

Anna Kobierecka-Dziamska

## **TRACES OF FAMILY EXPERIENCE IN THE BODY IMAGE**

### **– A CASE STUDY OF A YOUNG WOMAN**

Antoni Jurasz University Hospital No. 1 – Psychiatry Clinic, Bydgoszcz, Poland

**body image**

**family functioning**

#### **Summary**

The aim of the paper is to present the case of a woman with a negative body image in the context of her experiences emerging from her family of origin. The author presents the view that traces of family experience can be found in the female body image. The presented literature overview justifies this argument. Phenomenological analysis of experiencing the body by a young adult woman was carried out based on an interview, observation, questionnaires, and projective tools for the study of body image and family relationships. The author used the systemic perspective and attachment theory to explain the feelings, behaviours, and thoughts of the tested person about her body. The body image of the woman presented in this case study was varied, but largely negative, and family relationships can be described as distanced and difficult in terms of regulating emotions. The family also faced psychopathology in the form of alcohol addiction and domestic violence. In accordance with the adopted theoretical perspective, both family functioning and the quality of the relationships with the mother and the father of the young woman seemed to be linked and warrant the described manifestations of experiencing her own body. This analysis allows us to conclude that family perspective should be taken into account from the view of a person's body image as well as from the view of the treatment of problems connected with experiencing one's own body.

#### **Introduction**

The issue of body image in women takes an important place in scientific literature and psychological practice. This is an expression of the significant interest in the body in social space [1] but also more and more frequent expression of mental health problems through the body, for example in the form of self-harm, anorexia nervosa and bulimia, or psychosomatic disorders [2–6]. The body image and its many conditions is a subject we know relatively much about, however, for practitioners, to work on a way to experience the own body in people who take non-adaptive behaviour associated with their body, perceptually distort its image, or experience negative feelings towards it, is ever-challenging.

In this paper – based on literature review and a case study – the analysis of a young woman's body image in conjunction with her family of origin's experiences was made. Apart

from biological, socio-cultural factors and other interpersonal experiences, the family of origin is pointed out as an important predictor of the body image [7]. The underlying theses are those of Schier [3, p.7], according to whom “interpersonal experiences are saved not only in one’s mind but also in one’s body”, and Küchenhoff [in: 8], who believes that “the body contains traces of interpersonal experiences” [8, p. 50]. Referring to the title of the article, family experience constitutes a part of interpersonal experiences and reflects – as traces – on the way of perceiving and treating one’s own body. Traces shall be understood as one’s experience, emerging from the family of origin, which is stored in the long-term autobiographical memory and determines the body representation in one’s mind.

As a theoretical basis, the systemic paradigm and the attachment theory were taken. It was assumed that socio-cultural factors are important in conditioning the manner of experiencing one’s own body, however, the considered family perspective provides for opportunities of deeper psychological understanding of difficulties within the body image and making appropriate psychotherapeutic interventions.

### **Body image**

The body image is a complex phenomenon, understood nowadays as a part of self-image and the physical self [4, 5, 9]. In the related literature, numerous definitions of body image can be found. In this work, it has been assumed that it is a mental representation of one’s body, which contains cognitive, affective and behavioural dimensions [10, 11]. Body image formation is an integral part of personality development and goes hand in hand with the acquisition of motor, speech, thinking, and emotional self-regulation skills [4, 12]. This process involves several steps and in normative development, it completes the integration of the physical self with the psychic self [2]. It is worth pointing out that determinants of the body image and physical self are various and complex. They contain cultural, social, family, personality, and biological factors [4, 9, 13, 14]. Many authors believe that the development of the body image and body self occur primarily in the relationship with parents and depends on the quality of this relationship, i.e. the parents’ ability to recognize adequately the needs and physical sensations of a child and respond on them, give them meaning and show how to cope with them [2, 4, 12].

Reflection on body attitudes, body experiencing and manifestation of body expression is particularly important in the case of women. Although women in different cultural circles have been absorbed by their bodies for ages, post-modernity seems to be particularly oppressive in this aspect. Through mass media, the standard of a thin body, regardless of its anatomical construction and its phase in the life-cycle, has become widespread [1, 6, 13, 14]. The identity of modern women is strongly based on carnality. Many modern, healthy women (i.e. without eating disorders and mental disorders) are dissatisfied with their own bodies. Such dissatisfaction is currently defined in the literature as normative and extremely affects women’s physical and psychological health or their social functioning [4, 13–21]. It is worth pointing out that such a phenomenon as body dissatisfaction has not been explained by any consistent theory [13, 22]. Researchers suggest that in the aetiology of the negative body image of young women the following should be taken into account: the process of socialization, social comparisons, experiences connected with the body, weight, and eating, or personality traits. Empirical studies

indicate such relevant risk factors as: the extent of internalisation of socio-cultural norms, perfectionism, interoceptive awareness, and BMI [22].

### **Family determinants of body image**

The family, through its several performed functions and the richness within its dynamic boundaries, constitutes a primary sphere of individual development. Experiences gained in the family of origin are of immense importance to the emotional, personal, cognitive, and social development of the human being [23, 24]. The family is also a sphere of shaping attitudes towards carnality and sexuality. This complex process takes place through modelling, internalizing, and identifying with the attitudes and patterns of treating the body by the family which comes from the parents' earlier experiences connected with their relation to bodies, appearance, eating, and, moreover, cultural transfer [7, 13, 25–27]. The family system provides family members (mainly parents to children) information on their traits, which are both resources and weaknesses, also in respect of carnality. As it is seen by Plopa [23], “attributes that we ascribe to ourselves are a product of our social interactions” [23, p. 23]. On the other hand, following Stice [in: 13], it should be mentioned that family – parallel to the influence of peers and media – is “a transmitter of cultural norms” [13, p. 58], in which a woman's attractiveness and her success are determined by her appearance and slim figure. The body image created in one's mind contains, therefore, traces of social experiences, including important relationships.

In the light of the literature review, the conceptualization of the quality of family relationships may condition the body image on several levels: from the quality of the relationship with the mother, the father, and the characteristics of the functioning of the family as a whole. The mother–child relationship has a special place in psychology and is considered a key to the development of a child's internal world. Researchers dealing with the concept of attachment and clinicians see the bond with the mother as a kind of a matrix for many mental functions in the child like: regulation of emotions, mentalizing, the ability to build social relationships [28–30]. It is also significant for building awareness and the representation of the body in the mind of the child [2]. For her daughter, the mother is also an important object of identification and a model to follow. Hence, the mother's attitude towards her own body can become a part of her daughter's body image [7, 31], which has been confirmed by research [cf. e.g. 32–34].

The significance of the relationship with the father for shaping the daughter's body image has been very little analysed so far. Clinical reports show, however, that the father may support the development of his daughter in terms of her feeling of being a woman in her own body and having a positive body image, but can also interfere with this process. Girls devoid of the enjoyment of being pleasing to their fathers and of their affirmation may in the future hide their femininity and reject their own body while seeking recognition for it in a non-adaptive way [35, 36].

In the context of the family as a whole and its features of the functioning, building the body image by the daughter can be executed by two basic influence mechanisms: direct – in the form of messages communicated to the child and associated with the body, weight, and

food; and indirect – through modelling behaviours associated with the body, as diet or physical activity [37].

### **Material and Method**

The study aimed to analyse family determinants of the body image of a 33-year old woman, who gave her informed consent to take part in the research and its possible publication providing anonymity.

Based on the analysis of related literature, it was hypothesised that there is a relationship between the body image and functioning of the family of origin, the quality of the relationship with parents, and that in the body image “traces” of family experiences can be found. It was also assumed that the negative evaluation of one’s body image is associated with a high level of family dysfunction. To verify this hypothesis, a case study was used. It allows making an in-depth analysis of the subject’s family relationship and experiencing one’s body.

In this case, description information from the conversation and psychological observation was used. The conversation, preceded by making contact, concentrated on: insights, emotions, beliefs, behaviours, and the past and current experiences connected with one’s body, attitudes towards the body and appearance, family relationships, family history, memories of the relationship with the mother and the father. Information derived from questionnaires and projective methods was supportive in this research. To explore the family relationship, the following were used:

- Family Assessment Scale [38] which is the polish version of Olson’s FACES–IV adapted by Margasiński. The tool is based on the systemic understanding of the family and was used to percept various aspects of family life. The questionnaire consists of 8 different scales: two sustainability scales (sustain coherence and sustain flexibility), four unsustainability scales to measure extremes of coherence and flexibility values (disengagement, enmeshment, rigidity, chaos) and two additional scales, defined as quantitative (family communication and family life contentment). The research procedure assumed modification of the instruction: during answering, the subject was asked to refer to her family of origin.
- Retrospective Assessment of Parental Attitudes KPR–Roc [39] – a tool which enables to assess 5 dimensions – attitudes of the relationship between a child and a parent – (1) acceptance/rejection; (2) excessive demands; (3) autonomy; (4) inconsequence; (5) overprotectiveness. The questionnaire has sten norms.
- Draw–a–Family Test [40, 41] – a projective method with a long tradition and widely used in psychological clinical practice. It is used to explore not only a child’s family relationship but also that of adults<sup>1</sup>. Due to the loosely structured instruction, it was assumed that it is possible to make a deep, unconscious projection of the subject’s family relationships and the character of relationships with the particular members of the family [40, 41]. In the

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<sup>1</sup> It is worth mentioning that according to Frydrychowicz, Draw-a-Family Test is “the most effective testing method for children aged 5-11” [41, p.13] but according to Braun-Gałkowska, drawing can be also used for middle-aged and elderly people (cf. e.g. Braun-Gałkowska M. Satisfied and unsatisfied with the marriage in the light of Draw-a-Family Test. In: Łaguna M, Lachowska B, ed. Projective drawing as a psychological research method. Lublin: Towarzystwo Naukowe KUL, 2004, pp. 151-164).

assessment of the draw, indicators proposed by Braun-Gałkowska [40] and Frydrychowicz [41] were used, analysing: structure, content and information derived from the conversation (in accordance with the Frydrychowicz's [41] script).

In order to study the body image used were:

- Body Esteem Scale BES [42] in the Polish adaptation after Lipowska and Lipowski [43]. This is a tool for self-description referring to the emotional aspect of the body image, specifying the level of satisfaction of particular areas of the body. It has a Polish normalization [43] and is differentiated between the sexes. For women, there are highlighted dimensions such as: sexual attractiveness, weight control, and physical condition.
- Multidimensional Body–Self Relations Questionnaire MBSRQ [44] translated by Topór M., Matkowska M., Schier K., Rzeszutek M. from the Warsaw University, purchased from the questionnaire author – Cash T. It is a widely used tool for scientific research on the body image. For this work, it was used as an experimental tool (with regard to qualitative analysis of the subject's answers). In Polish research, it has received a high coefficient of reliability [4]. The questionnaire consists of 10 scales that refer to appearance assessment, efficiency, health and weight, appearance orientation, efficiency, health and illness, and also overweight preoccupation and body satisfaction.
- Drawing-Body-Image Test – “Nudie”, authored by Schier [4] – a projective method devoted to testing different aspects of the body image which are difficult to verbalize. The subject's task is to draw herself or himself unclothed, using available colours which denote the level of satisfaction (red – very satisfied, yellow – satisfied, black – neutral, green – unsatisfied, blue – very unsatisfied). Colour symbols were extracted from the KBMK–K Test, the author of which – M. Günther – has analysed the meaning of colours [in: 4, 45]. In the assessment of the test, taking into consideration experiences in applying the tool by the author [4] and other authors making use form drawing methods [13, 46, 47], there were taken into consideration: the number of used colours, the size of the drawing, proportions of the characters, details of the drawing, highlighting and omitting particular body parts, coverage of the drawing. The analysis of these indicators enables referring to: the level of one's own body satisfaction and its particular parts, differentiation of body representation, body boundaries, perceiving one's own body (*i.e.* as a whole or in a fragmented way), adequacy of the body image (in terms of size and proportions of particular parts of the body relative to each other). “Nudie” has been successfully used in quantitative research (satisfactory psychometric properties have been obtained) and in clinical research as well [cf. 4].

It is worth pointing out that the subject's drawings were consulted with psychologists having extensive clinical experience, the aim of which was to make the objective conclusions reached in the analysis. Taking into consideration the limitations of this research and the request of the subject, the drawings are not included for the reader.

### Case Description

Mrs J. is a woman of average height and apple-shaped figure (in the abdominal area the woman is clearly overweight and her legs are slim.) Mrs J.'s Body Mass Index (BMI) is 30.4 kg/m<sup>2</sup> and indicates obesity [48]. She has loose, shoulder-length blond hair and carefully made make-up. Mrs J. declared that she is healthy and does not have any chronic diseases.

In the individual contact, Mrs J.'s mood was sometimes disproportionate to the issues raised in the conversation, like she was talking about someone else, not herself. Sometimes, the woman smiled while talking about issues that embarrassed her, which is a defence mechanism known as reaction formation [49]. It is significant, too, that while responding to questions about her own experiences, she often referred to relationships with her significant others and described her own experiences in relation to other people, as if she was not able to interact with the researcher as an independent human being.

Mrs J. graduated from a vocational school and is a cashier. She has been married for 10 years. She considers the relationship with her husband as satisfactory. They have a 9-year-old son, who is – as Mrs J. stated – the “apple of her eye”<sup>2</sup>. She was born as the first child of her parents. She had two siblings: a 2 years younger brother (deceased) and an 11 years younger sister. Mrs J.'s mother is 52 years old and she works as an aid in a gardening company. Her father is 56 years old and is a locksmith.

In the woman's narration, she describes her childhood from the age of 6, when she went to school. She remembers she was a shy child with anxiety about school and other children. She did not feel accepted because of her overweight. Due to school stress, Mrs J. occasionally did not hold the urine at school and ran away from there. During primary school, during tests or situations of emotional arousal, she blushed, which was often negatively commented both in the family and by her peers. Mrs J. experienced it clearly that blushing was inappropriate. To win her peers' favour she bought them sweets in the school shop for money stolen from her mother.

#### Functioning of the family and the quality of the relationships with parents

Mrs J. described the atmosphere of the family home as “severe and devoid of joy”, which indicates reduced satisfaction her with family life. Her parents got married when the mother was 18 years old and her father 22. The economic situation at home was average but satisfactory. The mother ran the house and took care of the children, while the father worked. He suffered from alcohol abuse and he became aggressive after alcohol consumption. He used violence against his wife and children. The parents were close to divorce and they were through legal separation, however, they stayed together. Mrs J. concluded, “Now they are a normal but wounded family.”

In Mrs J.'s story, her mother was referred to as a “person suffering throughout her life,” that is absorbed in her mental pain. She spent most of the time running the house. Very often, she heavily focused on her children, which was experienced by Mrs J. in a negative way – as excessive control. Due to her husband's aggression and alcohol dependence, she tried to seek help for herself and the children in a centre for solving alcohol problems but on the other hand,

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<sup>2</sup>Quotation marks contain the original statements of the interviewed woman.

she helped her husband when he experienced unpleasant consequences in connection with his drinking. In this way, she entered a co-addicted position, for what Mrs J. resents her mother. She noted that her mother loved her father. Furthermore, she recalled that in social settings, her mother also reached for alcohol, got drunk and was "the life of the party." When the children started to live on their own, she found employment in a cleaning service, and now she works as a gardener. Mrs J. acknowledged that as a child, she had satisfactory contact with the mother, she could tell her everything, and her mother was supportive to her. Over the years, their knits loosened, which was connected in time with the growing closeness with her father as he took on therapy and stopped drinking, while the mother moved closer to the Church. The mother's piety, counting on God, Mary and Jesus annoyed the patient in the context of the mother's previous behaviour when she was smoking and drinking. When in difficult situations Mrs J. turned to her mother, the mother sent her to God, hinting that she wouldn't get help from her. Mrs J. mentions also that her mother had always cared about her looks and she felt it was exaggerated: each day, her mother had to have her hair done, she wore make-up, and carefully picked her clothes.

Mrs J. briefly describes the relationship with her father as distinctively close currently. She declares that she has forgiven him for the harm done against the family. The father has not been drinking for 11 years. It is significant that he was the parent who executed punishment (for failure to perform commands), which were primarily physical, using a "whip with six straps." Mrs J. mentions that she was able to get along with her father and then the penalty was less severe. Often, it seemed to her that her brother was receiving punishment for her and for himself; the father seemed to be especially harsh towards her brother.

Mrs J. mentioned her siblings in her narrative only briefly. She described her brother mainly as a man with problems, and a drug addict. He engaged in aggressive behaviour, had psychotic symptoms and committed suicide by hanging. Mrs J. believes that she and other family members were helpless in the face of her brother's addiction. She has the impression that her father blames himself for the death of his son. Both parents are at this moment very involved in the Church, probably looking for stress relief in connection with the tragic loss, and their helplessness and according to the interviewee – this is an exaggeration. The sister is a student and is seen as leading a peaceful and carefree life.

In the Draw-a-Family Test made by Mrs J., the characters were drawn in a schematic way (so-called striders, besides the mother who was drawn with clothes) and with visible distance (every each of the characters separately). The drawing as a whole was shifted to the upper left with the father in a so-called air corner [40]. The drawing was mostly made using black crayon with considerable white spaces without any additional elements. The characters seemed to be sad and their hands looked like claws. Each of the members of the family seemed to follow the mother.

Based on the analysis of the family drawing, a couple of hypotheses could have been pulled. The woman's perception of the relationships between the members of the family was that they were missing intimacy and their communication was characterised by aggression. The mother seems to be a dominant person who keeps the family together. She is perceived as somebody who cares about physical appearance (she is the only one who is dressed). Mrs J. seems to experience ambivalent feelings towards her father. He is seen as uninvolved and detached from the rest of the householders; he was described in the interview to the drawing as

the least pleasant because he "never cared about parenting and drank." In Mrs J.'s perception, there was sexual repression in the family, and femininity was attributable only to her mother. In the drawing, high levels of anxiety and depressed mood accompanying the characters can be seen, proving the emotional climate of the family specified during the interview ("no joy at home").

The analysis of the results of the Family Rating Scales [38] indicates the following: weak bonds in the family, resulting in restrictions in terms of provided support and care; experiencing trouble with the organization of family life and the changes in the leadership or roles in the family (increased chaos and rigidity); low ability to communicate with one another. In general, the results show that Mrs J. is dissatisfied with her family life. On the basis of the Questionnaire of Retrospective Assessment of Parental Attitudes by M. Plopa [39], the mother was remembered by Mrs J. as a person providing acceptance, closeness, and support, who communicated adequate requirements and allowing for the daughter's autonomy, predictable in her reactions, but excessively caring and overly involved in the daughter's personal affairs. On the other hand, the father appears as a person showing little acceptance, distanced in relationships, even indifferent, one who communicated adequate requirements to Mrs J. as a child, respecting her need for autonomy, moderately attentive but fickle and erratic in his attitudes presented to the child. It should be noted that the characteristics of the parents made on the basis of the results of the questionnaire and the drawing does not sit well with the description obtained during the interview. Perhaps what was difficult to express verbally was shown in the questionnaire and drawing, which is a less threatening form of communication.

What is the picture of the family and relationships with the parents emerging from the received information? The functioning of this family during the woman's childhood and youth seems to be difficult. We are dealing here with a family with alcohol problems which – as it is pointed out by researchers on this topic – is characterised by specific rules of communication and mutual relationships consisting of reduced sense of closeness, intensity of negative comments and deficit of positive feelings expression, limited abilities to solve problems, growing hidden and unsolved family problems, presence of violence. Families like this are also characterised by chaos, inconsistency, unpredictability, and instability [50]. What is visible in Mrs J.'s family is the distance between the family members and difficulties in experiencing closeness, as well as a problem with the regulation of emotions, which is seen in reaching for addictive substances: alcohol and drugs or running away from reality to the relationship with the Church and God. The possible aim of these strategies is dealing with tension, frustration, anger, anxiety, low mood, or stress in general in the face of addiction of a family member. Growing up in a family lacking the ability to regulate emotions was apparently the reason why Mrs J. has got difficulties adjusting her own feelings now. This can be experienced in the contact with Mrs J., as when faced with emotionally difficult content, she isolates her emotions or presents their opposite. The presence of alcohol addiction and domestic violence seem to be linked to the shame experienced by Mrs J. in contact with her peers, the feeling of being inferior, hence blushing, avoiding contacts, as well as attempts to gain popularity with the violation of social norms.

### Body image

While talking about Mrs J.'s body image, she focused on two main threads: overweight and the lack of breasts and strong dissatisfaction related to it. In contact with Mrs J. one could get the impression that the excess in terms of weight and deficit in the attribute of femininity, which is breasts, define her body self.

Mrs J. expressed a lack of body acceptance since her childhood. As possible causes of this condition she stated: "I was born obese", "as a small child I was plump, just as my son". The woman feels that obesity seems to accompany her from the beginning of her life; it is somehow innate and as such hardly subject to change. She recalls being laughed at in school because of her body weight. Both her parents and siblings were very slim while she was distinctly different in appearance from the rest of her family. From a psychological point of view, Mrs J.'s overweight may be – besides the manifestation of non-adaptive emotion regulation – also an unconscious expression of her identification difficulties with the rest of the family and an attempt to mark her own distinctiveness because of dissatisfaction with the family situation.

She herself blames the holidays with her grandmother in the countryside for her overweight. She stated: "Everything there was natural [i.e. food – author's note], and, you know, fattening." She mentions that her grandmother forced her to eat, and she "did not scorn this food," as she liked eating. The woman remembers that she was laughed at in school because of her weight as she was poor at sports and was not able to keep up with her peers. She therefore felt rejected and excluded and could not belong to the group of "better children," *i.e.* those who were slim and fit. It is possible that not only other children rejected her due to her overweight, but she herself could have withdrawn from relationships because of the deficit she experienced.

During her life, Mrs J.'s weight fluctuated. In her late adolescence and before getting married, Mrs J.'s weight was within the norm. In the past 10 years, she put on weight, and in the last two years she gained most – 20 kg, which she believes is an expression of "eating over work-related stress." Even at night when she wakes up she is able to reach for a chocolate bar and cannot explain this behaviour. At work, she finds it difficult to deal with people, as she feels that they observe and judge her.

Due to the psychological discomfort associated with obesity, she is planning to lose weight. She is annoyed at herself that "she has let herself be obese." She said, "I cannot look at myself in the mirror." The woman declares that she has not taken up any diet. She is going to simply eat less, give up sweets and avoid eating dinner. She notes, however, that she lacks a strong will and is hardly able to persevere in her determination. Two years ago, she bought exercise equipment but used it only for two weeks. She still keeps small-size clothes, which may be associated with a longing for a leaner self and at the same time, difficulty in accepting herself as she is.

Speaking of her body, Mrs J. mentioned her lack of breasts. She laughed embarrassed: "I haven't got any breasts. I did not grow it somehow." Medical consultation during adolescence confirmed that the bust was developing at a very slow pace but physicians ensured her that this situation would change. The bust was to enlarge due to pregnancy, but the woman did not notice the desirable changes. Breastfeeding her son was troublesome, too. It lasted 2 weeks, aroused helplessness because she "could not feed," and the boy was always crying.

Mrs J. has always wanted to have a larger bust. Due to the lack of breasts she avoided wearing deep neckline shirts and in summer on the beach and at the pool she felt ashamed. The woman believes that "every woman should have a bust. This is a feminine asset. And if she does not have it, this is a tragedy." The interviewee recalls that this feature of her has been the subject of negative comments among the closest (mother, brother), as well as the further family. The words of Mrs J. clearly indicate that she feels defective and devoid of her asset, and her family members expressing verbally this fact could have exacerbated the negative feelings.

Her small breasts also affected the level of her sexual satisfaction. She describes her sexual initiation in adolescence as "dramatic" – because of the lack of the bust. The first relationships did not last long "because of these breasts, because I was flat." It is significant to notice that Mrs J. attributes any failure in relationships with men to her body and not any of the mental characteristics of her or her partners. Later, the woman camouflaged her small bust with bras, and in intimate situations, she remained in lingerie or in a shirt, or she had intercourse with the lights off. She mentions that she had long managed to convince her fiancé that her breasts are of an average (within the norms) size. Although he was surprised by the actual size of the breast, he adopted them, according to Mrs J. In their marriage, however, he suggested to finance her a breast enlargement surgery, which Mrs J. understood as an expression of concern and desire to alleviate her suffering. She feels that her husband loves her, regardless of whether her bust is large or not. Mrs J. did not decide on surgical correction of her breasts because of the pain, the presence of a "foreign body", scarring, and possible complications. However, she never gave up dreaming of having breasts.

Currently, Mrs J. uncovers her body in intimate situations with her husband, however, she never reaches forward to it. She revealed that if her husband wants to have sexual intercourse, then she agrees. It seems that her needs related to her own sexuality are driven out by herself, as if she had deprived herself of the right to it.

While considering Mrs J.'s corporeality, another reference to her childhood should be made. During the interview, she said that during school period, she used to blush excessively and she suffered from urine incontinence. These manifestations of the functioning of her body may be understood as a somatisation of mental states in response to the experienced anxiety (here: probably social) [51]. Somatisation, which is a form of regression, allows for an escape from crippling, threatening emotions by implementing a response from the body [49]. Mrs J. could have escaped from separation anxiety (going to school as the experience of long separation from her mother).

It should be highlighted that an anxiety response pattern is characteristic for children raised up by addicted parents due to the unpredictability and lack of control in the relationship with the carer [52].

Also, the adolescence period seems to be significant for experiencing her own body. At this time, she was reaching for drugs (amphetamine, marijuana), substances (she inhaled glue), and alcohol. She also made self-inflicted injuries on her forearms. Under the influence of drugs and alcohol, she used to have sexual intercourse with casual men. Although growing up involves experimentation, even in the sense of one's own corporeality [53], the way to treat her body by Mrs J. during adolescence seems to have extended beyond the normative behaviour and proves self-harming inclinations. The genesis of self-harming behaviour can be seen, among others, in violence-nature experiences in the family and introjection of an aggressive

object that is represented by the child's skin, as well as inhibition of self-care as an ego function [54, 55]. The specificity of the adolescence period is of key importance, too. Due to numerous physical changes, a teenager needs to make the transformation of the existing body image – from a child's body into a sexually mature one. In some adolescents, this process takes place in a problematic way [53].

When talking about her body, Mrs J. acknowledged that she did not like many of her physical features: her hair because it is thin and spine because it hurts. She spoke favourably about her eyes, teeth, and her skin because it is free from pustules and scars, and also her legs because they are long. When asked what her body needs, she said it needs to lose weight and be taken care of. The latter she realizes through the use of good cosmetics. She also takes care a lot for hygiene, she does not tolerate the smell of sweat. However, she smokes cigarettes. It is worth adding that she does not take preventive care. The woman had not had a gynaecological examination for a long time. She also ignored her back pain. For several years, she had not been to the dentist. Mrs J. does not like being complimented about her body. What is more, she receives such compliments negatively. Her husband does not criticize her appearance. She is, however, being bullied by her slim sister due to her weight.

Referring to the prepared by the subject drawing of "Nudie" [4], it should be noticed that the drawn character was proportional, and the number of colours used indicates diversity in Mrs J.'s body image, which supports what she stated in the interview. She is satisfied with her head, face: eyes, nose and mouth, as well as with her hands, legs and feet. Dissatisfaction can be seen in the trunk: shoulders, arms, breasts, abdomen and hips. The hair is also negatively evaluated. There are some essential elements in the drawing that draw attention. First, the breasts are clearly marked with a colour corresponding to strong dissatisfaction (Mrs J. extensively addressed this fact during the interview.) Second, the woman did not mark the genitals, which may be a manifestation of a negative attitude towards her sexuality, which seems to be unwanted, rejected, and in adolescence, which is the period of sexual impulses awakening, even as hateful.

An intriguing fact about this drawing is that the figure looks immature, and even reminds a male, if it was not for the marked breasts. This may be evidence of a low sense of being a woman. It is possible that – due to rising up in a dysfunctional family – Mrs J. is accompanied by a feeling of being a child (with different childish and adolescence needs unmet) in an adult body.

Third, it is worth referring also to her leaving the head, shoulders, arms, abdomen, and hips blank in the middle. As Schier says [4, p. 107] "a drawing on which the figure is empty inside can tell of, among other things, the feeling of emptiness and withdrawal of emotions from the body." This is proved by Mrs J.'s limited capability of naming her internal states in favour of focussing on her physical appearance.

Another important aspect of the drawing is the marking of individual elements of the face and its overall assessment that Mrs J. is satisfied with. In direct contacts, the face is a stimulus of considerable strength. It draws attention and it is the face we react to in the situation of meeting another person [56]. Therefore, this area of the body is particularly subject to social assessment. The face of Mrs J. is carefully "designed" by make-up applied every day ("I don't go out without make-up"). Perhaps, its role is to distract others from the rest of the body and to mask what is true (*e.g.* emotions). Carefully outlined eyes can be the sign of a feeling of being

socially observed (what she experiences most strongly in her work and which is distress for her.) What is more, the facial expression is sad. It is possible that this reflects Mrs J.'s mood and is a manifestation of sadness that she constantly needs to play someone she is not. As it has been noted by Woititz [in: 57, p. 299], children from dysfunctional families are accompanied by "the fear of becoming exposed to one's own unattractiveness" by the others.

Closer attention should be paid to hands and legs that were clearly marked in the drawing, as these body parts were those that the interviewed woman was satisfied with. Hands symbolise action and agency, while legs represent independence and self-reliance. Probably these areas of functioning are a source of satisfaction for the woman and may have a connection with the experience of unpredictability and lack of control in the family of origin in connection with the addicted parent. It is worth mentioning that in quantitative empirical research distinct results have been obtained. These results indicate that women being an ACA (Adult Child of Alcoholic), in comparison to the control group, are less satisfied with their hands and feet [cf. 57].

In the study of the body image with the use of a questionnaire, Mrs J.'s own satisfaction of the areas related to her sexuality, including those, which are defined as attractive to men, was rated as very low. She was also negative about the strength and fitness of her body, revealing at the same time reduced commitment to being fit. She presented herself as a person strongly dissatisfied with her appearance, assigning a significant value to it and excessively engaged in activities associated with it. On the basis of the results obtained by Mrs J., it can also be concluded that it is accompanied by a feeling of being weak in terms of body health and a reduced degree of the effort made in taking care of her own health.

This information implies that Mrs J. experiences her body in a negative way – as an "anguish" due to the strong dissatisfaction with her weight and size of her breast, and as a tool to avoid and release unpleasant feelings (with excess food at present and psychoactive substances and self-inflicted injuries in the past.)

## Discussion

Analysing how Mrs J.'s family relationships could have influenced the way she perceived her own body, some connections appeared which need to be explained and interpreted.

Firstly, it is worth pointing out that the specificity of the functioning of Mrs J.'s family with an alcohol problem did probably not remain without influence on her self-image, her body image and Mrs J.'s functioning. As it has been written by Pasternak and Schier [57] "alcoholism of a parent remains permanent traces in the body image of Adult Children of Alcoholic and records somehow their traumatic experiences in their body" [57, p. 300]. In the light of empirical research, women risen up in families with an alcoholic problem have a negative image in many respects, especially in sexuality, attitudes towards their own femininity or body acceptance [52, 58]. What is more, a negative body image is related to experiencing fear and general discomfort in social situations [52], which was visible also in the case of Mrs J.

Referring to the manifestations of attitudes towards Mrs J.'s own body, it is worth taking a look at overeating, which has led Mrs J. to obesity since childhood. In the related literature, it has been indicated that high BMI is a relevant factor of body dissatisfaction [22].

Simultaneously, obesity is a sign of difficulties in psychical functioning. Overeating, which leads to obesity, is a gratification for long-term emotional pressure and frustration with the existing in conditions that are difficult to accept [59]. It also constitutes an expression of increased difficulties in emotion regulation which are characterized by inadequacy among ACA women and – as it is seen by Lelek and Bętkowska-Korpała [58, p. 8] – “it can take the form of avoidance of thinking about one’s own physicality or taking up activities like exercises, diet, over-concentration on one’s own body and beauty treatments which lead to visual enhancement”. Mrs J.’s family situation, because of her father’s alcohol addiction, his violence and her mother’s overprotectiveness with emotional unavailability at the same time, may be related to Mrs J.’s emotional discomfort. Food, which has been associated with something good (irresistible) and reducing unpleasant sensations, provided for a sense of security and peace, as it seems, mainly due to the contacts with the patient’s grandmother (it is the relationship with her in which Mrs J. got fattened). It also seems that the denial of food, understood as an expression of independence and distinctness, was seen as cumbersome and reconciling in the needs of others (here: the grandmother). Mrs J. had to unknowingly maintain this relationship that was important for her. Reaching out for food also now in adulthood is a manifestation of so-called emotional binge-eating [60] and is a strategy of dealing with negative affection. The body serves to release emotional tension.

How to understand, in turn, the dissatisfaction with the breast size? In cultural history, breasts have been attributed to a variety of meanings: sacred, erotic and political [cf. 61]. Above all, however, they are associated with the ability to feed children and are a sexual asset, enabling a woman to seduce men and take advantage of sexual pleasure. These two aspects: the relationship to motherhood and to her own sexuality and femininity seems to be of key importance to Mrs J. At the beginning of her maternity, she was anxious about her son and his condition, which could have raised ambivalent feelings towards parenthood. It is significant to notice that Mrs J.’s mother has probably also experienced uncertainty in the relationships with her children, hence her control and excessive concern. Although it is difficult to extrapolate the nature of the current relationship of Mrs J. with her son based on the obtained information, it should be taken into account that she might be repeating her mother’s behaviour not being aware of it, based on intergenerational transmission of motherhood patterns.

Motherhood is also intrinsically associated with breastfeeding. It has a number of psychological functions. According to Kościelska [62, pp. 94–95] “breastfeeding is a form of giving oneself and is an expression of mental readiness to share oneself with others. It also means acceptance of one’s body as good and capable of producing good food. In addition, it expresses acceptance of one’s sexuality and capability of intimate closeness. Finally, breastfeeding is tantamount to recognition of oneself as a part of nature”. In the relationship with her son, Mrs J. experienced breastfeeding failure, which may be associated with strong negative emotions she held towards her breasts. As a result, they could not give good food.

In the context of breastfeeding, it is worth to refer to Mrs J.’s overweight. Although it results from excessive snacking and reduced emotion regulation capacity, it can also be a kind of insatiability and starvation, most likely gained from the relationship with her mother, which has then been transferred to her own child (hence perhaps the difficulty in feeding her son) [62]. This deficiency seems to be an insufficient emotional adjustment hindering the conversion of somatic communication to verbal communication and perhaps resulting from the mother’s

preoccupation with family problems. It is possible that due to this mechanism, Mrs J. has difficulties in obtaining access to her own feelings, accepting them and dealing with them in a more adaptive and less disturbing way.

Mrs J.'s sexuality and femininity seem to be experienced in a negative way as sacrifice and a job to serve. She defers to her husband's sexual needs without taking into account her own necessities. It is hard not to be struck by the fact that Mrs J. identifies with her mother in respect of care for her appearance, which she treats as a task. Here, the mother seems to be a model of how to treat herself and her body: sacrificing herself (*i.e.* remaining in relationship with her husband who is abusing alcohol, him being violent and all the difficulties of raising three children in these conditions) and presenting at the same time an impeccable appearance, which is a mask and a denial of the experienced difficulties. Being in a relationship with her mother functioning this way, it was difficult to internalise her caring functions (which can be understood as deficit). This resulted in at least a partial block of the ability to self-care in Mrs J., which caused her poor orientation to her own health, as well as direct and indirect self-harming behaviour during adolescence and later [54, 55].

The quality of the relationship with the father also seems to be to some extent reflected in Mrs J.'s attitude to her body. By identifying with her father's hostility, who applied physical punishment and distanced himself emotionally, and due to his negative attitude to his own body (alcohol, in fact, destroys it), Mrs J. has learned to treat her body with hostility: as a teenager, she experimented with it (also probably due to the awakening sexuality, for which there might not have been consent in the family and in the context of the progressive separation process), while nowadays, she brings it to excessive weight and neglects preventive care, unconsciously provoking dissatisfaction with it.

Finally, negative comments on Mrs J.'s body in her childhood in the family and among her peers should be mentioned, as in the light of scientific literature, this is a risk factor of dissatisfaction with the body and excessive focus on appearance [63–65].

### **Limitations**

The research is not without limitations. One of them is the author's subjective perspective in the interpretation of the conversation content and judgement of the research results. The usage of projective methods can also arouse some doubts. Their scientific status has been discussed for a long time, nevertheless, these methods have been effectively used in clinical practice. Despite different methods, they provide information on the psychical functioning of the subject. In this research, projective techniques are not the only source of information about the internal world of the subject and their interpretation was based on formalised categories of interpretation. Moreover, projective methods have been supported by questionnaires and have been analysed by different, experienced specialists. Anyway, they should be used with caution, what was tried to keep. It is worth mentioning that in a qualitative case study, the reliability of the implemented questionnaires may differ as compared to quantitative research. Despite the fact that the majority of the used tools are being applied in clinical use (*e.g.* the Family Assessment Scale to work with families in order to analyse progress in therapy), it is necessary to keep caution as well. Another limitation is the inability to make a broader generalization of the research results.

## Conclusions

To sum up, it can be assumed that the presented case study reflects the complexity of family dynamics and the intrapsychic mechanisms which lead to the emergence of a specified representation of one's own body. However, it does not exhaust the topic not only in terms of the highlighted mechanism but also in the possible interpretation of displays of psychical functioning. As it was tried to present, "traces" of experiences acquired from the family of origin can be found in the body image. The hypothesis of the relationship between the body image and functioning of the family of origin and the quality of the relationship with parents was confirmed. The hypothesis that a serious dysfunctionality of the family is related to the assessment of the body was also positively verified. Due to the idiographic character of this research and its limitations, conclusions cannot be referred to the population of women dissatisfied with their bodies. Nevertheless, the presented observations may provide a starting point for further empirical search on family determinants of the body image of young women and contribute to the consideration of the family perspective in psychotherapeutic interventions targeting women who report problematic attitudes towards their bodies. The analysis of parents' representations, maladaptive family transfers connected with carnality and attitudes towards the body in a family can be useful.

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E-mail address: akobierecka@op.pl