THE DYSFUNCTIONAL RELATIONSHIP BETWEEN THE MOTHER AND THE DAUGHTER IN THE PATHOGENESIS OF ANOREXIA NERVOSA

A Thesis
Submitted in partial fulfillment
of the requirements for the degree of
Master of Arts in Educational Psychology

By:

Ruby Issam Sawaya

Department of Psychology, Education and Physical Education

Notre Dame University – Louaize
Lebanon

Fall, 2014

Thesis Committee *Name*	*Signature of Approval*	*Date**
Dr. Joseph Yacoub **Thesis Advisor**	Joseph R. Yacoub	Oct 21, 14
Dr. Simon Abou Jaoude **1st Reader**		August 25, 2014
Dr. Doris Jaalouk **2nd Reader**	Doris Jaalouk	Aug 25, 2014

NDU LIBRARY
20 JUN 2016
RECEIVED

DEDICATION

I dedicate this thesis to all mothers who have a child suffering from Anorexia Nervosa and especially to my mother who has saved me from Anorexia at a younger age.

ACKNOWLEDGMENTS

I would like to thank those who have highly contributed to my education at Notre Dame University.

I would like to thank Dr. Joseph Yacoub for his continuous support throughout my journey at NDU. From a Bachelor's Degree to a Master's Degree and way more; his contributions and guidance have highly influenced my education choices, career planning, and personal attributes. The support he provided and the availability by which he is known for, helped me get to where I stand today.

Dr. Simon Abou Jaoudeh for his effective and continuous coaching and guidance throughout my pursuit of self-development over the years; and for taking the great trouble to go carefully through the thesis process; he has made a number of suggestions as well as stimulating and challenging comments.

I also would like to express my gratitude to Dr. Doris Jaalouk for helping me put together the overflowing ideas into a professional work.

Abstract

Anorexia Nervosa is a severe psychiatric disorder consisting of the maintenance of extremely low weight, restrictive eating habits, purging techniques, an immense fear of gaining weight, and a distorted body image. The feelings of dissatisfaction with bodily image is usually distorted from the ideal image and has a negative connotation. Women with Anorexia Nervosa not only have a distorted self-image but also may suffer from identity crisis/confusion as they live the dilemma of growing old versus staying young, and dependency versus independency as the process of identity formation majorly relies on disruption by radical changes in social roles and cultural expectations.

The objective is to understand how a dysfunctional relationship with the primary caregiver, the mother, may lead a young female to developing Anorexia Nervosa, and the early contributing learning elements behind the dysfunctional primary relationship. Sixty randomly selected females from the "Notre Dame University" were asked to complete the Eating Attitudes Test (EAT- 26) to identify those with risk of Anorexia Nervosa. The EAT-26 test was followed by a questionnaire that looked at the relationship with the mother.

The results of the study show that females who are at high risk of Anorexia Nervosa are more likely to have a dysfunctional relationship with their mothers.

Keywords: Eating Disorders, Anorexia Nervosa, Mother-Daughter Relationship

Table of Contents

Introduction

Food, eating habits, and nutrient choices have been in our cultures and religions for decades, however, not much thought or research has been made to identify the importance of it in our daily life. Food shapes up our social, religious, and cultural background as it identifies us as human beings; "what we eat defines who we are" (Rozen, 1996). Psychologists and sociologists have studied eating patterns to identify the importance behind it, whether it be a social stigma or a psychological pursuit to reflect their inner well-being (Rozen, 1996).

Eating has several purposes divided upon a scale of physical needs to survive and psychological influences. There comes a point when well mentioned eating habits straddle the line between healthy and unhealthy. When taken to an extreme, these habits can have dangerous consequences. Mental health disturbances such as depression, anxiety, and mood swings are reflected in unhealthy eating habits (Polivy & Herman, 2005). Therefore eating habits change according to one's mental health and wellbeing. Eating habits due to psychological factors are considered normal habits until these habits interfere with the individuals day-to-day functioning thus become pathological, i.e. developing Eating Disorders.

Overeating and under eating are phenomena that have captured the attention and interest of mental health professionals in the past two decades, to the extent that they were trying to find the best operational definition that would reflect the pathological eating patterns. The situation becomes complicated by our inadequate understanding of what triggers eating and what indicates us to stop (Gilbert, 1986). Eating Disorders are one of the common psychological disorders mushroomed in the past fifteen years. The *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV 1994)* defines Eating Disorders as the "severe disturbances in eating

behavior" which has an effect on body weight, psychological and medical health of the sufferer. The term eating disorders is a broad category that holds within it two different types of disorders known as Anorexia Nervosa and Bulimia Nervosa (Gilbert, 2000). Although both types of Eating Disorders are very similar in content they highly differ in prognosis and symptomology. Anorexia Nervosa according to its Latin origin is "an" which means "without" and "orexia" which means appetite whereas Bulimia Nervosa is "bous" which means "ox" and "limos" which means "hunger" translated into ravenous hunger. In this study, the main focus is headed towards the loss of appetite and restriction of food rather than greediness and hunger struggles. Thus, Anorexia Nervosa.

Anorexia Nervosa has been highly prevalent (2.6%) among females and has increased in recent decades (DSM-IV, 1994). Understanding the causes of it contributes to a major controversy among the theorists that have tried to analyze the symptoms of Anorexia Nervosa and relate it to past and present experiences; whether the experiences are familial, sexual, or social in type. Anorexia Nervosa is a female oriented disorder, it is thus interesting to study the relationship of the daughter with the mother that might have influenced the onset of disordered eating habits. Hilde Bruch (1974) conducted a study on females with Anorexia Nervosa, and stated that patients with Anorexia Nervosa displayed a deficit in self-identity and autonomy. She concluded that individuals with eating disorders have a major disturbance in the relationship with the mother at an early stage of life whereby the mother misinterprets the child's primary needs and has not been able to fulfill her role as the primary caregiver (Gilbert 2005).

Mothers and daughters have been the subject of interest to many researchers. In psychology, studies have looked at the relationship between the mother and the child for many

years. The reason is that the mother is the primary caregiver that have contact with the child very early in life and for a long period of time.

Researchers have shown that a women's development is closely linked to their relationship with their mother. Their sense of self as a person evolves from their early attachment and later identification with their mother. This early relationship serves as a prototype for all other relationships.

Need for the Study:

According to the National Health Services (NHS), among most common psychological disorders eating disorders is ranked in the top 3. Of the Eating Disorders, Anorexia Nervosa is a mental health condition that can be life-threatening if left untreated. Anorexia Nervosa was compared by Turner and Durkheim, to be 'egoistic' suicide since the effects of starvation are visible in an individual's medical history in addition to the psychological trauma inflicted (Frude, 1998).

Eating disorders are gradually becoming a recurrent theme in the Lebanese society given that the Lebanese society is inclining towards being a consumer society. It is becoming more and more evident that the perception of the individual or the self, vis-à-vis family, friends and the larger society as a whole is rapidly changing and becoming a vital element in determining one's quality of life and his/her aspirations. In addition, the influence of the media on the proliferation of eating disorders cannot be denied and its significance stems from the fact that the media messages about the relationship between thinness and success are reaching the Lebanese youth.

The need for the study is to eventually address the issue of Anorexia Nervosa and understand the reasons behind its progressive development amongst Lebanese young women. It is interesting to question the probability of parenting models in Lebanon as one of the factors

leading to the dysfunction, then to encourage parents to have constructive discussions with their children and to understand the reasons behind this disorder. In addition, psychologists and pedagogics as well as youth advocacy organizations can eventually design interventions that are able to address this disorder and prevent it accordingly.

Dr. Zeeni (2014), an assistant professor in the Lebanese American University, has had extensive research into eating disorders in Lebanon and has not only realized that studies on such a topic is minimal, it is completely nonexistent. The interest she had in building the knowledge about a topic so broad and building awareness to individuals that may be at risk of eating disorder is due to the worrying findings that most patients seek professional help at a severe stage of the illness.

Hypothesis

To what extent the mother's parenting style has an impact on the daughter's eating habits increasing the risk of Anorexia Nervosa? What are the reasons that this is such an important relationship?

H_1: Young women at risk of Anorexia Nervosa tend to have a dysfunctional relationship with their mother as compared to individuals with normal eating and dieting habits.

H_2: Young women with a dysfunctional relationship with their mother tend to have negative self-image.

H_3: Young women with negative self-image have the possibility of developing an eating disorder, mostly Anorexia Nervosa.

Purpose of the Study:

The purpose of the study is to shed light on Anorexia Nervosa and dissect the reasons behind the prevalence of this disorder amongst Lebanese young women, noting particularly the high and positive correlation between the mother-child relationship and the development of Anorexia Nervosa. While the cause of Anorexia nervosa is not always poor parenting, nevertheless, the disorder is mainly at the center of self-perception and self-esteem and is therefore considered to be a by-product of a poor reinforcement mechanism usually at home. The ultimate purpose of the study is to understand whether the mother-child relationship has a direct effect on the development of Anorexia Nervosa and how it can then be curbed.

Part One: Literature Review

Chapter One: Understanding Anorexia Nervosa

Introduction

For the past two/three decades, there has been something of a revolution in the field of psychology, particularly related to eating patterns and psychological problems. Parents and friends know that something is wrong but don't know what they should do. Their lack of information may be paralyzing. Accepting that the daughter has an illness with psychological implications may be difficult.

The aim of this chapter is to provide the necessary framework about eating disorders in general and Anorexia Nervosa in particular.

1.1. Definition and Types of Eating Disorders:

Eating disorders are one of the most common detrimental psychological disorders coined almost 30 years ago. According to several symptoms visible within the eating habits of individuals diagnosed with eating disorders, they have become more differentiated into two main categories known as Anorexia Nervosa and Bulimia Nervosa (Shipton, 2004). Studies have shown that individuals with an eating disorder report significantly greater functional impairment, emotional distress, psychiatric comorbidity, and suicidality than individuals with normal eating habits (Stice, Marti & Rohde, 2013). The age of onset to individuals developing an eating disorder is between 16 and 20 years of age with a duration of at least 1.7 years for Anorexia Nervosa and 8.3 for Bulimia Nervosa (Stice, Marti, Shaw & Jaconis, 2009). The overall lifetime prevalence of any eating disorder is 13.1% as the majority of cases show remission of the disorder within one year (Stice, Marti & Rohde, 2013).

The two main types of eating disorders are Anorexia Nervosa and Bulimia Nervosa characterized by an overwhelming drive to be thin and an immense fear of being fat. They both

follow the same objective of achieving happiness through thinness; however, they do differ drastically in the symptoms and diagnostic criteria they follow (Gilbert, 2005). Anorexia Nervosa is defined as the deliberate loss in weight either through severe calorie restriction or induced by major purging techniques (Shipton, 2004). In Anorexia the fear of obesity and constant pursuit of thinness puts lives of individuals with Anorexia Nervosa in considerable danger. Bulimia Nervosa on the other hand is defined by the powerful and intractable urge to eat resulting with episodes of overeating and followed by purging techniques or the use of laxatives to eliminate the food intake (Ogden, 2003). Bulimia is considered more dangerous as it may go unnoticed for years as individuals with Bulimia Nervosa maintain a normal body weight throughout the course of the disorder. Despite the fact that Bulimia is considered more dangerous, both disorders have a high mortality rate. The ratio for Anorexia Nervosa is 5.9 and 1.9 for Bulimia Nervosa, the mortality rate due to suicide attempts is 4.7 and 6.5 respectively (Stice, Marti & Rohde, 2013). "Eating Disorders are marked by chronicity, relapse distress, functional impairment, and risk for future obesity, depression, suicide attempt, anxiety disorder, substance abuse, and morbidity" (Stice, Marti, Shaw & Jaconis, 2009).

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000), there are several other types of eating disorders visible within our cultures and ethnic groups. The first disorder is known to be binge eating disorder that is characterized by distressed binge eating without the engagement in compensatory behavior. The other two disorders, Rumination Disorder and Pica Disorder, are more specific to childhood eating disorders that are thought of as a developmental disorder of separation and individuation (Shipton, 2004). Rumination Disorder, also categorized as a childhood disorder is visible within individuals with mental retardation characterized by regurgitating and re-swallowing digested food. Pica

Disorder, an infantile disorder characterized by eating nonnutritive substances for a significant period of time. Last but not least, Obesity is also considered a sub-division of eating disorders that is characterized by the measurement of Body Mass Index (BMI) and excessive body fat in an individual. The BMI for clinically obese individuals is between 30 and 39.9 and severe obesity is above 40 (Ogden, 2003).

In all the above mentioned disordered eating, the commonality is the fixation of the oral stage according to Sigmund Freud's psychosocial development. He states that the child from birth till the age of one year has a need for pleasure that is obtained through the mouth by sucking or biting on objects (mother's breast, finger, etc.). If this need is over satisfied or under satisfied, it results in an oral fixation leading to lack of trust and independence in adulthood. This stage is manifested in adulthood through the pursuit of continual oral stimulus whether it be food, smoking, or biting nails (Freud, 1923). Anorexia Nervosa however, is the repression of oral stimulus manifested by the restrictive eating attitude (Boucharat, Maitre, & Wolf, 1970). Thus it is important to delve deeper into the definition and detailed analysis of Anorexia Nervosa.

1.2. Definition of Anorexia Nervosa and its Subtypes:

Early literature in religion contains implications of what today might be considered as Anorexia Nervosa however, these implications did not mention any suffering that requires treatment but rather of holy people who repudiates the pleasures of the flesh for the salvation of the soul (Beumont, Al Alami, & Touyz, 1987). Anorexia Nervosa has been visible among cultures ever since the 3rd century, however, it has been perceived as means to reach sainthood, peace, and devotion rather than a cry for help and psychological pain (Shipton, 2004). In the past, individuals would resort to self-starvation in order to reach personal or even societal objectives; such as the cases of Gandhi, Avicenna, Catherine of Sienna, and St. Wilgerfotis

(Shipton, 2004). In situations as such, food is viewed as a symbol of social status; it is the primal symbol of social worth (Ogden, 2003). As Gandhi exhibited self-starvation as means to reach peace for his country, a spiritual rather than psychological purpose, he set an example of how socially oriented aspects of life influence the perspectives on Anorexia Nervosa. It has been stated by Gordon (2000) that "historically the hunger strikes were employed by the socially oppressed as means of embarrassing or humiliating those in control and ultimately extracting concessions from them" (Ogden, 2003). On the other hand, self-starvation holds a societal connotation however it has also became a cry of help from those who resorted to self-starvation a mean to control their body weight, food consumption, and feelings of hunger.

Anorexia Nervosa is a psychological disorder listed in both the Diagnostic and Statistical Manual of Mental Disorders and the International Classification of diseases (ICD10) (WHO 1992). In both manuals, the definition of Anorexia Nervosa is not a one straight definition used to describe a disorder as broad as Anorexia Nervosa but a list of characteristics describing its symptoms; it is a multi-determined syndrome (Guinzbourg, 2011). The simplified definition of it is a continuous pursuit of being thin regardless of the individuals' body weight and height. Two prominent French physicians, Louis Victor Marcé and Charles Lasègue, described separately Anorexia Nervosa in 1873 followed by William Gull in 1874 who coined the term as the "nervous loss of appetite" (Garner & Garfinkel, 1997). Several attempts to describe a disorder as broad as Anorexia Nervosa has been put into place; some definitions were based on psychological disturbances and lack of control such as weight phobia as described by Crisp in 1967 and a morbid fear of fatness as described by Russell in 1970 (Ogden, 2003).

Currently, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR, 2000) defines Anorexia Nervosa according to four different criteria:

A. Refusal to maintain body weight at or above a minimally normal weight for age and height (e.g., weight loss leading to maintenance of body weight less than 85% of that expected; or failure to make expected weight gain during period of growth, leading to body weight less than 85% of that expected).
B. Intense fear of gaining weight or becoming fat, even though underweight.
C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or denial of the seriousness of the current low body weight.
D. In postmenarcheal females, amenorrhea, i.e., the absence of at least three consecutive menstrual cycles. (A woman is considered to have amenorrhea if her periods occur only following hormone administration such as estrogen,).

The International Classification of Diseases (ICD10) (WHO 1992) defines Anorexia Nervosa with a visible symptom of body weight loss. The definition is based on the percentage of body weight according to the expected weight of the individual, based on their age and height in the absence of all other medical conditions. To be able to identify the presence of a malfunction in one's eating habits, one should consider the Body Mass Index (BMI) through the formula that divides the weight in kilograms by the square of height in meters (Gilbert, 2005). The normal range for Body Mass Index is between 20 and 25, below 20 is notably considered underweight (Gilbert, 2005) and Anorexia Nervosa maintains 15 per cent below the expected body weight (ICD10, WHO 1992).

On the other hand, the medical malfunctions and physical disfigurement do have severe consequences on the bodies of the sufferers from Anorexia Nervosa. "The disorder takes a physical toll on sufferers. Long-term starvation causes muscle weakness and loss of muscle

strength, which also affects the heart. Sufferers may develop cardiac abnormalities and arrhythmias. They may have dry skin and excessive growth of dry brittle hair over the nape of the neck, cheeks, forearms, and thighs, called 'lanugo' hair. They often have cold hands and feet, and peripheral edema (swelling). The lack of food would extract the vitamin and protein level in the body leaving individuals with low energy and chronic constipation. Long-term amenorrhea (lack of menstrual periods) may lead to premature bone loss and places sufferers at a higher risk of osteoporosis. Indeed, there is evidence that young women with Anorexia Nervosa have an increased risk of fractures in later life" (Gilbert, 2005). Anorexia Nervosa is a disorder with about three times the risk of dying as opposed to other psychiatric illnesses and according to Steinhausen (1999) 5 percent of patients with Anorexia Nervosa die.

The symptoms and consequences of Anorexia Nervosa also vary as the types of Anorexia Nervosa differ; the first type is generally known as the 'restricting type' and the second type is the 'binge eating/purging' type (Gilbert, 2005). As described by the Diagnostic and Statistical Manual of Mental Disorders (DSM IV, 2000), the restricting type of Anorexia Nervosa is when the individual has not regularly engaged in binge-eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). The second type of Anorexia Nervosa is the binge eating/purging type whereby the person has regularly engaged in binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

1.3. Risk Factors of Anorexia Nervosa:

Anorexia Nervosa does not have one specific cause but a mélange of stimulus that might trigger the development of such a disorder. Studies done by Ratam and Gillberg (1991) reported a correlation between the loss of a family member and the development of eating disorders for instance (Ogden, 2003). Another study conducted by Draucker (2000) states that a history of

sexual abuse is more common in patients with Anorexia Nervosa of the bulimic subtype than patients with Anorexia Nervosa of the restrictive type. A third study by Stern (1983, 1985) shows that the relationship between an infant and a caregiver is essential and might lead to the development of Anorexia Nervosa if there has been a dysfunction in one of the following 3 lines; mental state sharing, self-other complimenting, and state formation. On a more medical level, the cause of Anorexia Nervosa is defined by the low levels of neurotransmitters especially the Norepinephrine and Serotonin in the hypothalamus (Frude, 1998).

The causes of Anorexia Nervosa are also divided into several bits and pieces in the world of psychology. Some explain Anorexia Nervosa in terms of sexuality and oral fixations, while others go more in depth into the unconscious rejections of adulthood, or regression towards childhood family based commitments and patterns (Frude, 1998). It is believed that individuals with Anorexia Nervosa fear sexuality, it is a classic theory suggesting that impregnation occurs orally and thus patients with Anorexia Nervosa control impregnation through a symbolic oral fixation; controlling food intake that happens to be oral in nature (Scully, 1996). Females who fear sexuality is a result of a Post-Traumatic Stress Disorder (PTSD) resulting from a negative sexual experience, whether it means a sexual assault, abuse, or incest (Tackett, 2002). As they grow older, the survivors of negative sexual assaults suffer several psychological and somatoform disorders that effect their daily functioning. Some unconsciously resort to eating disorders as a way to deny their femininity and show unwillingness to embrace their womanly sexuality (Briere & Elliott, 1994).

The second influencing factor of Anorexia Nervosa is the parent-child conflict that is known as a transactional phase in one's developmental history, this phase as described by Erik Erikson's developmental stages is autonomy vs. shame and doubt. In this stage, the child learns

independency and if conflict arises between the child's and the parents' needs, the child will have difficulty regulating eating habits and thus become dependent on environmental cues (Scully, 1996). As the child's needs become neglected, and the priority rises to the parents' needs, the control and authority is yet not the child's property. Thus, eating habits become the symbol of power and control and by the refusal of food, the individual is refusing any authority over the body other than one's own (Corrington, 2010). Both parenting styles, the mother and the father's, have a great impact on the daughter's onset of disordered eating. However, the main influencing factor on the onset of the disorder is the daughters' relationship with the mother. The parenting style of the mother and her attitude towards the autonomy and independency of her daughter may result in feelings of lower self-esteem and self-worth in the daughter (Scully, 1996).

1.4. Effects of Anorexia Nervosa:

Self-starvation has drastic effects on the functioning of the brain and other organ systems of individuals as the structure of the brain is abnormal due to illness; the ventricles enlarge, the sulci widens, and the grey and white matter change in size due to the loss in body mass (Duvvuri & Kayne, 2009). The organ systems that are effected by malnutrition and Anorexia Nervosa are the cardiovascular system, reproductive system, and gastrointestinal system. The excessive exercise, lack of nutrition, and minimal food intake cause the heart muscle to weaken and thus increase hypertension and cardiovascular difficulties (Semple & Smyth, 2013). The amenorrhea that is a main symptom of Anorexia Nervosa as described in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV, 2000) causes the birth of low weight infants or a more severe case of infertility (Semple & Smyth, 2013). In regards to gastrointestinal complications, a patient with Anorexia Nervosa would experience diminished motility, delayed gastric emptying,

bloating, constipation, acute gastric dilation or gastric rupture, and abdominal pain (Gopal, Ropper & Tramontozzi, 2011). Other symptoms of fatigue, weakness, and syncope (loss of consciousness) are visible due to the lack of nutrition and obsession with excessive exercising (Sidiropoulos, 2007).

Although the medical effects are severe and life threatening, they are not easy to identify unless the patient is administered to the hospital for such complications. However, there are effects to Anorexia Nervosa that are visible in the naked eye and may help in the early diagnosis of Anorexia Nervosa. These physical signs and symptoms are: loss of muscle mass, dry skin, brittle hair and nails, caused skin over interphalangeal joints, anemia, hypercarotinaemia (yellow skin and sclera), body hair, eroded tooth enamel, peripheral cyanosis, hypotension, bradycardia, hypothermia, atrophy of the breasts, swelling of the parotid and submandibular glands, swollen tender abdomen, and peripheral neuropathy (Semple & Smyth, 2013). In addition to other visible symptoms of osteoporosis, fluid retention, and disturbed sleeping patterns (Shipton, 2004).

With all the chaotic effects caused by Anorexia Nervosa the list continues to delve into the psychological wellbeing of the individual leaving them with thoughts and feelings of insecurity, loneliness, guilt, inadequacy, helplessness, and a low sexual appetite which in turn describe the symptoms of depression (Frude, 1998). Depression is a common effect that individuals with Anorexia Nervosa might experience and since Anorexia Nervosa is a chronic disorder it may be seen alongside to other psychiatric illnesses such as Obsessive Compulsive Disorder, Body Dysmorphic Disorder, and personality Disorders (Gilbert, 2005).

Conclusion:

Understanding Anorexia Nervosa is yet complicated as not all individuals that pursue thinness are sufferers of Anorexic Nervosa. An individual should have been exposed to several

symptoms ranging from psychological disturbances, to medical malfunctions, and physical disfigurement to be diagnosed with Anorexia Nervosa. The psychological disturbances accompanied by Anorexia Nervosa tackle the emotional wellbeing of the individual and their self-perception, in addition to the comorbid disorders that might be prevalent to the course of the disorder. Individuals with Anorexia Nervosa in general tend to suffer from emotional difficulties in relation to self-image, social and emotional relationships. They may also display sign of low self-esteem due to the deteriorated perception of self, unstable and intense personal relationships, and the constant feelings of emptiness and solitude (Gilbert, 2005).

Due to the fact that such a disorder has hazardous consequences on individuals and their families, and due to the fact that they are gradually becoming a recurrent issue in the Lebanese society, the topic of Anorexia Nervosa has been of specific interest to accomplish this study. The risk factors of Anorexia Nervosa are several ranging from childhood conflicts with the mother, to familial difficulties, and many more. Having more than one risk factor to it has also triggered my interest into delving deeper into the mother and daughter relationship as there are certain elements in the relationship that have not been tackled. The lack of self-autonomy, the overly protective mother, the controlling mother and many more have been at the base of research for centuries. This study thus aims at studying the level of criticism the daughter is exposed to and the extent to which the mother exerts certain expectations to be achieved by the daughter.

The next chapter attempts to expand the understanding of the emergence of the self-image in light of the mother-child relationship and thus may be used as an area in which subjects can enact their numerous developmental deficiencies.

Chapter Two: The Emergence of the Self-Image: The Developmental Stages of Mother-Child Relationship

Introduction:

This chapter attempts to review in details the development of the mother and child relationship starting from the analysis of mealtime behavior, to autonomy formation, leading to the establishment of one's self image and perception; all of which have a dire influence on the development of the onset of disordered eating habits.

The mother-child relationship is at the core of our research since extensive clinical reports indicate that disruptive early experiences with the mother and a distorted sense of self are at the base of the development of Anorexia Nervosa (Bers, Besser, Harpaz-Rotem, & Blatt, 2013). It is suggested that Anorexia Nervosa is an expression of a daughter's rage and aggression towards the mother that derives from the reactivation of earlier conflicts (Bers, Besser, Harpaz-Rotem, & Blatt, 2013). The relationship between the two is thus fusional with overprotective traits, controlling yet lacks warmth, and faces difficulties with the separation and independence of the child (Campos, Sampai, Junior, Junior, Battistoni, & Turato, 2012).

The conflicts in early years of development may lead to negative feelings about oneself such as neglect, insecurity, self-disappointment, unloved, and uncared for (Ehrensing & Weitzman, 1970). These feelings are a result of the mother's failure to provide adequate external responses to the child's inner state, the mother's failure to encourage independence during the separation and individuation phase leading to a confusion between emotional and biological needs (Canetti Kanyas, Lerer, Yael, & Bachar, 2008).

1.1. Primary Learning Environment:

"Learning is an enduring change in the mechanisms of behavior involving specific stimuli and/or responses that results from prior experience with those or similar stimuli and responses" (Domjan, 2006). The definition of learning states that learning is a process that starts as soon as an individual is born; the learning process of life begins automatically as the minds of newborns is active even though behavior is disorganized (Thompson, 2001). The moment the child is born and the early years of life form a critical foundation for the individual's future well-being. Therefore, parents should cater to a child's every need in order to develop a newborn into a child that walks, talks, solves problems, and manages relationships with adults and other children (Thompson, 2001). In the light of that, the psychosocial development of this child is as well highly important and dependable on the primary caregiver – the mother, as she is the person that ensures all the child's needs are being met. The child as a dependent individual in the primary years of life tend to be extremely demanding, and as the demands are being met lovingly by the mother, the child develops trust (Bellam, 1969). This stage is defined by Erik Erikson as the "Basic Trust versus Basic Mistrust" and normally covers the first year of life whereby the child develops the trust and hope that the mother reflects their inner perception of trustworthiness which forms the basis of the child's self-identity. The malfunction in this stage of life is not only influenced by the neglect of the child's needs but also in the overindulgence in catering to the child's needs resulting in fear of inconsistency and unpredictability of the world (Fleming, 2004).

Since primary caregivers are the essence of the infant's environment; their protection, nurturing, and stimulation shape early development (Thompson, 2001). In the first year of life, the basic needs of the child are restricted to bathing, toiletry and feeding. Hence, the mother's

response to the child's needs is easily observed and disordered behaviors are effortlessly pinpointed. In a study conducted on disordered eating in infantile ages, it was shown that children with feeding disorders engage in higher disruptive mealtime and negative attitudes from the mother than healthy control children (Chatoor, Hirsch, Ganiban, Persinger, & Hamburger, 1998). In this study, the parenting style of the mother was observed on three different dimensions: first, is the timing of the response to the infant's cues, the second is the pacing of the feeding process, and the third is the termination process. Mothers and children who have experienced feeding problems display various maladaptive interactional behaviors such as neglect, incoordination, and overt hostility (Chatoor, Hirsch, Ganiban, Persinger, & Hamburger, 1998). It is believed that disordered feeding and eating habits is caused by maternal deprivation (Chatoor, Hirsch, Ganiban, Persinger, & Hamburger, 1998). According to John Bowlby (1952) the individual should experience a warm, intimate, and continuous relationship with the mother by which both individuals would find satisfaction and enjoyment in order to avoid mental illnesses. Bowlby believed that maternal deprivation, and the failure to reach satisfaction and enjoyment in the relationship between mother and child would lead to dramatic decline in mental health and wellbeing (Bowlby, 1952).

The attachment theory assumes that humans form emotional bonds with primary caregivers that facilitate the development of self, known as the internal working model. This concept of internal working model is to mediate the attachment-related experiences (Pietromonaco & Barrett, 2000). John Bowlby (1952) states that the internal working model is a process created during the early years of life where the attachment to the primary caregiver is established. It is first and furthermost dependent on the motherly care patterns to establish thoughts, feelings, and behaviors in adult life (Pietromonaco & Barrett, 2000).

1.2. Early Mother-Infant Relationship:

As a child grows older, the individualized relationship with the mother is redeveloped; the "I-It" relation moves to an "I-Thou" relation as described by Martin Buber. The sense of illusory merged omnipotence with the mother is developed into a psychic structure, a firm sense of self (Praglin, 2006). The transition between the two phases, from perceiving the mother as an object to seeing her as a whole person, symbolizes the distinction between fantasy and fact, inner and outer world, similarity and differences (Praglin, 2006). The phase is referred to by Donald Winicott (1975) as the transitional phase. As such comes along the mourning phase in the child's life where the object being mourned is the mother; the source of love, goodness, and security is being castrated as the child learns independence (Klein, 1940). During that phase, the good enough mother that has been dedicated to the child's every need instantly becomes an agent of reality formation whereby the needs of the child are starting to be met by oneself (De Gear, 2011).

Throughout the early years of life, the child incorporates the mother figure inside his/her body; inside the mind of a child the mother is the internal object (Klein, 1940), a term commonly used in Kleinian theory to denote an inner mental and emotional image of an external figure. According to Melanie Klein, the internal object develops deep unconscious phantasies that are built in the unconscious mind with inner harmony, security, and integration. This internal working model makes the child feel comfortable and at ease to the external environmental experiences; an inner world that allows the child to be exposed to negative life challenges without losing hope and security. As the child gets exposed to such external experiences, the enjoyment and positivity of the mother proves that the loved object inside as well as outside are intact, uninjured. As such the child's confidence is nourished, the confidence in other people's

goodness is strengthened, and feelings of ambivalence, fear and internal destruction are diminished. However, Klein postulated that the negativity and lack of enjoyment results in ambivalence, lack of trust and hope, and confirms anxieties about inner annihilation and external persecution (Klein, 1940).

As much as the inner world has an effect on the psychological wellbeing of the child, the external influences may also shape their negative experiences regardless of how empathetic and loving the mother proves to be. It has been stated above that if the mother is a good enough mother and helped her child through positivity, enjoyment, and comfort, the child will always be positive. However, some experiences that are external in nature might cause anxieties in the child. John Bowlby postulated that these attachment behaviors are adaptive responses to separation from the primary attachment figure. The attachment theory described by John Bowlby is "a continuous tie to a specific person (the mother in this study) that the child turns to when feeling vulnerable and in need of protection" (Gullestad, 2001). According to the attachment theory, there are four different types of attachments that can help in etiology of mental illnesses or psychological wellbeing. The attachment behavior system provides a conceptual linkage between ethological models of human development and modern theories on emotion regulation and personality. The four types are: secure attachment, anxious-ambivalent attachment, anxious-avoidant attachment, and disorganized attachment. The mother serves as a mediator of feelings in the child's life, as the person teaches the child how to effectively regulate their feelings and serve as a safe-base to their child in times of need. There is an increasing amount of research suggesting that the attachment style in individuals with Anorexia Nervosa might be a deficiency in the secure attachment type with complexities concerning the relationship between avoidance and defense.

The attachment system essentially asks a fundamental query: is the attachment, nearly, accessible and attentive? In that stage of life, where the child is being put in direct contact with the outer world, the child starts to learn hand movement coordination, self-eating, toilet training, and catering for their own needs (Fleming, 2004). Activities such as psychomotor skills, walking, talking, and dressing also play a major role in learning how to control body functions (Fleming, 2004), At that age, the child learns autonomy and begins the process of becoming independent of their primary caregiver. This process is very essential in a child's life and is called Autonomy vs. Shame and doubt by Erik Erikson. In that phase, the child learns how to master toilet training as a first step and if the child fails to achieve that it results in feelings of shame and doubts in one's capabilities.

Several studies and literature reviews have been written on the positive correlation between difficulties in early mother-daughter interactions and failure to develop autonomy from parental figure and the onset of Anorexia Nervosa (Cunha, Relvas, & Soares, 2009). The inability of separating from the mother figure results in feelings of anger and rage as the female grows up into a mature adult. As a result, the daughter controls her body in an extreme manner to avoid the sensation of body development and thus establish a distorted sense of autonomy and effectiveness (Bers, Besser, Harpaz-Rotem, & Blatt, 2013). The refusal to eat and denial of hunger is symbolized as a statement of pure autonomy; the unusual independence even of food, she will survive without the consent or help of anyone but herself, the refusal of food is the end point of "the absolute loss of self" (Bers, Besser, Harpaz-Rotem, & Blatt, 2013).

Dependency is what mothers of individuals with Anorexia Nervosa seek; the feeling that the child is in constant need for their help and gratification. Dependency is an acquired drive conceived by the mother-child tie (Ainsworth, 1969) through the dominating and controlling

motherly attitude to attain submission and perfection from her, forcing her to create a sense of fusion (Bers, Besser, Harpaz-Rotem, & Blatt, 2013). Females with Anorexia Nervosa thus have a complicated choice of either wishing for or fearing such a fusion with the mother resulting in disordered eating to establish their body and self, separate from the mother (Bers, Besser, Harpaz-Rotem, & Blatt, 2013). Despite all the causes that have been stated already, the mother child relationship still has a negative attribute to the onset of Anorexia Nervosa as it results in a disordered sense of self (Bers, Besser, Harpaz-Rotem, & Blatt, 2013).

Patients with Anorexia Nervosa describe their mother as intrusive, over-involved, excessively concerned with appearance, and lacking sensitivity to their needs and abilities resulting in an impaired sense of self (Bers, Besser, Harpaz-Rotem, & Blatt, 2013). The mothers of these patients with disordered eating habits tend to devalue their femininity and offer a very poor identification model (Campos, Sampaio, Junior, Junior, Battistoni, & Turato, 2012). They are at the base of the identification model for their daughters. Mothers tend to expose their perception of self and self-identification to their daughters as they are the image the child confuses with the imaginary self (Lacan, 1966). The child is more dependent on the world to create one's self perception and thus the mother becomes at the center of identity which is a composite of images and effects (Ragland-Sullivan, 1982).

1.3. The Emergence of Self-Image:

Freud (1923, p.26) was aware of the body as the foundation for the personality when he stated that the first ego is the body ego. With this statement, he conveys that the sense of self originates in early bodily sensations and stimulation. In the same sense, Didier Anzieu (1985) mentioned the skin ego in a book he wrote to describe how the ego is surrounded and enveloped by the skin. It is the first narcissistic envelope by which the feeling of well-being is based (Solan,

1998). Even Jean Piaget's emphasis on earlier experiences being sensorimotor implies that the earliest sense of self is a bodily one. Thus one of the earliest experiences of self is centered on bodily experiences (Sugarman, & Jaffe, 1990). There is no sense of self separate from body self. The body self is the hub of interactions with significant others, drives experiences, affects, behaviors and early ego forerunners (Craig, 1990).

Based on the fact that ego formation begins in early life and it is an essential stage of human development, it is important to delve into the milestones that shape the mother-daughter relationship; a phase coined by Jacques Lacan as the mirror stage in the paper "Ecritis" published in 1966 and delivered at the International Psychoanalytic Association Congress in Zurich. The mirror stage starts with the child at the age of six months as soon as the child recognizes his/her own image through the mirror, before the child has mastered walking or even standing up. The process is initiated by a primary caregiver that allows the child to lean forward and take a better look at the image portrayed by the mirror. To better understand the concept of mirror stage as an identification tool, Jacques Lacan (1966) writes: "the transformation that takes place in the subject when he assumes [assume] an image – an image that is seemingly predestined to have an effect at this phase, as witnessed by the use in analytic theory of antiquity's term, imago". The assumption of the image is still trapped in the inability of the child to independently walk or stand thus the image is a manifestation of symbolic matrix which the "I" is precipitated in a primordial form (Lacan, 1966).

The child realizes their psychological and physical autonomy with passing time. At the beginning, awareness of self-autonomy is realized through the ability to feed oneself without total dependence on the mother, the second step is viewing oneself in the mirror without the mother figure imbedded within. The child would start to perceive the "I", the "ideal-I" that is yet

not influenced and affected by societal determination (Lacan, 1966). As the child identifies with the ideal-I perceived in the mirror, the fragmented image once perceived by the lack of motor coordination develops into an orthopedic form of its totality. Thus, the ego of the child is established (Lacan, 1966).

The mirror stage is a drama whose internal pressures pushes precipitously from insufficiency to anticipation, from a fragmented image to a whole being. The mirror stage proved to have several functions in the developmental stages of a child: first, it serves as a decisive turning point in the mental development of a child, then it establishes a relationship between the child and its reality, and third, it typifies an essential libidinal relationship in the child (Lacan, 1966). Hence, the mirror stage aids the process of forming an integrated sense of self.

For Lacan, the mirror stage established the ego as essentially dependent on others. As the child matures and enters into social relations through language, the other will gradually become a different, which will give each an identity with its own neurosis, psychic disturbances and particular characteristics.

The individual inherits helplessness and insufficiencies by fusion with other, especially the mother. However, the individual is forced to perceive separateness from the mother through what Jacques Lacan called phallic signifier. The phallic signifier imposes a sense of limitation and boundaries to the self. The learning of psychic differentiation from the mother is painful and referred to as castration; fear of losing "self" continuity (Ragland-Sullivan, 1982).

Conclusion:

As the family environment is at the base of the influencing factors of Anorexia Nervosa and other mental health illnesses, several reports were written on the perception of the daughter to the mother at an age whereby Anorexia Nervosa is prevalent, the relationship between the

mother and the daughter during the same time, and the resulting effects it has caused on the personality of the daughter. Families with daughters suffering from Anorexia Nervosa have a central feature of communicational problems, a distorted pattern of psychosomatic families including enmeshment, overprotection, rigidity, and lack of conflict resolution (Cunha, Relvas, & Soares, 2009). High parental demand, family discord, and destructive mother-daughter communication plays an essential role in the prognosis of Anorexia Nervosa (Cunha, Relvas, & Soares, 2009) as patients with Anorexia Nervosa are prone to feedback sensitivity and thus are destroyed easily by negative or harsh comments addressed by the mother (Shott, Filoteo, Jappe, Pryor, Maddox, Rollin, Hagman, & Frank, 2012). This destructive attitude from the mother towards the daughter results in a desperate struggle to feel adequate, worthy, and effective, but in a way that leave them feeling even more inadequate, unworthy, and ineffective (Bers, Besser, Harpaz-Rotem, & Blatt, 2013).

The destructive attitude is initiated by the mother as a primary value of the daughter's worth however, is not restricted to the mother's criticism, feedback, and comments to negatively influence one's self-competence and self-liking (McAdams & Krawczyk, 2014). The mother plays a major role in shaping the daughter's self-competence and liking thus developing her self-esteem but also the media and societal pressure also plays a significant role in shaping one's self-knowledge. The impairment of self-knowledge among females with Anorexia Nervosa is significantly high as the level of criticism and negativity compiled with their sensitivity to feedback result in a distorted body image, self-worth, and self-appreciation (McAdams & Krawczyk, 2014).

Chapter Three: The Continuum between Functional and Dysfunctional

Introduction:

Beauty as a social criteria is a word so small yet holds to it different meanings according to each and every individual. Beauty can add a negative or a positive attribute to a person depending on their experiences. The definition of beauty to some individuals may mean extreme eating habits so dire to other it may only mean enjoyment. There is much more to being physically beautiful and attractive than just having good looks. It is not only having acceptable features, a thin body and a perfect smile that makes a person beautiful. A person's beauty is defined by the person's physical attractiveness, the charisma, the attitude, the personality reflection, the body language and most importantly by other people's perception of beauty. However, nowadays, beauty is identified by the physical appearance (Etcoff, Orbach, Scott, & D'Agostino, 2004).

Although it has been said that *beauty is in the eyes of the beholder*, in our today society this is no longer the truth. Beauty is nowadays defined by how society, beauty pageants, and ones self-esteem bestows upon it. Beauty has a standard, a skin color, a certain height and weight. Beauty is associated with positive qualities (Langlois, Kalakanis, Rubenstein, Larson, Hallam, & Smoot, 2000).

1.1. Body Image and Social Acceptance:

Body Image and body dissatisfaction has been a cause to disordered eating habits as appearance is a central evaluative dimension for females in our culture (Stice, Presnell, & Bearman, 2001). A distorted body image has been prevalent through cultures due to the expectations imposed on females and thus their perception on how they look and how attractive they seem would form their boundaries and limit their eating habits (Ogden, 2003). Body

dissatisfaction is a result of several attitudes through which the individual is exposed to since childhood whether it is social or cultural. The society has a great impact on body satisfaction and perception, in addition to the beliefs imbedded through development, the extended family and their traditions, and the mother-daughter relationship (Ogden, 2003). Psychosocial influences play a major role in the onset of Anorexia Nervosa however, familial transmission of risks emerged to be a strong focus of research (Strober, Freeman, Lampert, Diamond, & Kayne, 2000).

Appearance and attractiveness are important components of one's self-concept and it affects how one is perceived and treated by others yielding to a wide array of psychological sequel particularly in areas of social confidence and integration, body image and sexuality, and behavioral problems and depression which result in lower self-confidence (Maddern, Cadogan, & Emerson, 2006). Feelings of negativity, maladaptive thought processes, and unfavorable self-perception accompany individuals with low self-confidence and self-esteem (Rumsey & Harcourt, 2003). Individuals who thus believe that their self-worth is determined by their appearance have significantly lower self-esteem therefore, joining an acceptable social group becomes ultimately challenging (Rumsey & Harcourt, 2007). A study done by Blechert et al. (2010), suggests that individuals with disordered eating and disrupted body image tend to focus on their ugly body parts than their own beauty but they tend to admire the beauty in other individuals which makes social interaction a burden.

Concerns on body image and how an individual is perceived by self and others shape up most of their living hours; concerns that relate to their size, figurement, facial features, and body shape. Some of these perceptions of self are desired while others are not, thus changes to the outward appearance becomes a sole objective. Following such a pattern only proves that the

physical appearance an individual is bound by contributes to how they are perceived in society (Rumsey & Harcourt, 2004). Back in 1792, women bodies became visible everywhere; "the thought implanted in the minds of individuals since infancy is that beauty is woman's scepter, the mind shapes itself in the body, and roaming around its gilt cage only seeks to adorn its prison" (Shipton, 2004). The pressure has been imposed on the female gender based on their external physical appearance. Society with its definition that beauty lies in the physical appearance and influences the intellectuality and friendliness of a person has become the aspiration of many to enhance their self-concept (Maddern, Cadogan & Emerson, 2006). The thin body reflects that a person displays a high level of self-control over one's desires, impulses, and inner state of well-being thus they are exposed to psychological stability and a marker of internal order (Ogden, 2003). Controlling body appetite, whether through fasting or abstinence, enables women to resist the prevailing values of the society that they are unable to control (Corrington, 2010). As a result, "Anorexia Nervosa begin as a girl fastens onto a highly valued societal goal to define her identity and seek perfection" (Corrington, 2010).

This is a social stigma as Brownell stated that thinness is equated with moral perfection, hardworking, ambitious, freedom, success and purity whereas over-weight is equated with laziness and stupidity (Ogden, 2003). The stigma that associates with body image and influences the severity and visibility of Anorexia Nervosa is that being thin is attractive, popular, successful, and friendly (Shipton, 2004). This stigma has been communicated specifically through the media where they portray that the most successful and beautiful women are thin (Ogden, 2003).

1.2. The Media & Pro-Anna Movement:

The media and the fast past of technology had positive impacts such as the availability of knowledge and information, creativity and innovation amongst others, offered individuals vast opportunities for self-expression, however, the negative impacts can be said to have accentuated already existing behaviors which were deemed as dysfunctional and cumbersome. Cases of Eating Disorders, especially Anorexia Nervosa, have increased dramatically at a time when icons of American beauty, Miss America contestants and playboy centerfolds, became thinner and the media published numerous articles and blogs for extreme weight loss (Keel & Klump, 2003). The media's evolution was part of such importation where many images, aspirations and perceptions are daily broadcasted to millions of people through magazines, televisions, internet and social media platforms. It has become very easy to find websites on the net supporting Anorexia Nervosa, the Pro-Anna movement, and teaching others how to cut down on calorie consumption from 300 calories a day to 150 calories after 30 days. In the light that 150 calories a day pile up to a cereal bar or bowl, an apple, or 8 pieces of strawberry with a tip of chocolate (http://www.proanatipsandtricks.net/). Thus leading to a drastic change in healthy food and eating habits from a high consumption of dairy products; a mélange of fruits and vegetables, milk and dairy products, fatty and sugar foods, meat and fish, and plenty of complex carbohydrate foods such as bread, pasta, cereals, and potatoes (Ogden, 2003) to one meal per day and one grouping of food per meal.

The "ProAnna" movement is a social based society that allows Anorexia Nervosa to be a normal state of mind rather than a disorder. Patients with Anorexia Nervosa would open blogs and websites that will help high risk individuals to develop Anorexia Nervosa. These websites and blogs would show other girls the advantages of being anorexic, modeling, and would support

them in the process, and thus the eating habits of the young ladies will be influenced. The "ProAnna" movement works with the associative learning process as it refer to the impact of contingent factors on behavior which are normally used as reinforcers to undesired behavior; a process known as social learning (Ogden, 2003). The expectation imposed on a woman through the media and social standards will help in losing control over the thoughts and beliefs of being thin and satisfying the expectations to the fullest. As the expectations increase the control diminishes resulting in feelings of disappointment, guilt, and depression as to the failure of achieving a thin body (Ogden, 2003).

Conclusion:

In the first part of this research paper we have discussed the topic of Eating Disorders namely Anorexia Nervosa; characterized by severe disturbances in eating habits, body shape and weight leading to impairment in health and psychosocial functioning (Gilbert, 2005). Anorexia Nervosa is an eating disorder most destructive to human being suffering from it as it has a high mortality rate, functional impairment, emotional distress, and other psychiatric comorbidity (Stice, Marti, Shaw, & Jaconis, 2009). Anorexia Nervosa does not have one risk factor but multiple influencing factors ranging from familial rearing patterns to traumatizing life experiences. In this part we also discussed each and every step of the mother and daughter relationship from birth until the current age whereby the daughter might have a high risk in developing Anorexia Nervosa. From Sigmund Freud to Donald Winnicott, Melanie Klein, Erik Erikson, John Bowlby, and Jacques Lacan we were able to derive the different stages of the individuals' life with the factors that may lead to dysfunctional relationships with primary caregivers and thus lead to disordered eating habits.

In the second part of this research paper, the actual study takes place, to try and assess the significant correlation between mother-daughter relationship and risk of Anorexia Nervosa. In the second part we will be discussing in full the methodology used to measure the correlation, the instruments of measurements in full details, and the results obtained from our sample participants.

Part Two: The Study

Chapter One: Methodology

Introduction:

As the female is growing up, maturing, her body is also growing into a feminine adult's body. Her self-perception, self-worth, self-esteem, and body image are being established. This is where the conflict of what she ought to be and what she has become arises. This is where the troubled eating begins. Individuals with Anorexia Nervosa, as described by Steven Stern, have developmental paralysis; they are frozen between legitimate needs for self and some form of characterological self-denial, self-sacrifice, or self-distortion (Shipton, 2004).

Professionals of the field would study the little girl's rearing patterns and sense of autonomy, parental preoccupation with thinness, parental pressure towards high achievement and conformity, and dysfunctional family system (Frude, 1998). What we are interested in is delving deeper into the mother and daughter relationship and studying the extent to which the mother influences the quality of communication and emotional disturbances.

In the first part of this research, we have drawn the clinical picture of a troubled psychological illness that has a high prevalence in females in their early adult life – Anorexia Nervosa. From the etiology, to the several influencing factors, we have covered mainly the needed factors to raise awareness to a disorder that is dramatically increasing in number and causing fatal consequences on sufferers and their direct environment. Our main focus was to establish the connection between the dysfunctional relationship between mother and daughter and the risk of developing Anorexia Nervosa.

Starting with the explanation of the methodology, this part of the paper will discuss in details the procedures used to identify the dysfunctional relationship between mother and daughter, the instruments of measurement used and the results established. The instruments of

measurement are based on two separate questionnaires that will pinpoint the significant bond between the two and allow us to obtain quantitative analysis to the obtained answers.

1.1. Sample:

This study is a quantitative and a qualitative study that focuses on the content analysis of the questionnaire to describe the influence of mother-daughter relationships on the rik of developing Anorexia Nervosa in the daughter's life. The study is based on a randomly selected group of 60 females (n = 60) from "Notre Dame University", aged between 17 and 21, that are then divided into two separate groups. The first group are the individuals who are at high risk of developing Anorexia Nervosa, known as partial Anorexia Nervosa, with a Body Mass Index below the normal range (BMI less than 20) and the second group are the healthy control group. In definition, partial Anorexia Nervosa are individuals who endorse in most of the symptoms of Anorexia Nervosa however, do not fit the criteria for Anorexia Nervosa as mentioned in the Diagnostic and Statistical Manual of Mental Disorders. Partial Anorexia Nervosa are individuals who (1) endorse the criterion for low body weight but who endorse any one of the three symptoms, (2) endorse in all symptoms except amenorrhea, (3) endorse all symptoms except low body weight, and (4) endorse in only two out of the four symptoms of Anorexia Nervosa (Stice, Marti, Shaw, & Jaconis, 2009). Then the Semi-Structured Interview followed by the Eating Attitude Test are analyzed to identify the quality of the relationship between the mother and daughter.

1.2. Instruments of Measurement:

Two different instruments of measurement were employed. The first instrument of measurement is the Eating Attitudes Test (EAT 26) that will allow us to screen the individuals that are at high risk of developing Anorexia Nervosa from the sample under study. The second

instrument of measurement is a semi-structured interview that delves deeper into the essence of the relationship with the mother. The quantitative scores of the Eating Attitude Test (EAT-26) correlated with the qualitative analysis of the semi-structured interview allows us to pinpoint the dysfunction.

1.2.1. The Eating Attitude Test:

The Eating Attitude Test is a self-assessment questionnaire designed by David Garner and Paul Garfinkel in 1979. The Eating Attitude Test is an economical, self-report measure designed to study the severity of symptoms of Anorexia Nervosa. It is a widely used standardized report derived from a 40-item questionnaire that measures the symptoms on a scale presented in a 6-point, forced choice, self-report format. The Eating Attitude Test is a multiscale psychometric tool used to provide a profile of psychological, attitudinal, and behavioral traits common in patients with Anorexia Nervosa.

The Eating Attitude Test (EAT-26) has been validated using 2 groups of females divided into a control group (healthy control) and females with Anorexia Nervosa. The results yield significant correlation suggesting a high level of concurrent validity (Garner & Garfinkel, 1979). The Eating Attitude Test is not made to diagnose an eating disorder without professional diagnosis or consultation; however, it assesses the 'eating disorder risk'. If the score of the Eating Attitude Test (EAT-26) is 20 or above, the participant is at high risk of developing an Eating Disorder and thus should be interviewed by a qualified professional to determine if he/she meets the diagnostic criteria for an Eating Disorder.

According to David Garner and Paul Garfinkel (1979), the Eating Attitude Test (EAT – 26) is specifically a useful assessment tool to identifying early risk factors of Anorexia Nervosa as the assessment is based on three important subscales. The first subscale is the

dieting subscale, whereby the participant is answering questions on extreme dieting habits and feelings of guilt accompanied by certain food consumption that may have excessive calories or fat. The second subscale is Bulimia and food preoccupation scale items and pertains to habits of overeating and purging with an immense preoccupational thought about food that is life controlling. The third subscale is the oral control subscale, this subscale delves deeper into controlling attitude over food which is a main attribute to individuals suffering Anorexia Nervosa. These habits not only include restrictive food intake but also tackles eating behaviors such as cutting the food into small pieces and eating extremely slowly in comparison to others.

The answer code for the Eating Attitude Test (EAT 26) is a continuum that starts with "always" to "never", having in between different frequency of actions such as "usually", "often", "sometimes", and "rarely". These frequency actions are then numericalized on a scale from zero to three. "Always" is 3, "usually" is 2, "often" is 1, and the three remaining frequencies score 0. The scoring system mentioned above pertains to answers of questions 1 till 25; however, number 26 I scored oppositely, where, "never" scores 3, "rarely" scores 2, "sometimes" scores 1, and the remaining three frequencies score 0 (Garner & Garfinkel, 1979).

The interpretation of the Eating Attitude Test (EAT – 26) also follows a three criteria rule in order to be able to identify the presence of an eating disorder. The first criteria is the score of the Eating Attitude Test (EAT – 26) i.e. questions 1 – 26, if the score is slightly above or under 20 the participant has normal eating habits. However, if the score is significantly above or below 20, the individual is at a high risk of developing an eating disorder. In the case of Anorexia Nervosa, the score should be above 20. The second criteria is the low body weight

compared to age-matched norms. This is identified by the Body Mass Index that is equated according to an individual's weight and height. Then the Body Mass Index is compared in a table considering the age, sex, and norms. The third criteria is a set of behavioral questions indicating possible Eating Disorder symptoms or recent significant weight loss. If the participant score any of the boxes besides "never", he/she are at high risk of developing an Eating Disorder namely Anorexia Nervosa (Garner & Garfinkel, 1979).

1.2.2. Semi-Structured Interview

The semi structured interview was formulated based on the extensive literature review on the dysfunctional relationship between the mother and the daughter and due to the lack of a readymade questionnaire that would analyze the correlation between Anorexia Nervosa and the mother-daughter relationship. The semi structured interview was then administered to a diverse population, 7 people, to ensure the cohesive wording and relevance to the topic of choice. As a third and final step, the semi structured interview was administered to the target sample.

The semi structured interview consists of a set of question that helps us determine the relationship between the participants and their mother. The semi-structured interview is divided into three parts: the first, though anonymous, consists of a general background of the participants' medical history and parental information. Such information is particularly helpful to classify the educational background and career history of the parents, and specifically to explore the medical history of the participant in an attempt to rule out any general medical condition that may have influences on the general finding of the assessment. The other two parts are questions pertaining to the daily relationship with the mother, different activities and behavioral attributes between the mother and the daughter, and

feelings that accompany this relationship. The semi-structured interview is filled by the daughter according to how she perceives her mother and not vice versa.

The second part of the semi-structured interview consists of fifteen close-ended questions that describe how the daughter feels about the mothers' attitude towards her. The questions basically show the quality of the relationship: friendliness, destruction, criticism, the support provided, and the level of acceptance regardless of the differences between the two. The answers to the questions in this part of the study are then divided into five different categories of mother-daughter relationship. The categories are as follows:

1. Acceptance vs. Rejection: this category studies how well the mother is accepting of the personality traits of the daughter and the choices she makes in life. The acceptance vs. rejection of the daughter may result in negative feelings of rejection and thus unloved and uncared for. The questions that are relevant to this category are:
    a. Do you feel that your mother respects you for who you are?
    b. Do you feel that your mother understands you well?
2. Supportiveness vs. Abandonment: this category sheds light on the supportive attitude the mother provides her daughter with. The support she gains in any decision she makes regardless of the consequences of her actions. It is the category that shows that the mother values her daughter's ideas and thoughts. The questions in this category are:
    a. Do you feel that your mother has been there for you in most situations?
    b. Do you feel your mother has kept all her promises to you?
    c. Do you feel abandoned or denied, or rejected by your mother?
3. Friendliness vs. Hostility: this category identifies the aggressive or friendly relationship and bond that brings the two to a healthy relationship. It shows how well the mother and

daughter blend in situations that may or may not be positive in nature. It shows if the mother displays an aggressive attitude towards her daughter that may be destructive in nature resulting in feelings of shame, guilt, and low self-confidence. The questions in this category are as follows:

a. Do you feel that the communication level between the two of you is adequate?
b. Do you feel that the bond between the two of you satisfies your need for connection?
c. Do you feel warm affection thinking of your mother?
d. Do you feel violently treated by your mother?

4. Trust vs. Mistrust: in this category, and based on past experiences, the trust the daughter puts in her mother to share intimate or shallow experiences with her and thus seek advice. If the mother has shown negativity towards her daughter, the trust would be ultimately difficult between both causing a dysfunction in the relationship. The questions in this category are:
    a. Do you fear or dislike your mother's pinion in any way?
    b. Do you feel you can approach your mother for advice?
    c. Do you feel you can share with your mother intimate experiences?
5. Praise vs. Criticism: this category plays a major role in the dysfunctional relationship between the mother and the daughter, as criticism leads to low self-esteem and confidence resulting in feelings of unworthiness and ineffectiveness. In this category it analysis the expectations the mother exerts on her daughter. Failing to praise the daughter would result in constant feelings of underachievement thus the constant pursuit of trying to prove herself to the mother for appreciation. The questions in this category are:

a. Do you feel your mother is proud of your accomplishments?

b. Do you feel your mother has been criticizing you while growing up?

c. Do you feel jealous of your mother or vice versa?

The third part of the semi-structured interview is mainly created to retrieve further details on the daughter perception of the relationship with her mother. The third part tackles questions of perception of the other, the likeliness she displays towards her mother, the level of expectations exerted on the daughter, and the level of influence the mother has on the daughter. In the third part, the content analysis of the participants' answers examines the feelings the individual has. Such information may assist us to see the daughter is aware of the dysfunction and gives her a chance to think of how she would prefer to have this relationship fixed.

1.3. Procedure

As a first step, participants were asked to sign a consent form for participating in the study. The consent form will clearly state the purpose of the study, the procedures to conducting the study, and confidentiality agreement to the information disclosed by the participants. The consent from will also have the full identity of the researcher with contact details for any inquiries the participants might have.

Then sixty randomly selected females from "Notre Dame University" were asked to complete the Eating Attitude Test (EAT – 26) followed by a semi-structured interview based on questions about the females relationship with their mothers. In addition, both the Height and weight of participants were self-reported in order for us to be able to compute the Body Mass Index (BMI) and determine if the individual is significantly underweight or not.

Following that, the Eating Attitude Test (EAT – 26) were scored and interpreted and accordingly, the two groups under study will be divided into two group for analysis. The first group are the individuals' with high risk of developing Anorexia Nervosa and the second group is the control healthy group. The analysis of the questionnaires has two formats, the first is quantitative in nature using the Statistical Package for the Social Sciences (SPSS) and the second format is content analysis of the open-ended questions asked in the semi-structured interview.

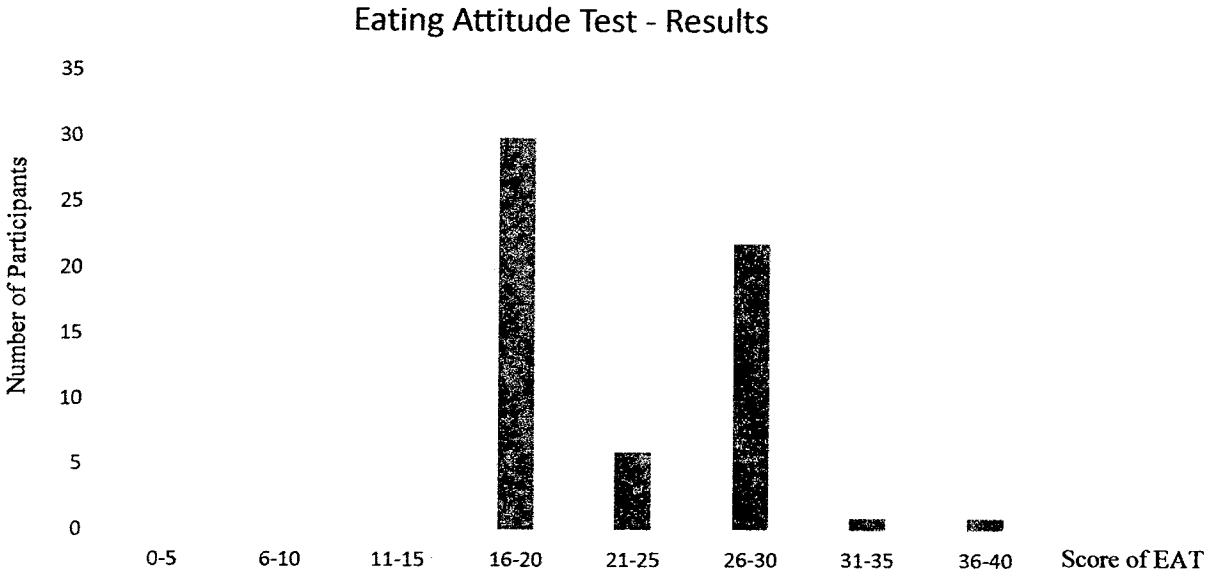
Throughout this chapter, we were devising techniques and strategies for collecting and organizing data that are beneficial to our study. When used properly, the data collected would then be analyzed and statistically explained to lead to the results of the study conducted and discussed in the next chapter.

Chapter Two: Results and Discussion

1.1 Eating Disorder Test: The Boundary between Normal and Pathological

The aim of the Eating Attitude Test is to categorize individuals eating habits into healthy eating habits, normal and disturbed eating habits, pathological. Thus, sixty participants filled in the Eating Attitude Test as stated earlier in the procedure. Preliminary analysis revealed that thirty participants show a risk of Anorexia Nervosa. The other thirty participants showed normal eating habits.

According to the Eating Attitude Test's scoring and interpretation procedures, there are three steps to follow. The first step is the addition of the sum of answers to the set of questions related to the frequency of the behavior of eating habit; the average for normal eating habits is 20 the sum that is below 10 indicates Bulimia Nervosa and any result higher than 20 indicates Anorexia Nervosa. The results of this part of the test shows Anorexia Nervosa in thirty participants.



Graph 1.1. Summary of the results of the Eating Attitude Test

Graph 1.1 shows a full summary about the results of the sixty participants on the Eating Attitude Test. The x-axis shows the number that refers to the sum of the answers to the twenty-six questions on frequency habits. The participants who scored between 16 and 20 are the participants with normal eating habits however, those who scored higher than 20 are the individuals with high risk of developing Anorexia Nervosa. According to the interpretations of the Eating Attitude Test, individuals with a very low score (below 10) or a score above twenty should seek professional help. The y-axis refers to the number of participants who scored a value between the intervals mentioned on the x-axis.

The second step of the scoring and interpretation process is the analysis of the Body Mass Index. The Body Mass Index is calculated through the following formula: the individual's body mass divided by the square of their height [BMI = weight (KG) / height^2 (m^2)]. The Body Mass Index is then compared through a table according to the age of the participant (Garner & Garfinkel, 1979). In this study, the participants self-reported their weight and height that were calculated through the Body Mass Index formula. The scores that are equivalent to the normal Body Mass Index for the age group is 19.

The third step of scoring and interpretation of the Eating Attitude Test is the analysis of behavioral questions indicating a change in pattern over the past six month period. The results of the participants did not show a significant pathology or extreme cases of Anorexia Nervosa as none of the results show purging techniques, extreme binge eating, or excessive exercise for more than two to three times a month. Studies by Shisslak et al. (1995) show that 91% of college females control their weight through dieting whereas 22% diet all the time.

1.2 Semi-Structured Interview: Regressive Resolution of a Developmental Crisis

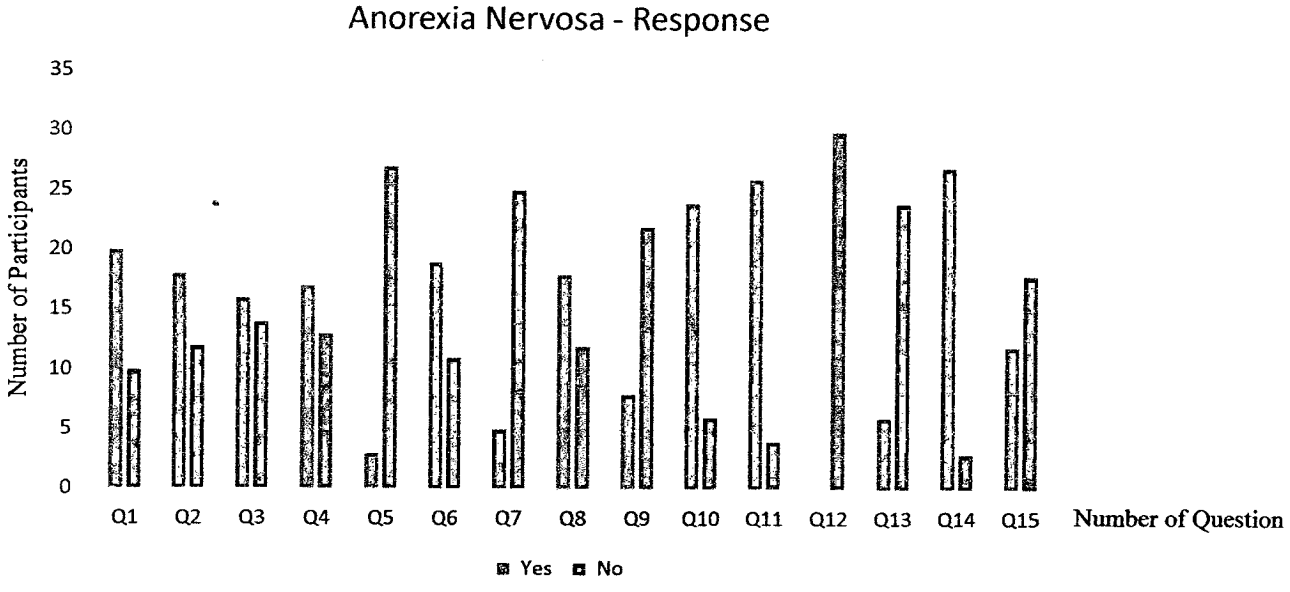
The semi structured interview is formulated based on literature review of the mother and daughter relationship to shed light on the influences they might have on early developmental crisis and the onset of Anorexia Nervosa.

The Semi-Structured Interview is also divided into three groups, the first group of questions tackles the general medical conditions of the individual in order to rule out their effect on the onset of disordered eating. The second part of the interview is based on fifteen closed-ended questions that would help us describe the relationship between the mother and the daughter. The third part of the interview is a set of open-ended questions that would need to be analyzed according to content in order to better understand the effects of the mother's rearing style on the daughter's life and eating habits.

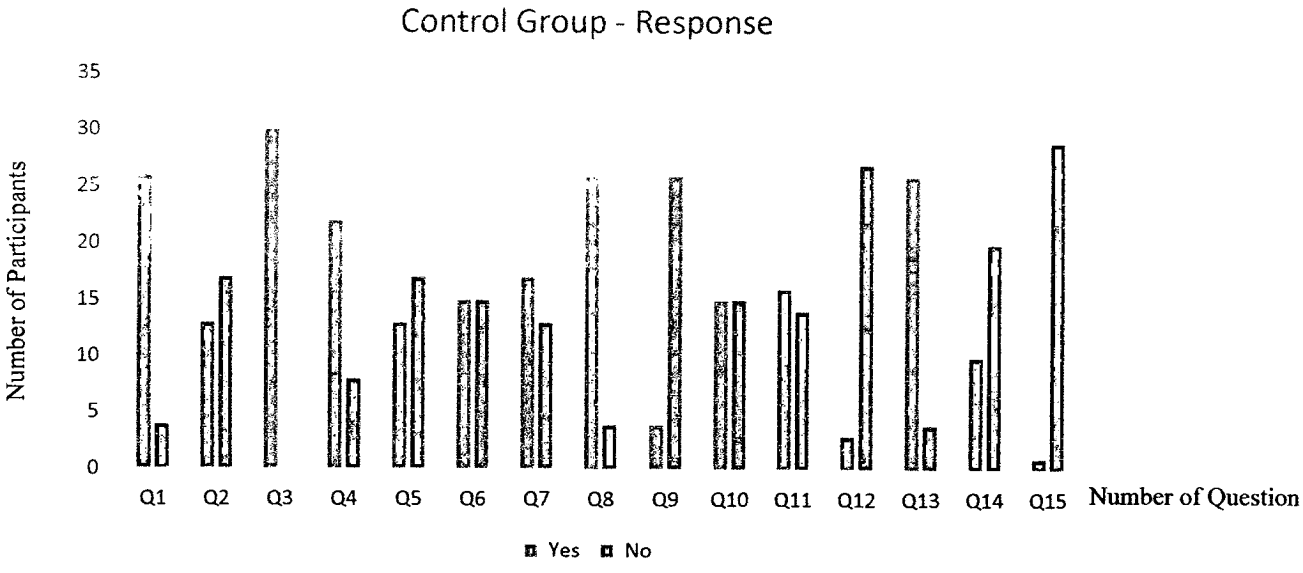
In the first part of the Semi-Structured Interview, eight among the sixty participant has shown a history of sexual harassment and physical abuse by individuals in their close society however, they did not necessary score excessively high on the Eating Attitude Test. In the section about medical conditions participants did not report a condition that has any association with the risk of the disorder. Another part questions past professional intervention by which one of the participants, who scored 37 on the Eating Attitude Test, did seek professional psychological help specifically to treat Anorexia Nervosa. It was ultimately interesting in this situation to point out that although this participant had a normal Body Mass Index and was not significantly underweight, she has scored the highest on the Eating Attitude Test. Her dieting habits, exercising frequency, and distorted body image show that she has a high tendency for Anorexia Nervosa however, the severeness of her case is not yet visible on her body.

In the second part of the Semi-Structured Interview, the closed-ended set of questions, the interpretation follows three different steps. The first step is the count of the answers of the participants. The answers to the fifteen questions are represented in the graphs 1.2 and 1.3 that shows how many participants answered "yes" and how many answered "no" (refer to graph 1.2 and 1.3 below).

In graph 1.2 the results include participants who scored above 20 on the Eating Attitude Test, i.e. those with high risk of developing Anorexia Nervosa, whereas, graph 1.3 include participants who scored between 16 and 20 on the Eating Attitude Test i.e. those with normal eating habits.



Graph 1.2. Summary of responses on the closed-ended questions of the Semi-Structured Interview for those who scored above 20 on the Eating Attitude Test



Graph 1.3. Summary of responses on the closed-ended questions of the Semi-Structured Interview for those who scored below 20 on the Eating Attitude Test

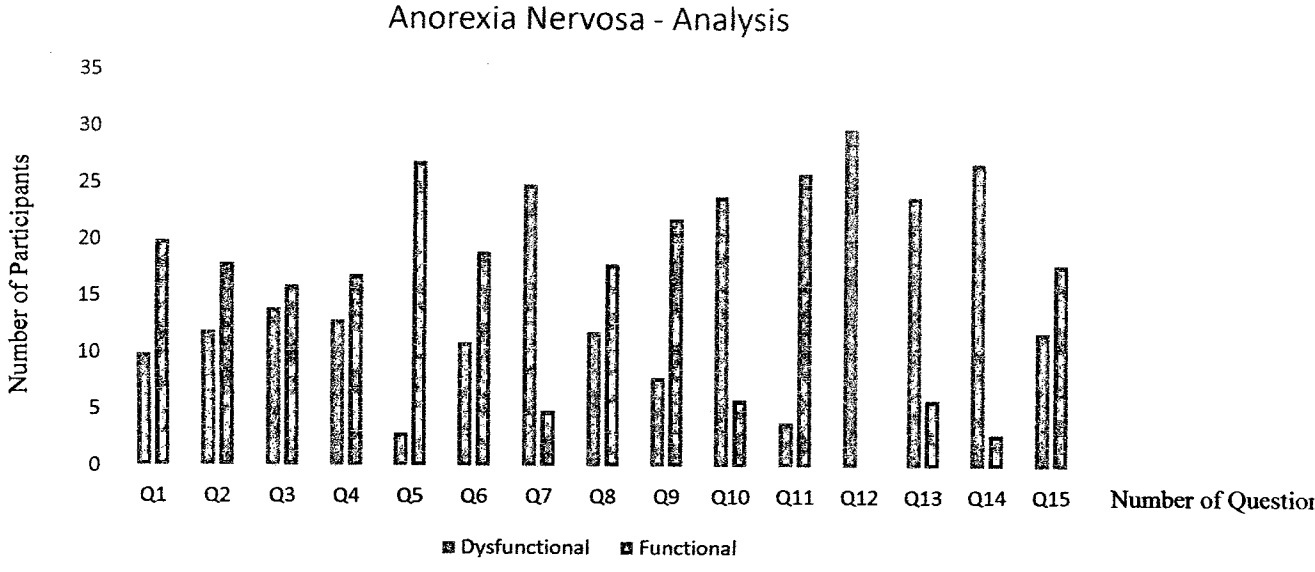
In the second part of the interpretation and according to each question asked, the responses are analyzed and categorized into two sets: dysfunctional and functional. The categorization is based on the description of the questions as follows:

1. Do you feel your mother respects you for who you are? If the participants answers no to this question it shows a dysfunction in the relationship as no signs of respect for the individuation of the daughter is present.
2. Do you feel your mother understands you well? If the answer to this questions is no it reflects the misunderstanding between the two and thus resulting in a dysfunction.
3. Do you feel that your mother has been there for you in most situations? If the answer is no it also reflects a dysfunction in the relationship between the two because it shows a lack of support and gratitude towards the daughter.

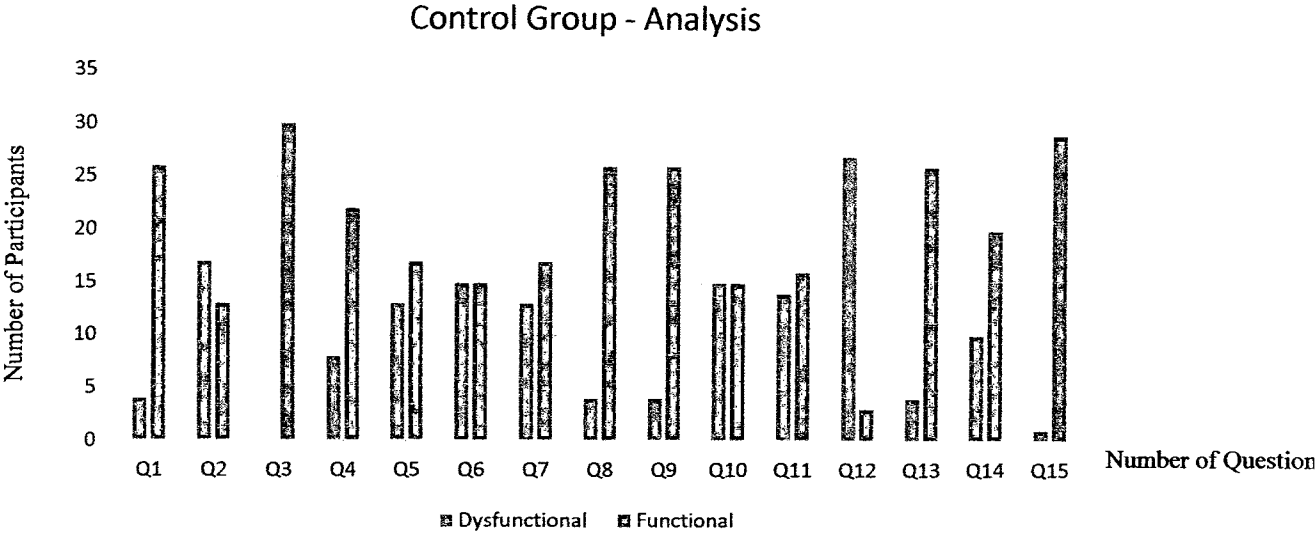
4. Do you feel that your mother has kept all her promises to you? A no answer to this questions shows that the mother has disappointed her child at several intervals allowing the daughter to lose trust in her mother which also shows a dysfunction.
5. Do you feel abandoned or denied or rejected by your mother? A no answer to this question shows a functional relationship with the daughter as she feels loved and accepted by the mother.
6. Do you feel that the communication level between the two of you is adequate? If the answer is no, it means that the daughter is not being well satisfied and needs more of the communication than she is actually getting which reflects a dysfunction. Communication skills between the mother and the daughter is specifically essential as the mother should provide the daughter with the proper advice, teaching skills, and behavioral attributes. The mother through communication would set the boundaries and limits for her daughter in different aspects of life experiences.
7. Do you feel that the bond between the two of you satisfies your need for connection? Here too, the bond is not satisfying and the daughter would ask for more if the chances arises. Thus a no answer shows a dysfunction.
8. Do you feel warm affection thinking of your mother? Answering no to this questions reflects the continuous need to more affection from the mother which describes a dysfunction in the relationship.
9. Do you feel violently treated by your mother? If the answer is no here, the mother does not appear to have a destructive attitude towards her daughter, it falls under the functional category.

10. Do you fear or dislike your mother's opinions in any way? A no answer reflects a functional relationship between the two based on trust.
11. Do you feel you can approach your mother for advice? The no response shows a dysfunction as it reflects a judgmental attitude from the mother. In situations as such, the daughter would fear her mother's judgments on matters that might also be trivial and thus would ignore turning to her for advice or help.
12. Do you feel you can share with your mother intimate experiences? The no response shows a dysfunction as it reflects both trust and judgments. When the daughter is able to confront her mother with her deepest secrets, she guarantees that the mother would support her, help her in a way that lacks biases. Then the daughter can trust that the mother would provide her with the necessary advice with the only concern being the daughter.
13. Do you feel that your mother is proud of your accomplishments? The no response shows a dysfunction as it leaves the daughter with feelings of worthlessness. If the mother does not show support and praise her daughter for the good work and effort she places, the daughter will be filled with guilt feelings and feelings of worthlessness.
14. Do you feel your mother has been criticizing you while growing up? The no response in this situations shows a positive and constructive attitude. If the answer is no it shows that the mother is positive and supportive to her child.
15. Do you feel jealous of your mother or vice versa? A no response here shows a positive and functional relationship as jealousy shows that the daughter is filled with negative feelings towards her mother rather than seeing her as an ideal; a person to look up to.

The results of the functional and dysfunctional categories for each question are shown in graphs 1.4 and 1.5 for both the control group and the Anorexia Nervosa group displayed below:



Graph 1.4. Analysis of responses on the closed-ended questions of the Semi-Structured Interview for those who scored above 20 on the Eating Attitude Test



Graph 1.5. Analysis of responses on the closed-ended questions of the Semi-Structured Interview for those who scored below 20 on the Eating Attitude Test

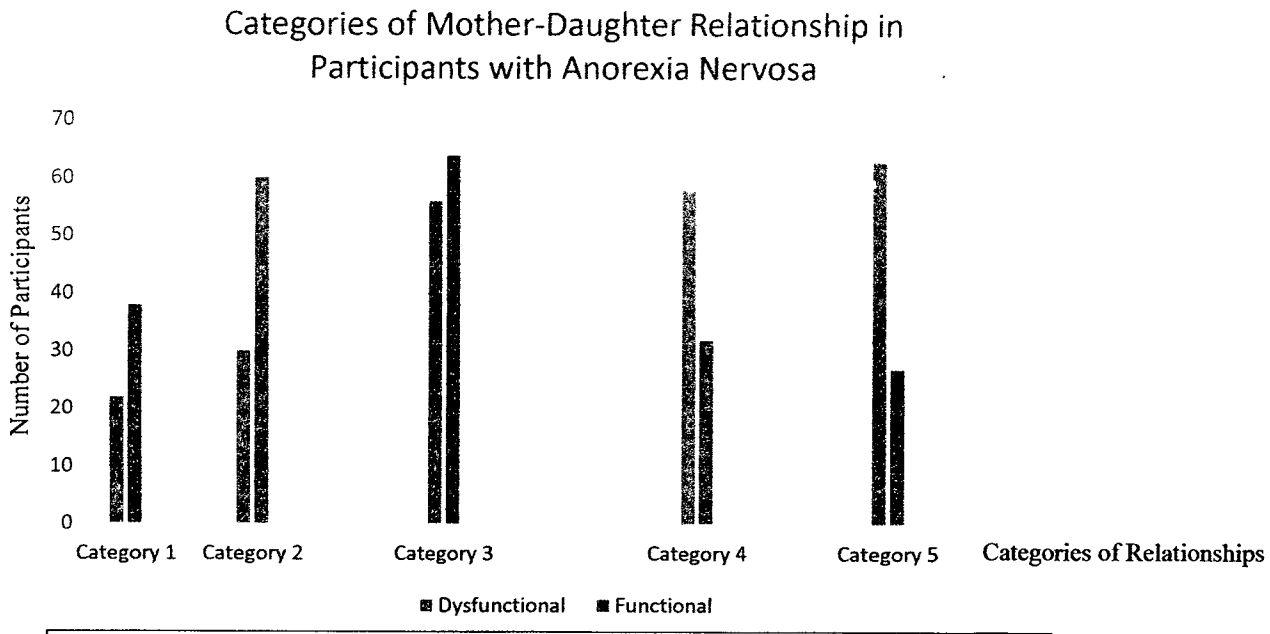
The third part of the interpretation of the closed-ended results of the Semi-Structured Interview are based on the categories that were discussed in the previous chapter. The results in the previous graphs are translated into five categories: acceptance vs. rejection, supportiveness vs. abandonment, friendliness vs. hostility, trust vs. mistrust, and praise vs. criticism. The below tables (1.1 and 1.2) shows the summary of the categories, the questions in each category, and the responses.

Categories of MD Relationship	Semi-Structured Interview (closed-ended questions)	Anorexia Nervosa Group			
		Dysfunctional	Functional	Dysfunctional	Functional
Acceptance Vs. Rejection	Do you feel your mother respects you for who you are?	10	20	22	38
	Do you feel your mother understands you well?	12	18		
Supportiveness vs. Abandonment	Do you feel that your mother has been there for you in most situations?	14	16	30	60
	Do you feel that your mother has kept all her promises to you?	13	17		
	Do you feel abandoned or denied or rejected by your mother?	3	27		
Friendliness vs. Hostility	Do you feel that the communication level between the two of you is adequate?	11	19	56	64
	Do you feel that the bond between the two of you satisfies your need for connection?	25	5		
	Do you feel warm affection thinking of your mother?	12	18		
	Do you feel violently treated by your mother?	8	22		
Trust vs. Mistrust	Do you fear or dislike your mother's opinions in any way?	24	6	58	32
	Do you feel you can approach your mother for advice?	4	26		
	Do you feel you can share with your mother intimate experiences?	30	0		
Praise vs. Criticism	Do you feel that your mother is proud of your accomplishments?	24	6	63	27
	Do you feel your mother has been criticizing you while growing up?	27	3		
	Do you feel jealous of your mother or vice versa?	12	18		

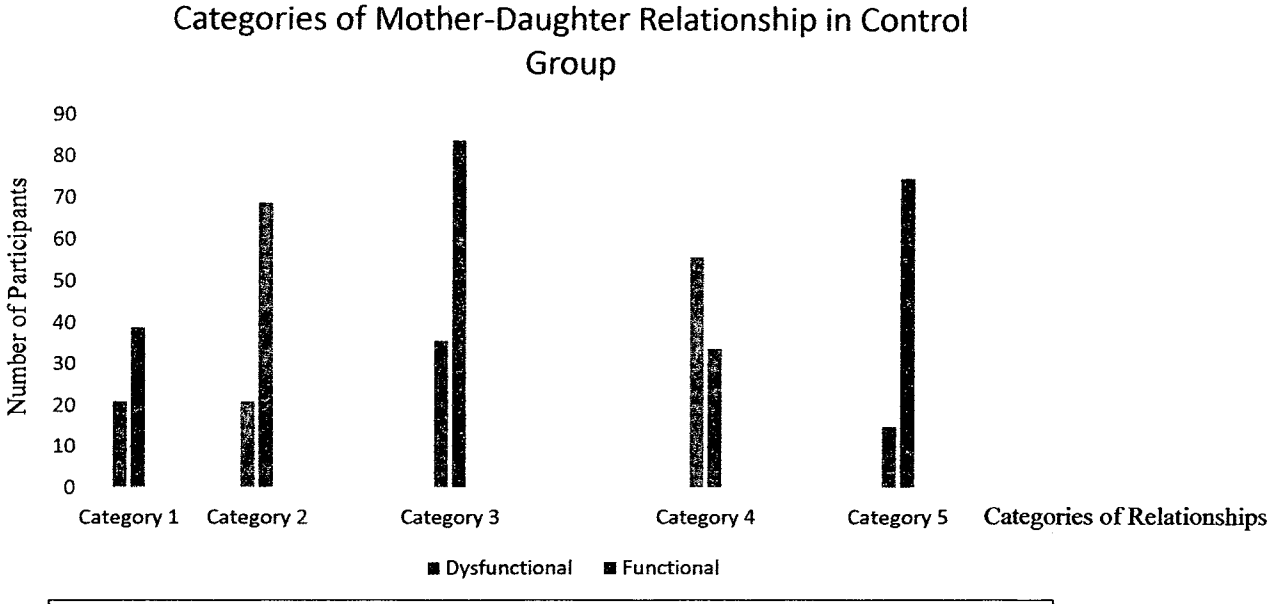
Table 1.1. Analysis of the categories of Mother-Daughter Relationship for those who scored above 20 on the Eating Attitude Test

Categories of MD Relationship	Semi-Structured Interview (closed-ended questions)	Control Group			
		Dysfunctional	Functional	Dysfunctional	Functional
Acceptance Vs. Rejection	Do you feel your mother respects you for who you are?	4	26	21	39
	Do you feel your mother understands you well?	17	13		
Supportiveness vs. Abandonment	Do you feel that your mother has been there for you in most situations?	0	30	21	69
	Do you feel that your mother has kept all her promises to you?	8	22		
	Do you feel abandoned or denied or rejected by your mother?	13	17		
Friendliness vs. Hostility	Do you feel that the communication level between the two of you is adequate?	15	15	36	84
	Do you feel that the bond between the two of you satisfies your need for connection?	13	17		
	Do you feel warm affection thinking of your mother?	4	26		
	Do you feel violently treated by your mother?	4	26		
Trust vs. Mistrust	Do you fear or dislike your mother's opinions in any way?	15	15	56	34
	Do you feel you can approach your mother for advice?	14	16		
	Do you feel you can share with your mother intimate experiences?	27	3		
Praise vs. Criticism	Do you feel that your mother is proud of your accomplishments?	4	26	15	75
	Do you feel your mother has been criticizing you while growing up?	10	20		
	Do you feel jealous of your mother or vice versa?	1	29		

Table 1.2. Analysis of the categories of Mother-Daughter Relationship for those who scored below 20 on the Eating Attitude Test



Graph 1.6. Categories of Mother-Daughter Relationship in Participants with Anorexia Nervosa



Graph 1.7. Categories of Mother-Daughter Relationship in Participants with Anorexia Nervosa

The third and final part of the Semi-Structured Interview is a set of open-ended questions that would allow the participants to further expand on the relationship with their mother. The questions are along the line of communication and activities, perception of qualities, and feelings towards the mother and her way of treatment. Majority of the participants with risk of developing Anorexia Nervosa indicated that the mothers are controlling, unfriendly, destructive, and critical. The communication level between the two is restricted on trivial matters rather than major life decisions and intimate experiences. Participants with a high risk of developing Anorexia Nervosa would state that their mother has massive expectations of them and is never satisfied by their achievements.

Answers to the open-ended set of questions show that participants with risk of Anorexia Nervosa tend to believe their mother have a great influence on how they behave and feel, and on their decision making, choices, and interests.

Part Three: Conclusion

Chapter One: Synthesis and Conclusion

Introduction:

After reviewing the literature and working the methodology now comes the actual research process which is to transform the data collected and studied into meaningful units and themes. In the previous chapter we have considered the general findings of both assessment tools conducted. Indeed the findings show a clear negative and escalating relationship to unfold in families of individuals at risk of Anorexia Nervosa. In this chapter we will attempt to explain in details the mother and daughter relationship as well as the influencing factors of Anorexia Nervosa. My aim is to challenge the dominant conceptualization of Anorexia Nervosa as a pathology. I am concerned about the maternal inner self constructed through the early steps of the relationship.

1.1 Synthesis of Results

The importance of risk factor studies is that they carefully establish the antecedent of measures of risk and compare their occurrence in matched samples of cases and controls. Hence, the hypothesis formulated earlier.

H_1: Females with risk of Anorexia Nervosa tend to have a dysfunctional relationship with their mother.

H_2: The dysfunctional relationship with the mother renders the individuals negative self-image.

H_3: The negative self-image might influence the development of Anorexia Nervosa.

This part of the study is divided into three parts to analyze the results of each of the above mentioned hypotheses.

1.1.1 It Is Not About The Relationship:

The semi-structured interview is at the base of the mother-daughter relationship. The questions asked in this part of the study examines the relationship between the mother and the daughter in females who have a risk of Anorexia Nervosa and the normal control group. According to the categorization of the questionnaire into five separate groups, the semi-structured interview showed that the highest prevailing influencing factor on the mother-daughter relationship is the category on "Praise vs. Criticism" i.e. category 5 in graphs 1.6 and 1.7 in the previous chapter. In this category three main factors are questioned; the support and praising attitude of the mother towards her daughter's accomplishments, the criticism the mother offers her daughter as she grows up, and the third is the negative feelings of jealousy that limits self-development and perception.

The first question in the category on praise vs. criticism is: Do you feel your mother is proud of your accomplishments? This questions is quite necessary as it sheds light on the support system provided by the mother, the expectations she bestows upon her daughter, and the acceptance she reflect to her daughter's abilities as a grown up individual. The second question in this category is: Do you feel you mother has been criticizing you while growing up? This question highlights the negative attitude the mother provides her daughter with, the negative comments she always has towards her daughter's looks, attitude, and behavior. Lastly, the third question tackles jealousy; do you feel jealous of your mother or vice versa? This questions takes us back to the early stages of life whereby the self-perception of the person is created with the help of the mother. Specifically the mirroring stage where the mother allow the daughter the privilege of self-recognition and thus self-perception.

The expectations the mother portrays on her daughter shapes her future, her decisions, and the choices she is bound to make. Failure to achieve what the mother expects out of her daughter whether in terms of success, behavior, appearance, or attitude, will fill them with guilt feelings, worthlessness, and disappointment rather than satisfaction and proudness. As one of the participants mentioned in the semi-structured interview: *"she forces upon me the life she dreamt for herself; my actions, my choices, and my attitude are not mine but hers to reflect"*. Another participant mentions with anger and resentment: *"I hear her say as I walk by, look at my daughter she is studying engineering. However, what she doesn't notice is the anger I feel for making me pursue nothing of my dreams"*. Yet another participants writes *"It has never been my choice. I chose a major I am passionate about and every time I look at her face I see deception, just because I chose a major I want. The success I achieved of maintaining a high GPA after failing in school was not enough to make her proud of me, and only because I did not decide to be a doctor just as she has always dreamt"*. By this, the mother is limited her daughter's sense of independence and autonomy as she control her daughter's different aspects of life.

Mother's parenting style and her attitude towards autonomy and independency may result in feelings of low self-esteem and self-worth (Shully, 1996) as mentioned in previous chapters. Mother's believe they are being supportive to their children when they do everything on their behalf, however, mothers are unaware of the feeling of lower self-esteem and self-worth they keep their daughters in. This relationship with the mother is disruptive leaving the daughter with a distorted sense of self and full of feelings of rage and aggression towards her mother (Bers, Besser, Harpaz-Rotem, & Blatt, 2013). A participant in the study expresses with anger; *"She is unbelievable, she does not allow me to do anything alone, she*

has to be the one in control. And if I try, if I mistakenly attempt to fix something alone, it always turns out wrong. She makes me feel stupid and worthless instead of teaching me how". With another quote stating: *"I remember when I was younger in age I used to feel that everything is very hard to achieve, paperwork for school, paying the tuition, applying for university and so forth. Then I sat to myself and thought, why do they feel so hard and impossible to achieve whereas if I try I simply find them easy? Then I thought that throughout my life my mother has been the one doing all the requirements for every one of us, I always felt incapable until I had to make a change and take a lead in my life..."* And yet another participant expressed her frustration from the mother's continuous control over her life and her choices: *"she limits my abilities; my ability to depend on myself, to trust myself, and to believe in myself. I can never reach her expectations and I blame her for my failure because she taught me to live with guilt. Instead of allowing me to make my choices, I always feel the need to satisfy her perception of me."*

In addition to the above mentioned, there is yet an important aspect to discuss that has a dire effect on an individuals' self-esteem and thus self-perception; criticism. Self-esteem by definition is an individual's personal judgments of himself/herself. An individual's self-esteem is created and enhanced through the self-evaluation and self-assessment of their self-worth. Our qualities, capabilities, and ways of thinking define us thus defining our self-esteem (Young & Hoffmann, 2004). Praise vs. Criticism in this aspect of an individual's life has a great impact on the creation of self-esteem. If a person is constantly criticized and bombarded with negative comments, their self-evaluation will be distorted and so will be their self-esteem. Yet another participant expresses her rage and anger towards her mother's criticizing attitude: *"Allow me to talk about the never-ending criticism, yes criticism, the*

criticism that haunts me day and night on the slightest detail whether it be how I dress or how I speak or even how I eat. Sometimes I feel trapped, trapped in a corner of deception, of worthlessness, all I really need is her approval before I leap". As a result of constant criticism, an individual would feel worthless and incapable. These feelings would result in a distorted image of self.

1.1.2 It Is Not About Me:

As Pietromonaco and Barrett (2000) mentioned in their study that first and furthermost it is dependent on the motherly care to establish thoughts, feelings, and behavior in adult life, the mother is thus the essence of the internal working model created within her daughter as she is maturing. The games, the movies, the Walt Disney cartoon characters, and the media had all played a role in increasing the destructive early experiences the daughter passes through. And since some scientists explain Anorexia Nervosa as a regression towards childhood family based commitments and patterns (Frude, 1998), the rearing patterns the Lebanese young females grow up in is essential to look into. Females are in a never ending battle between self-perception and a distorted definition of beauty. Girls get to play with dolls and Barbies, or watch movies and advertisements that use women who are always beautifully portrayed with make-up, blonde hair, and perfectly shaped thin bodies. Setting a benchmark of expectations and laying down unrealistic ideals for children to look up to.

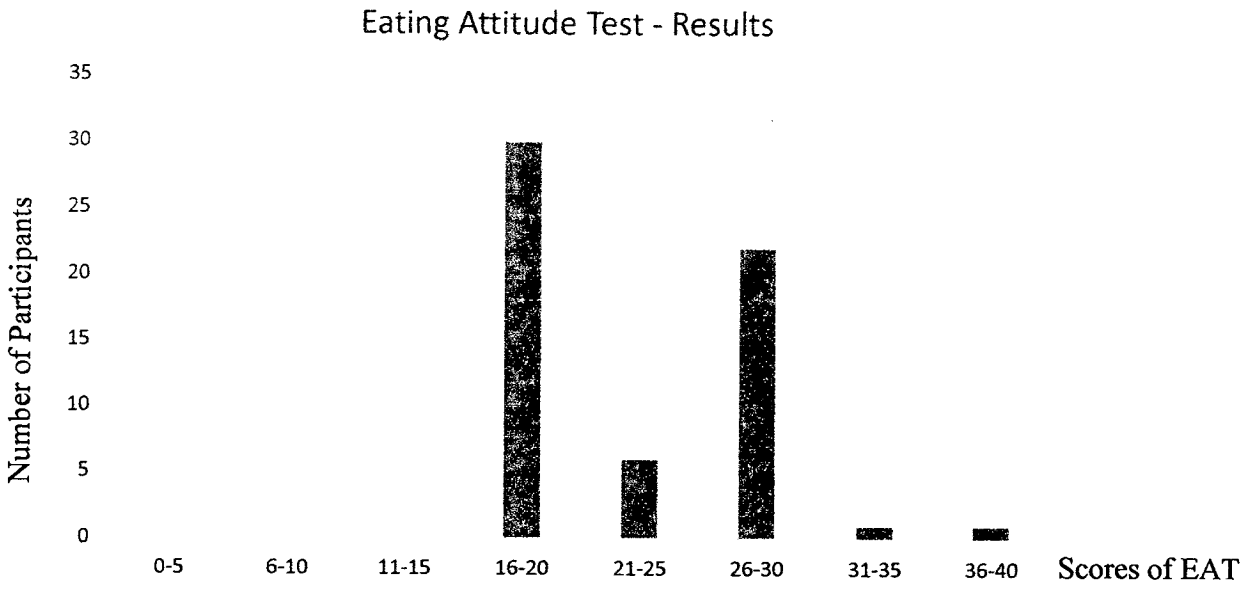
The whole of our waking hours as women are built around beauty, or what society has defined as beautiful. Barbies, dolls, cartoon character, or even models used in media advertising or fashion shows are never but thin and perfectly curved. In movies, individuals that are fat are always portrayed as failures, enemies, and ugly. This is a social stigma as Brownell stated that thinness is equated with moral perfection, hardworking, ambitious,

freedom, success and purity whereas over-weight is equated with laziness and stupidity (Ogden, 2003). Here I quote one of the participant's words: *"My mother always compares me to very pretty and well behaved women in our society, I can hear her words in my ears constantly, look how beautiful and classy this women is followed by, you should be more like that if you wish to marry..."* In this area of enhancing ones self-perception, the mother also plays a big role in allowing the daughter to feel beautiful. Seeking the mother's approval reassures the daughter and rebuilds her self-perception. The constant criticism showed by the mother would allow the daughter to feel less beautiful and have a distorted body image. In an attempt to show how criticism affects the individual's self-perception I quote: *"I am never sure when I look good, if I lose weight am too thin if I gain weight I am too fat. If I wear some make-up on I get criticized for trying to make myself look good but if I don't I look pale and sick. Whatever I do I get criticized, and all I seek is my mother's approval of how I look. I just want to hear her say I am beautiful."*

From such a stand point, the expectations are being set at a young age and as they grow up and fail to achieve the definition of beauty, feelings of guilt arise. As the Eating Attitude Test shows us, females with a risk of Anorexia Nervosa tend to have preoccupied thoughts, for several hours a day, about being thin and getting rid of every bit of fat present on their bodies. Females with a risk of Anorexia Nervosa believe that people in their society think that they are too thin however, they are unable to believe so.

1.1.3 It Is Not About The Food:

The results of the Eating Attitude Test are divided into 5 unit intervals to show the majority of the participants who are scoring into the range of normal eating habits and pathological eating habits. Thirty of the participants have displayed normal eating habits while the remaining thirty of the population display pathological eating habits. Out of the participants with disordered eating habits, 73% showed habits and behaviors with excessive dieting habits (individuals who scored between 26 and 30 on the Eating Attitude Test). These individuals showed a high level of dieting habits through food control and excessive calorie count accompanied by feelings of guilt and discomfort after food consumption. These individuals also display excessive exercising hours as they exercise a minimum of one hour per day. Individuals with mild disordered eating habits, those who scored between 21 and 25 on the test, pile up to 20% of the population. Those individuals displayed dieting and exercising habits that are somehow in the normal range however, display a distorted self-image as they believe they can still lose weight whereby others believe they are very thin. The rest of the population under study, are the minorities of the bell curve, whereby the dieting behavior shows a pathology. These individuals form 7% of the population under study whereby they display excessive dieting habits, food restriction and minimal calorie intake, the use of laxatives, and purging techniques when the feelings of guilt of food consumption becomes unbearable. An understanding of the total condition stems from the below graph that summarize the findings of the Eating Attitude Test:



Reference to Graph 1.1. Summary of the results of the Eating Attitude Test

1.2. Conclusion of the Study

It is not about the relationship, it is not about me, it is not about the food; it is about the junction of the relationship, me, and the food that results in Anorexia Nervosa. We have seen what weight, age, beauty, fashion, surgery, and exercise are doing to women in our society. All the education, liberty, and confidence cannot make us disbelief that being thin is better.

Anorexia Nervosa has been a topic of high debate and controversy across centuries; from a definition of societal status, to a peace making objective, to a cry of help and reflection of psychological pain. As the definition of Anorexia Nervosa differed with time and the effect of Anorexia Nervosa has been experimented and researched, the perception to such a disorder has made massive changes in how life is perceived.

The wide topic of Eating Disorders in general and Anorexia Nervosa in specific are topics that are not to be discussed especially by women who have experienced the difficulty of the

situation. Due to the severe psychological and medical pain this disorder has inflicted and due to the denial of family members of the situation, Anorexia Nervosa has gone unnoticed. For that reason, the topic of this study is to raise awareness to families who believe they are making a difference in their daughter's life in realizing the factors that may influence the onset of the disorder. There is a thin line, a very thin line, as to where the initiation of troubled eating habits and normal eating habits start.

In this study it has shown that the lack of praise and constant criticism has been one of the influencing factors in developing Anorexia Nervosa or within the group of individuals with high risk of developing Anorexia Nervosa. Even though the hypothesis and results point to the dysfunctional mother-child relationship, one cannot overlook comorbid disorders that are exhibited as a result of poor parenting, bullying and other factors such as the influence of the father figure, sexuality, and medical conditions.

1.3. Limitations to the Study

It is highly significant to touch across the limitations of the study conducted upon interpreting the findings as they may interfere with the final results and discussion of the study. The first limitation to this study is the number of individuals with Anorexia Nervosa which are relatively low. The second limitation is the semi-structured interview that is created to assess the relationship between the participants and their primary caregivers, especially the mother, which limited our ability to delve into other emotional disturbances that might have caused the onset of the disorder. In addition, the semi-structured interview does not study the role of the father on the onset of the disorder. The third limitation to the study is the presence of any sexual harassment or abuse as the individual develops and matures and might have dire consequences on the individuals' mental health. The fourth limitation is the history of substance abuse that could

cause excessive weight loss and lost appetite such as heroin and cocaine addictions. The semi-structured interview attempt at ruling out medical condition however, there might be medical complications that may cause weight loss and Anorexia Nervosa like symptoms. The fifth limitation to the study is based on comorbid disorders alongside Anorexia Nervosa. The fact that the single interview questionnaire is focusing on the here and now of the individual's background, and the Eating Attitude Test (EAT-26) is focusing on the behavioral habits of eating, it is hard to anticipate the presence of a second disorder that might have influenced the onset of Anorexia Nervosa.

Appendix A

Consent to Participate in Research

You are invited to participate in a research study conducted by Ruby Sawaya, a registered student in the Master's program of the Department of Psychology at Notre Dame University (NDU). The results of this research will contribute to the fulfilment of Ruby Sawaya's Master's Thesis.
If you have any questions or concerns about the research, please feel free to contact Ruby Sawaya at (961) 3 949584 or by e-mail sawayaruby@gmail.com.

PURPOSE OF THE STUDY

This research paper aims to study the dysfunctional primary relationship between a mother and her daughter, and its effect on the possibility of developing an Eating Disorder, Anorexia Nervosa.

PROCEDURES

If you agree to participate in this study, we would ask you to do the following:
1. You will be presented with a number of questions mainly regarding yourself, your eating habits, and your relationship with family members.
2. You will then be asked to answer these questions.
3. The duration of this questionnaire is between 15-20 minutes.

Please make sure to read all of the questions carefully and answer them by choosing the option that best expresses your answer. There are no right or wrong answers.

CONFIDENTIALITY

No personal or identifying information will be disclosed at any time or in any report, publication, or article. No identifying information will be requested. No one will be able to know which questionnaire responses are yours.

SIGNATURE OF RESEARCH SUBJECT

I understand the information provided for the study. My questions have been answered to my satisfaction, and I agree to participate in this study. I have been given a copy of this form.

_____
Name of Subject

_____ _____
Signature of Subject Date

Appendix B

Eating Attitudes Test (EAT 26)
D.M. Garner & P.E. Garfinkel

Instructions: this is a screening measure to help you determine you might have an eating disorder that needs professional attention. This screening measure is not designed to make a diagnosis of an eating disorder or take the place of a professional consultation. Please fill out the below form as accurately, honestly and completely as possible. There are no wrong or right answers. All of your responses are confidential.

Part A: Complete the following Questions						
Date of Birth: Month:		Day:		Year:		
Gender: Female:		Male:				
Height:						
Current Weight:						
Highest Weight (excluding pregnancy):						
Lowest Adult Weight:						
Ideal Weight						
Part B: Complete the following questions	**Always**	**Very Often**	**Often**	**Sometime**	**Rarely**	**Never**
1. Am terrified about being overweight						
2. Avoid eating when I am hungry						
3. Find myself preoccupied with food						
4. Have gone on eating binges where I feel that I may not be able to stop						
5. Cut my food into small pieces						
6. Aware of the calorie content of food that I eat						
7. Particularly avoid foods with a high carbohydrate content (e.g. bread, potatoes, rice, etc.)						
8. Feel that others would prefer I ate more						
9. Vomit after I have eaten						
10. Feel extremely guilty after eating						
11. Am preoccupied with a desire to be thinner						
12. Think about burning up calories when I exercise						

13. Other people think I am too thin						
14. Am preoccupied with the thought of having fat on my body						
15. Take longer than others to eat my meals						
16. Avoid foods with sugar in them						
17. Eat diet foods						
18. Feel that food controls my life						
19. Display self-control over food						
20. Feel that others pressure me to eat						
21. Give too much time and thought to food						
22. Feel uncomfortable after eating sweets						
23. Engage in dieting behavior						
24. Like my stomach to be empty						
25. Enjoy trying new rich foods						
26. Have the impulse to vomit after meals						

Part C: Behavioral Questions: In the past 6 months have you:	**Never**	**Once a month or less**	**2-3 times a month**	**Once a week**	**2-6 times a week**	**Once a day or more**
Gone on eating binges where you feel that you may not be able to stop?						
Ever made yourself sick (vomited) to control your weight or shape?						
Ever used laxatives, diet pills, or diuretics (water pills) to control your weight or shape?						
Exercised more than 60 minutes a day to lose or to control your weight?						
Lost 20 pounds (9 KGs) or more in the past 6 months?						

Appendix C

Semi-Structured Interview

Date: _____

Parents' Information

	Mother	Father
Nationality		
	---	---
Educational Degree		
	---	---
Profession		
	---	---

Parental Status: ☐ Married ☐ Divorced ☐ Separated

Medical History

Sickness / Medications

Surgery

Hereditary or Developmental Disorders

Accidents

Previous Medical/Psychological Intervention

☐ Family Medicine ☐ Pediatric ☐ Psychiatrist
☐ Psychotherapist ☐ Psychologist
☐ Psychomotor therapist

Have you been exposed to any form of abuse and/or violence? Please specify.

_____
_____
_____
_____

Describe your relationship with your mother:

Part A: Closed-Ended Questions

1.	Do you feel that your mother respects you for who you are?	Yes	No
2.	Do you feel that your mother understands you well?	Yes	No
3.	Do you feel that the communication level between the two of you is adequate?	Yes	No
4.	Do you feel that the bond between the two of you satisfies your need for connection?	Yes	No
5.	Do you feel warm affection thinking of your mother?	Yes	No
6.	Do you feel that your mother has been there for you in most situations?	Yes	No
7.	Do you feel that your mother has kept all her promises to you?	Yes	No
8.	Do you feel that your mother is proud of your accomplishments?	Yes	No
9.	Do you feel abandoned or denied or rejected by your mother?	Yes	No
10.	Do you feel violently treated by your mother?	Yes	No
11.	Do you fear or dislike your mother's opinions in any way?	Yes	No
12.	Do you feel your mother has been criticizing you while growing up?	Yes	No
13.	Do you feel jealous of your mother or vice versa?	Yes	No
14.	Do you feel you can approach your mother for advice?	Yes	No
15.	Do you feel you can share with your mother intimate experiences?	Yes	No

Part B: Open-Ended Questions

1. How would you describe your mother?

_____

_____

_____

_____

2. What do you like about your mother? What do you dislike about her?

_____

_____

_____

_____

3. What kind of everyday communication do you have with your mother?

4. What expectations do you think your mother had for you? Have you met these expectations?

5. How much time do you spend with your mother? What type of activities do you share together and how do you feel about yourself when you spend time with your mother?

6. On what level did your mother influence you (behavior, Choices, interests, etc.)?

7. If you are experiencing a crisis in your life, who would you turn to?

8. Do you wish that your relationship with your mother is different? In what way?

References

Ainsworth, M. D. (1969). OBJECT RELATIONS, DEPENDENCY, AND ATTACHMENT: A THEORETICAL REVIEW OF THE INFANT-MOTHER RELATIONSHIP. *Child Development, 40*, 969-1025.

Bellam, G. (1969). The First Year of ife. *The American Journal of Nursing, 69*(6), 1244-1246.

Berner, L. A., Shaw, J. A., Witt, A. A., & Lowe, M. R. (2013). The Relation of Weight Supression and Body Mass Idex to Symptomatology and Treatment Response in Anorexia Nervosa. *Journal of Abnormal Psychology, 122*(3), 694-708.

Bers, S. A., Besser, A., Harpaz-Rotem, I., & Blatt, S. J. (2013). AN EMPIRICAL EXPLORATION OF THE DYNAMICS OF ANOREXIA NERVOSA: Representations of Self, Mother, and Father. *Psychoanalytic Psychology, 30*(2), 188-209.

Blackwell, D. (1997). Holding, Containing, and Bearing Witness: The Problem of Helpfulness in Encounters with Torture Survivors. *Journal of Social Work Practice, 11*(2), 81-89.

Blechert, J., Ansorge, U., & Tuschen-Caffier, B. (2010). A Body-Related Dot-Probe Tak Reveals Distinct Attentional Patterns for Bulimia Nervosa and Anorexia Nervosa. *Journal of Abnormal Psychology, 119*(3), 575-585.

Boucharat, J., Maitre, A., & Wolf, R. (1970). Role of early oral fixations in the psychopathology of anorexia nervosa. *Annales Médico-Psychologiques, 2*(4), 577-582.

Bowlby, J. (1951). MATERNAL CARE AND MENTAL HEALTH. *Bulletin of the World Health Organization*, 355-534.

Broucke, S. V. D., Vandereycken, W., & Norre, J. (1997).*Eating disorders and marital relationships*. Britain: Routledge.

Campos, L. K., Sampaio, A. B., Junior, C. G., Junior, R. M., Battistoni, M. M., & Turato, E. R. (2012). Psychological characteristics of mothers of patients with anorexia nervosa: implications for treatment and prognosis. *Trends in Psychiatry and Psychotherapy, 34*(1).

Canetti, L., Kanyas, K., Lerer, B., Yael, L., & Bachar, E. (2008). Anorexia Nervosa and Parental Bonding: The Contribution of Parent - Grandparent Relationships to Eating Disorder Psychopathology. *JOURNAL OF CLINICAL PSYCHOLOGY, 64*(6), 703-716.

Chatoor, I., Hirsch, R., Ganiban, J., Persinger, M., & Hamburger, E. (1998). Diagnosing Infantile Anorexia: The Observation of Mother-Infant Interactions. *J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY, 37*(9), 959-967

Craig, J. (1990). *Psychodynamic Treatment of Anorexia Nervosa and Bulimia.* New York: Gullford Press.

Cunha, A. I., Relvas, A. P., & Soares, I. (2009). Anorexia nervosa and family relationships: Perceived family functioning, coping strategies, beliefs, and attachment to parents and peers. *International Journal of Clinical and Health Psychology, 9*(2), 229-240.

D'Agostino, H. (2004). THE REAL TRUTH ABOUT BEAUTY: A GLOBAL REPORT.

DeGear, E. B. (n.d.). Egyptian Returnees as Unwelcome Playmates? Winnicott's Psychopathology of Play' and its implications for the current state of biblical scholarship. *Psychology and Biblical Studies.*

Domjan, M. (2010). *The Principles of Learning and Behavior.* Belmont: Wadsworth Cengage Learning.

Draucker, C. B. (2000). *Counselling survivors of childhood sexual abuse*. Britain: SAGE publications Ltd.

Duvvuri, V., & Kaye, W. H. (2009). Anorexia Nervosa. *THE JOURNAL OF LIFELONG LEARNING IN PSYCHIATRY, VII*(4), 455-462

Ehrensing, R. H., & Weitzman, E. L. (1970). The Mother-Daughter Relationship in Anorexia Nervosa. *Psychosomatic Medicine, 32*(2), 201-208.

Engel, S. G., Wonderlich, S. A., Crosby, R. D., Mitchell, J. E., Crow, S., Peterson, C. B., . . . Gordon, K. H. (2013). The Role of Affect in the Maintenance of Anorexia Nervosa: Evidence from a Naturalistic Assessment of Momentary Behaviors and Emotion. *Journal of Abnromal Psychology, 122*(3), 709-719.

Fleming, J. S. (2004). Erikson's Psychosocial Developmental Stages. 9.1 - 9.24.

Freud, S. (1923). *The Ego and the Id. The Standard Edition of the Complete Psychological Works of Sigmund Freud*, Volume XIX (1923-1925): The Ego and the Id and Other Works, 1-66.

Frude, N. (1998). *Understanding abnormal psychology.* Oxford, UK or Malden, USA: Blackwell Publishers Inc.

Gallop, J. (1983). Lacan's "Mirror Stage": Where to Begin. *SubStance, 12*(38), 118-128.

Garner, D., & Garfinkel, P. (1997). *Handbook of Treatment of Eating Disorders.* New York: Gullford Press.

Garner & Garfinkel. (1979). The Eating Attitudes Test: Psychometric features and clinical correlates. Psychological Medicine, 12, 871-878.

Garner et al. (1982). The Eating Attitudes Test: Psychometric features and clinical correlates. Psychological Medicine, 12, 871-878.

Gilbert, S. (2000). *Counselling for eating disorders.* Britain: SAGE publications Ltd.

Gilbert, S. (2005). *Counselling for Eating Disorder.* UK: SAGE Publications.

Gopal, A. A., Ropper, A. E., & Tramontozzi III, L. A. (2011). *Psychiatry.* Singapore: Mc Graw Hill.

Grabe, S., Ward, M. L., & Hyde, J. S. (2008). The Role of the Media in Body Image Concerns Among Women: A Meta-Analysis of Experimental and Correlational Studies. *Psychological Bulletin, 134*(3), 460 – 476.

Guinzbourg, M. (2011). Eating disorders - a current concern. *Similarities and Differences among the Anorexia, Bulimia, and EDNOS Categories, 32*, 27-45. doi: 10.1027/1192-5604/a000014.

Gullestad, S. E. (2001). Attachment theory and psychoanalysis: controversial issues. *THE SCANDINAVIAN PSYCHOANALYTIC REVIEW, 24*, 3-16.

Hockmeyer, A. (1988). Object Relations Theory and Feminism: Strange Bedfellows. *A Journal of Women Studies, 10*(1), 20-28.

Isserlin, L., & Couturier, J. (2012). Therapeutic alliance and family-based treatment for adolescents with anorexia nervosa. *49*(1), 46-51. doi: 10.1037/a0023905.

Johnson, C. (1991). *Psychodynamic treatment of anorexia nervosa and bulimia.* London: The Guilford Press.

Johnson, S. J., Dweek, C. S., & Chen , F. S. (2007). Evidence for Infants' Internal Working Models of Attachmet. *Association for Psychological Science, 18*(6), 501-502.

Keel, P. K., & Klump, K. L. (2003). Are Eating Disorders Culture-Bound Syndromes? Implications for Conceptualizing Their Etiology. *Psychology Bulletin, 129*(5), 747-769.

Klein, M. (1940). Morning and Its Relation to Manic-Depressive States. *The International Journal of Psycho-Analysis, 125*(53), 95-122.

Lacan, J. (1966). *ECRITIS.* New York. London: WW. NORTON & COMPANY.

Langlois, J. H., Kalakanis, L., Rubenstein, A. J., Larson, A., Hallam, M., & Smoot, M. (2000). Maxims or Myths of Beauty? A Meta-Analytic and Theoretical Review. *Psychological Bulletin, 126*(3), 390-423

Lavender, J. M., De Young, K. P., Wonderlich, S. A., Crosby, R. D., Engel, S. G., Mitchell, J. E., . . . Peterson, C. J. (2013). Daily Patterns of Anxiety in Anorexia Nervosa: Associations With Eating Disorder Behaviors in the Natural Environment. *Journal of Abnormal Psychology, 122*(3), 672-683

Levin, K. (1993). *Unconscious fantasy in psychotherapy.* London: JASON ARONSON INC.

Lilenfeld, L. R., Kayne, W. H., Greeno, C. G., Merikangas, K. R., Plotnicov, K., Pollice, C., . . . Nagy, L. (1998). A Controlled Family Study of Anorexia Nervosa and Bulimia Nervosa. *Arch Gen Psychiatry, 55*, 603-610.

Linder, M. (1993). Time for Lacan: Looking after the mirror stage. *Assemblage, 21*, 82-83

Maddern, L. H. M., Cadogan, J. C., & Emerson, M. P. E. (2006). Outlook: A psychological service for children with a different appearance. 11(3), 431-443. doi: 10.1177/1359104506064987.

McAdams, C. J., & Krawczyk, D. C. (2014). Who am I? How do I look? Neural differences in self-identity in anorexia nervosa. *The Author, 9*, 12-21.

Ogden, J. (2003). *The psychology of eating: from healthy to disordered behavior.* UK: Blackwell Publishers Ltd.

Pietromonaco, P. R., & Barrett, L. F. (2000). the Internal Working Models Concep: What Do We Really Know About THe Self in Relation to Others? *Review of General Psychology, 4*(2), 155-175.

Polivy, J., & Herman, P. C. (2005). Mental Health and Eating Behaviours A Bi-directional Relation. *Canadian Journal of Public Health, 96*, S43-S46.

Praglin, L. (2006). The Nature of the "In-Between" in D.W. Winnicott's Concept of Transitional Space and in Martin Buber's das Zwischenmenschliche. *UIVERSITAS, 2*(2), 01-09.

Ragland-Suillivan, E. (1982). Jacques Lacan: Feminism and the Problem of Gender Identity. *SubStance, 3*(36), 6-20.

Rozin, P. (1996). Towards a Psychology of Food and Eating: From Motivation to Module to Model to Marker, Mortality, Meaning, and Metaphor. *Current Directions in Psychological Science, 5*(1), 18-24.

Rumsey, N., & Harcourt, D. (2003). Body image and disfigurement: issues and interventions. *1*(2004), 83-97. doi: 10.1016/S1740-1445(03)00005-6.

Rumsey, N., & Harcourt, D. (2007). Visible difference amongst children and adolescents: Issues and interventions. *Developmental Neurorehabilitation, 10*(2), 113-123.

Scully, J. H. (1996). *Psychiatry.* PA USA: William & Wilkins.

Schwartz, B., Wasserman, E. A., & Robbins, S. J. (2002). *Psychology of Learning and Behavior.* New York: W. W. Norton & Company, Inc.

Semple, D., & Smyth, R. (2013). *Oxford Handbook of Psychiatry.* United Kingdom: Oxford Uniersity Press.

Shipton, G. (2004). *Working with eating disorders - a psychoanalytic approach.* New York, NY: Palgrave Macmillan.

Sidiropoulos, M. (2007). Anorexia Nervosa: The physiological consequences of starvation and the need for primary prevention efforts. *MJM, 10*(1), 20-25

Shott, M. E., Filoteo, V. J., Jappe, L. M., Pryor, T., Maddox, T. W., Rollin, M. D., . . . Frank, G. K. (2012). Altered Implicit Category Learning in Anorexia Nervosa. *Neuropsychology, 26*(2), 191-201.

Solan, R. (1998). NARCISSISTIC FRAGILITY IN THE PROCESS OF BEFRIENDING THE UNFAMILIAR. *The American Journal of Psychoanalysis, 58*(2).

Stice, E., Marti, N., & Rohde, P. Prevalence, Incidence, Impairment, and Course of the Proposed DSM-5 Eating Disorder Diagnosis in an 8-Year Prospective Community Study of Young Women. *Journal of Abnormal Psychology, 122*, 445-457.

Stice, E., Marti, N., Shaw, H., & Jaconis, M. An 8-Year Longitudinal Study of the Natural History of Threshold, Subthreshold, and Partial Eating Disorders From a Community Sample of Adolescent . *Journal of Abnormal Psychology, 118*, 587-597.

Stice, E., Presnell, K., & Bearman, S. K. (2001). Relation of Early Menarche to Depression, Eating Disorders, Substance Abuse, and Comorbid Psychopathology Among Adolescent Girls. *Developmental Psychology, 37*(5), 608-619.

Strober, M., Freeman, R., Lampert, C., Diamond, J., & Kaye, W. (2000). Controlled Family Study of Anorexia Nervosa and Bulimia Nervosa: Evidence hared Liability and Transmission of Partial Syndromes. *Am J Psychiatry, 157*(3), 393-401.

Tackett, K. k. (2002). The Health Effects of Childhood Abuse: Four Pathways by which Abuse Can Influence Health. *Child Abuse and Neglect, 6/7*, 715-730

Thompson, R. A. (2001). Development in the First Year of Life. *The Future of Children, 11*(1), 20-33.

Toy, E. C., & Klamen, D. (2012). *Case Files® Psychiatry.* United States of America: Mc Graw Hill.

Van Vonderen, K. E., & Kinnally, W. (2012). Media Effects on Body Image: Examining Media Exposure in the Broader Context of Internal and Other Social Factors. *American Communication Journal, 14*(2).

Wildes, J. E., Marcus, M. D., Crosby, R. D., Ringham, R. M., Dapelo, M. M., Gaskill, J. A., & Forbush, K. T. (2011). The Clinical Utility of Personality Subtypes in Patients with Anorexia Nervosa. *Journal of Consulting and Clinical Psychology, 79*(5), 665-674