23	13.30	4.01		
	BN	31	14.06	5.03		
	CN	41	15.00	5.13		
	CNP	32	13.75	4.69		
	Total	147	13.78	4.86	1.921	0.110
Husband's total adjustment	ANR	20	110.30	17.30		
	ANB	23	110.21	14.25		
	BN	31	112.93	16.45		
	CN	41	119.29	12.60		
	CNP	32	118.18	12.09		
	Total	147	115.06	14.65	2.653	0.036

Note: ANR, restrictive anorexia nervosa; ANB, bulimic anorexia nervosa; BN, bulimia nervosa; CN, control group without pathology; CNP, control group with pathology.
*CN versus ANB ($p = 0.034$).

Taking into account that some authors (Olin & Fenell, 1989) suggest that anxiety and depression can influence the dyadic adjustment, we performed an analysis of covariance (ANCOVA) to study whether there were significant differences between groups in the DAS and its factors, considering BDI and SAS as concomitant variables. The results showed that there was interaction between the BDI and husbands' satisfaction, and the differences among groups disappeared with the corrected means. With regard to the remainder of the variables the results show that SAS and BDI did not influence the DAS. In order to study whether

Table 3. Comparison among the five groups in the Dyadic Adjustment Scale and its subscales in the wives

	Group	*N*	Mean	SD	*F*(df = 4)	*p*
Wife's consensus	ANR	20	50.00	5.81		
	ANB	23	49.73	9.49		
	BN	31	50.09	9.44		
	CN	41	52.92	5.79		
	CNP	32	52.56	7.20		
	Total	147	51.35	7.65	1.263	0.287
Wife's satisfaction	ANR	20	36.75	5.47		
	ANB	23	37.56	7.23		
	BN	31	37.12	5.86		
	CN	41	41.43	4.30		
	CNP	32	39.53	4.59		
	Total	147	38.87	5.64	4.343	0.002*
Wife's affectional expression	ANR	20	8.80	1.96		
	ANB	23	8.78	2.17		
	BN	31	8.58	2.52		
	CN	41	9.80	1.63		
	CNP	32	9.46	1.68		
	Total	147	9.17	2.02	2.291	0.063
Wife's cohesion	ANR	20	11.15	3.93		
	ANB	23	10.21	4.78		
	BN	31	11.25	5.31		
	CN	41	14.56	4.57		
	CNP	32	11.25	5.02		
	Total	147	12.00	5.00	4.255	0.003**
Wife's total adjustment	ANR	20	106.70	11.90		
	ANB	23	106.30	18.19		
	BN	31	107.06	18.42		
	CN	41	118.73	10.55		
	CNP	32	112.81	13.18		
	Total	147	111.40	15.23	4.603	0.002***

Note: ANR, restrictive anorexia nervosa; ANB, bulimic anorexia nervosa; BN, bulimia nervosa; CN, control group without pathology; CNP, control group with pathology.
*CN versus ANB ($p = 0.043$), CN versus BN ($p = 0.028$).
**CN versus ANB ($p = 0.020$).
***CN versus ANB ($p = 0.033$), CN versus BN ($p = 0.026$).

there were differences between individuals without symptoms of anxiety (SAS ≤ 44) or depression (BDI ≤ 10) in the ANR, ANB and BN groups taken together ($n = 20$) versus the CN and CNP groups together ($n = 56$), we performed a series of *t*-tests and only found significant statistical differences in wives' satisfaction ($t(74) = -2.609$, $p = 0.011$) and wives' total adjustment ($t(74) = -2.392$, $p = 0.019$), with lower scores in ED group.

Regressions

Finally, we carried out a logistic regression considering group as a dependent variable, and SAS, BDI, DAS and its subscales as independent variables. The results showed that the BDI predicted the assignment to the ANB ($B = 0.165$, $p = 0.011$, Wald $= 6.461$), and CN group ($B = -0.330$, $p = 0.002$, Wald $= 9.541$) in husbands, predicting correctly the 15 per cent of husbands from the ANR, the 30.4 per cent from the ANB, the 38.7 per cent from the BN, the 78 per cent from CN and the 25 per cent from CNP groups. Whereas in wives, cohesion ($B = 0.195$, $p = 0.010$, Wald $= 6.670$) and BDI ($B = -0.405$, $p = 0.001$, Wald $= 11.303$) predicted the assignment to the CN group. Predicting correctly the 20 per cent of wives from the ANR, the 17.4 per cent from the ANB, the 38.7 per cent from the BN, the 90.2 per cent from the CN and the 34 per cent from the CNP groups.

DISCUSSION

Our results show that dyadic adjustment is poorer in couples with a daughter with an eating disorder than in control couples without pathology. This poor dyadic adjustment could be an aetiological factor in ED, as several authors have already suggested (Crisp, 1995; Minuchin, Rossman, & Baker, 1978; Selvini & Viaro, 1988). These authors noted that the poor dyadic relationship of the parents of patients with ED favoured the appearance of 'rigid triads', where the parents involve one of their daughters in their conjugal conflict (Minuchin, 1975). The autonomy of that daughter would be limited and, according to these authors, the ED would be a way of expressing through the body the familial conflict that has not been made explicit in other ways. This hypothesis must be treated with caution, because it blames the parents, adding stress to people who suffer from an important subjective and objective burden. Poor dyadic adjustment has been found in couples with drug-addicted children (Brook, Whiteman, & Gordon, 1983), as well as in parents with children suffering from an ED (Crisp, 1995; Humphrey, 1988; Selvini et al., 1998; Strober, 1981; Vandereycken, 1994). These results suggest that the poor dyadic adjustment in parents of children with disorders does not seem to be specific to a particular pathology, but could be due to the burden.

Our correlations show that anxiety and depression are strongly and negatively associated to dyadic adjustment, and that anxiety and depression are positively associated in parents and daughters. These findings suggest that these symptoms could be increased in family interactions and strongly related to the burden. The fact of having a

child with a severe physical or psychical pathology is, on the other hand, a chronic stressor that produces burden in the family (Brown & Rutter, 1966). Such burden can produce a negative influence in the dyadic relationship when dealing with the problem presented by their child which can worsen the dyadic adjustment. This approach suggests that the child's disorder is the cause of the deterioration in the dyadic relationship. Therefore, there may be a circular process where the bad relationship of the parents would have negative repercussions on the child, regardless of whether it had initially contributed to the appearance of the pathology in the child, and simultaneously, the patient could produce burden that could have negative repercussions on the couple.

Controlling for depression and anxiety, the differences in husbands' satisfaction disappeared, but the lower satisfaction, cohesion and total adjustment in the dyadic relationship in mothers of daughters with some ED versus controls without pathology (CN group) was maintained, emphasizing the dissatisfaction. The dissatisfaction in mothers with daughters with ED has already been pointed out by Humphrey (1988) and Vandereycken (1994). Finally we found that, excluding the cases with anxiety and depression, satisfaction and the total adjustment were lower in mothers with a daughter with an ED than controls. These findings suggest that some aspects of the mothers' dyadic adjustment are not related to mood disorders and that they could be due to other factors, although the hypothesis of the burden cannot be excluded because it can influence the dyadic adjustment without provoking mood symptoms.

The regressions including SAS and BDI in husbands showed that the BDI predicted assignment to the ANB and the control group without pathology. Whereas, in wives the BDI and the cohesion predict assignment to the control group without pathology. These findings reaffirm the importance of mood symptoms and show that the mothers' cohesion could also be taken into account in the therapy of families with a daughter with an ED.

We cannot conclude anything in this study with regard to whether the dyadic adjustment observed in parents of daughters with ED is an aetiological factor or a consequence of the ED. The most realistic explanation, since we did not know how the couple's relationship was before the child became ill, is that the burden damages the couple's relationship, which in turn could impair the child in a circular way. Our results suggest that poor dyadic adjustment in parents could be a negative influence in the course of the disorder because they will be unable to give support to their daughter, as has already been stated by Stoneman, Brody, and Burke (1989). In order to help the parents in their difficulties, we think that the interventions in ED should include them. If the therapist considers the poor dyadic adjustment to be a result of the

family burden, they will probably not blame the parents, and this would enhance the collaboration between therapist and parents in order to help the patient. Improving the dyadic adjustment of the parents can be of benefit to everybody. The daughter might then feel abole to rely on her parents more so that the challenges presented by her disorder could be dealt with in a more satisfactory and united manner and the parents might come to rely on each other more in the face of this stressful situation. If the dyadic conflict precedes the disorder and the daughter's problem serves to make the couple stable, working on such difficulties may still be beneficial, provided that we do not forget that the problem is the ED and that the fact of facing the dyadic problems should not create more stress in a family that already carries a great burden.

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